Procedures and Treatments

1. Biofeedback;

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. Rehabilitation services and Manipulative/Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. Speech therapy to treat stuttering, stammering, or other articulation disorders;

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details;*

6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty;

8. Psychosurgery (lobotomy);

9. Treatment of tobacco dependency, excluding screenings and counseling;

10. Chelation therapy, except to treat heavy metal poisoning;

11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details,* are satisfied;.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis);

15. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

16. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

17. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

6. Services and supplies provided at Cancer Treatment Centers of America are not covered under the Plan.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus;
3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
4. The reversal of voluntary sterilization;
5. The reversal of tubal ligation or vasectomy.
6. In vitro fertilization regardless of the reason for treatment;
7. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
8. 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);
9. Services provided by a doula (labor aide);
10. 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.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services;

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details.* Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details.*

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 12, *Glossary;*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services;

5. Private Duty Nursing received on an inpatient basis;

4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details;*

5. Rest cures;

8. Services of personal care attendants; and

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants);

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses;

3 Eye exercise or vision therapy;

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

5. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse;

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes;

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
   - That exceed Eligible Expenses or any specified limitation in this Benefit Booklet.
   - For which a non-Network provider waives the Copayment, 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;

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization;

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

11. Health services and supplies that do not meet the definition of a Covered Health Service as defined in Section 12, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Benefit Booklet under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights*.
    - Not otherwise excluded in this Benefit Booklet under this Section 7, *Exclusions and Limitations*.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible, Coinsurance or Copay, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay 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 Retiree.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits.*

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where

Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- the specific reason or reasons for the denial;
- 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 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 adverse benefit determination and any time limits for filing such a civil action;
- 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; and
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims.

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 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 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 claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

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:

- the specific reason or reasons for the adverse determination of your appeal;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination and any time limits for filing such a civil action and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request; and
- 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.

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: 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 legal action.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required

UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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 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 appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9- COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term "allowable expense" is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee or retiree pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Only expenses normally paid by the Plan will be paid under COB
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Retiree under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan may pay an additional amount.

You will be responsible for any Deductible, Coinsurance or Copay payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If this Plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- individuals with end-stage renal disease, for a limited period of time;
- participants not actively working and receiving long-term disability benefits for up to six months;

After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare.

If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This cross-over process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of

applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare

makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representatives shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name, or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been contributed to or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not

have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays and Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the

service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 12 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible, and Benefits for which you must pay a Copay. 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 Retirees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations.*

Covered Person – the Retiree or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6, *Clinical Programs and Services*, "Covered Person" means all domestic Retired Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or

- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider – a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works.*

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – an individual who meets the eligibility requirements described in the General Information Booklet.

Employer - Duke Energy Corporation.

EOB - see Explanation of Benefits (EOB).

ERISA – the Employee Retirement Income Security Act of 1974 (ERISA), the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.

- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions and Limitations.*

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights,* and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights,* and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay for Covered Health Services every calendar year. Refer to Section 4, *Plan Highlights,* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Catastrophic Option under the Duke Energy Retiree Medical Plan and/or the Duke Energy Retiree Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retiree – a former employee of the Company who is eligible for benefits under the Plan as described in the General Information Booklet.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-

Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through 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.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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ATTACHMENT I - NOTICES

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና ሀን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل اي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန် သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮚ ÞP ᏗCZᏢᏗ Ꮧ4ᏍᏗ ᏥA&W ᏛᏓ GᏤP ΛᏫ ÞR ᏗJAΛᏗ ACᏍΛᏗ ᏆΘᏲᏍᏗT, ᏧᏏᏬᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono'ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kākī ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 [illegible] TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा नि:शुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wɛ̈rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveţi dreptul de a obţine gratuit ajutor şi informaţii în limba dumneavoastră. Pentru a cere un interpret, sunaţi la numărul de telefon gratuit care se găseşte pe cardul dumneavoastră de sănătate, apăsaţi pe tasta 0. TTY 711

Language	Translated Taglines
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܚܢܘܢ ܐܝܬܠܘܟܘܢ ܙܕܩܐ ܕܦܠܚܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܬܚܢܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܡܬܦܫܩܢܐ ܩܪܘ ܠܡܢܝܢܐ ܕܛܠܦܘܢ ܕܟܬܝܒܐ ܥܠ ܦܬܩܐ ܕܝܠܘܟܘܢ ܕܒܛܐ ܐܝܟ ܦܠܓܐ ܕܚܘܠܡܢܐ ܘܕܘܫ TTY 711. 0
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láìsanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

Prescription Drug Program Guide for the Duke Energy Retiree Medical Plan

2018

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SECTION 1 – WELCOME

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

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

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

CVS Caremark will help protect your privacy as follows:

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

SECTION 2 – HOW THE PROGRAM WORKS

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

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay the applicable prescription drug co-pay or coinsurance amount.

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

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. Under CVS Caremark's Maintenance Choice program, if you are taking a long-term medication, you must choose to receive 90-day supplies through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you. Whether you choose delivery or pick-up, you will pay the same applicable co-pay or coinsurance amount.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply co-pay or coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS

retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

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

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

Process for Mail Order Medications
There are several methods you may use to fill your newly prescribed long-term medications through the CVS Caremark Mail Service Pharmacy.

- **Option 1**: Ask your doctor to select the CVS Caremark Mail Service Pharmacy using their provider ePrescribing tools, or your physician may call 800.378.5697.

- **Option 2**: Use the CVS Caremark mobile app for your smart phone to photograph your prescription order and submit the new prescription electronically to the CVS Caremark Mail Service Pharmacy.

- **Option 3**: Get started using the CVS Caremark Mail Service Pharmacy with FastStart®. Log on to www.caremark.com/faststart to provide the requested information, and CVS Caremark will contact your doctor for the 90-day prescription you need. You also can call FastStart® toll-free at 800.875.0867 for assistance.

- **Option 4**: Alternatively, you can complete the mail order form, which is available at www.Caremark.com, and send it with your new prescription order and payment method for any applicable copayment to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service for the first time, you then have the option to use the automated refill service for future refills by CVS Caremark. Visit www.Caremark.com for more information on the Auto Refill process.

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

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

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.

- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

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

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (100% covered with no co-pay or coinsurance)
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes 100% covered with no co-pay or coinsurance)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% covered after standard co-pay, if applicable, up to $2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime, 100% covered with no co-pay or coinsurance)
- Anti-obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

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

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)

- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Retiree Dental Plan)

Medical Plan Annual Deductibles and Out-of-Pocket Maximums

Except as otherwise noted below for the Medical Plan's Catastrophic option, the prescription drug program co-pays and coinsurance amounts are not subject to or applied toward your Medical Plan annual deductibles or ***medical*** out-of-pocket maximums, if applicable. This means that the prescription drug program under the Medical Plan provides applicable benefits for covered prescription drug expenses even before you satisfy your annual deductible, if applicable.

Except as otherwise noted below for the Medical Plan's Catastrophic option, the prescription drug program co-pays and coinsurance amounts are applied toward your Medical Plan annual ***prescription drug*** out-of-pocket maximums, if applicable. This means that once you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums, you do not have to pay any further co-pays or coinsurance amounts for covered prescription drugs. Please note that the Medical Plan has separate annual ***medical*** out-of-pocket maximums. If you satisfy the Medical Plan's separate annual ***medical*** out-of-pocket maximums, but have not yet satisfied your applicable annual ***prescription drug*** out-of-pocket maximums, you still have to pay any applicable co-pay or coinsurance amount for covered prescription drugs until you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums.

Catastrophic Option

Under the Medical Plan's Catastrophic option, prescription drug program co-pays and coinsurance amounts do apply toward your Medical Plan annual deductibles, if applicable.

In addition, the prescription drug program co-pays and coinsurance amounts also are applied toward your Medical Plan's applicable annual out-of-pocket maximums. For the Medical Plan's Catastrophic option, the annual prescription drug and annual medical deductible and out-of-pocket maximums are combined. This means that once you satisfy your applicable annual out-of-pocket maximums, you do not have to pay any further co-pays or coinsurance amounts for covered prescription drugs or medical expenses.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

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

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

Refer to the prescription drug benefit summary on page 19 for more information about applicable co-pays and/or coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Certain Contraceptive Medications Covered at 100%

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

- Generic contraceptive medications; and
- Brand contraceptive medications where there is no generic available.

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

Certain Routine Vaccines Covered at 100%

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

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)
- Influenza (Fluzone)

- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

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

CVS Caremark Specialty Medications and Specialty Guideline Management

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

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

- clinically appropriate;
- safe; and
- effective for the patient throughout the duration of therapy.

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

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

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

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also

require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

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

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

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

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

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

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

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

Maximum Drug Limitation Program

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

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

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

Prior Authorization

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

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

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

Drug Utilization Reviews

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

SECTION 5 – COORDINATION OF BENEFITS

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

Please Note: CVS Caremark does coordinate benefits for Medicare Part B coverage for participants with that coverage. Please see the section titled "Medicare Part B Medications" below for more details.

Medicare Part B Medications

(Applicable only to Medicare Part B enrollees)

If you have Medicare Part B coverage, you will be able to fill prescriptions as described below:

Take your prescription to a Medicare Part B retail pharmacy. If you choose to use a Medicare Part B retail pharmacy for your Medicare Part B medication or supply needs, you will be asked to present your Medicare ID card.

- The participating Medicare Part B retail pharmacy will work with you to bill Medicare on your behalf.
- Most independent pharmacies and national chains are Medicare Part B providers. If you want to locate a retail pharmacy that is a Medicare Part B provider, visit the Medicare website at **www.medicare.gov**.

Medicare Part B allows only 30 days worth of medication except for Diabetic Supplies. For Diabetic Supplies, you can receive up to a 90-day supply; however, you can only test up to 3 times a day. If you test more than 3 times a day, you will need to provide further documentation as to why it is necessary for you to test so often. Further documentation can include the results of blood tests conducted by your physician's office.

All prescriptions must be in writing; CVS Caremark cannot take a verbal prescription over the phone. However, CVS Caremark can accept a faxed copy.

Call CVS Caremark at 888-797-8912 to find out what types of drugs or supplies are covered by Medicare Part B.

CVS Caremark needs to have an original Assignment of Benefits (AOB) form filled out before your Medicare Part B prescriptions can be filled at mail order. If the AOB form is not filled out,

CVS Caremark will divert those prescriptions and make an outbound call to obtain a copy of the AOB form. An AOB form will also be included in each order; however, you only have to fill out an original once each year. To obtain an AOB form, call CVS Caremark Customer Service at 888-797-8912.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

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

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

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2018, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2019 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable co-pay or coinsurance amount, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2018 would have 45 days (until February 14, 2018) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

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

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

Reviews & Appeals

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

Review Timing for Post-Service Claims

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

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

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

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

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

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

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

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

Review Timing for Urgent Care Claims

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

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

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

Notice of Adverse Determination

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

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

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's review procedures, 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 adverse benefit determination on appeal and any time limits for filing such a civil action;
- 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; and
- 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.

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.

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:

- 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 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 adverse benefit determination and any applicable time limits for bringing such a civil action;
- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge; and
- 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.

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."

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 claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to 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 benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable co-pays, coinsurance and plan limits, please call CVS Caremark Customer Service or visit **www.Caremark.com**. For more detailed information on the Medical Plan, refer to the Duke Energy Retiree 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:
Certain contraceptive medications and routine vaccines	**$0**	**$0**
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	Lower of **$10** or the cost of the medication*	Lower of **$25** or the cost of the medication*
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	**25%** of the cost of the medication up to a maximum of **$50***	**25%** of the cost of the medication up to a maximum of **$125***
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	**50%** of the cost of the medication up to a maximum of **$100***	**50%** of the cost of the medication up to a maximum of **$250***
***Out-of-Pocket Maximum** The out-of-pocket maximum is a combined medical and prescription drug out-of-pocket maximum.	$5,900 per year for individual coverage/$17,700 per year for family coverage	

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

Retiree Medical Plan

Health Savings Plan 1 option

January 2018

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

Duke Energy Retiree Medical Plan General Information

(Pre-65 Retirees)

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Retiree Medical Plan ("Medical Plan") provides information that is applicable to all Medical Plan coverage options available to retirees who are not yet age 65 and their eligible dependents who are not yet age 65. This booklet addresses eligibility for coverage under the Medical Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered dependents may be able to continue coverage if it ends. It also contains information such as who provides coverage, who administers the Medical Plan, who decides claims for benefits, ERISA rights and Duke Energy Corporation's right to amend or terminate the Medical Plan.

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

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

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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 and disease management benefits.

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

Duke Energy myHR™ Service Center

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

Eligibility

Eligible Retirees

If your employment terminates on or after January 1, 2018, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must be:

- employed by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the "Company," as applicable) offering access to retiree coverage under the Medical Plan;
- at least age 50 and credited with at least 5 years of retiree eligibility service; and
- under age 65.

Note: You are not eligible for coverage under the Medical Plan if you are a current employee of Duke Energy or its affiliates. If you are a current employee of Duke Energy or its affiliates and eligible for coverage, you must enroll in the Duke Energy Active Medical Plan for medical coverage, even if you are a rehired retiree or an under age 65 eligible dependent of another Company retiree who might otherwise be eligible for coverage under the Medical Plan if you weren't a current employee of Duke Energy or its affiliates.

You also are not eligible for coverage under the Medical Plan, if you are a Legacy Piedmont Employee[1] hired prior to January 1, 2008 (prior to January 1, 2009, if you are a Legacy Piedmont Employee covered under the Nashville bargaining unit contract).

[1] When used in this booklet, the term "Legacy Piedmont Employee" refers to an individual who (1) was employed by Piedmont Natural Gas Company Inc. and its subsidiaries (collectively, "Piedmont") immediately prior to the acquisition of Piedmont by Duke Energy Corporation effective on October 3, 2016 or (2) was hired by Piedmont following such acquisition but prior to 2018.

Other Retiree Eligibility Information

If your employment with Duke Energy and its affiliates terminated before January 1, 2018, your eligibility for retiree coverage is governed by the eligibility rules in effect at that time.

If you enroll for coverage for yourself, you may be able to elect coverage under the Medical Plan for your eligible spouse/domestic partner and/or child(ren) who are under age 65. Please refer to the sections *Enrolling in the Medical Plan* and *Mid-Year Changes* for additional information. Your eligible spouse/domestic partner and/or child(ren) who are age 65 or older may be able to elect individual medical and prescription drug coverage through a Medicare exchange available to eligible retirees who are age 65 or older. Additional information about the individual medical and prescription drug coverage available through the Medicare exchange will be provided to your eligible spouse/domestic partner and/or child(ren) when they reach age 65.

Duke Energy Corporation reserves the right to amend, modify or terminate retiree coverage offered under the Medical Plan at any time, including termination of eligibility.

Eligible Dependents

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

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

In order to be eligible for coverage under the Medical Plan, your eligible dependent must be under age 65. Under age 65 eligible dependents of eligible retirees who are age 65 or older are eligible for coverage under the Medical Plan. Your eligible dependents age 65 or older are eligible for individual medical and prescription drug coverage through a Medicare exchange. Additional information about the individual medical and prescription drug coverage available through the Medicare exchange will be provided to your eligible dependent(s) when they reach age 65.

Spouse Eligibility

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

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

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

You must immediately report any spouse who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your spouse's loss of eligibility is not reported

within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible spouse, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your spouse after your spouse ceases to be eligible will be considered a misrepresentation of your spouse's eligibility.

Domestic Partner Eligibility

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

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

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

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

Child Eligibility

Your child is:

- your biological child, up to age 26; **or**
- your legally adopted child, including a child placed in your home for legal adoption by you as long as the child remains in your home and the adoption procedure has not been terminated, and whether or not the adoption has become final, up to age 26; **or**
- your stepchild, up to age 26; **or**
- your foster child, up to age 26; **or**
- your domestic partner's biological child, legally adopted child (including a child placed in your home for legal adoption by your domestic partner as long as the child remains in your home and the adoption procedure has not been terminated, whether or not the

adoption has become final), stepchild or foster child, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**

- any other child for whom you, your spouse or your domestic partner has legal guardianship, full or joint legal custody or managing conservatorship under a valid court decree, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26.

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

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

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

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

Surviving Spouse, Domestic Partner and Child Eligibility

If you die while you and your spouse/domestic partner are covered under the Medical Plan, your surviving spouse/domestic partner may continue Medical Plan coverage by making contribution payment arrangements with the Duke Energy myHR Service Center. This coverage can be continued until the earliest of your spouse's remarriage, your domestic partner's establishment of a new domestic partner relationship, your spouse's/domestic partner's attainment of age 65, the death of your spouse/domestic partner and the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan).

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

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

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

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage. If coverage under the Medical Plan is declined or ends, your covered dependents may be eligible for continued coverage under COBRA for up to 36 months in certain situations.

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

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

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Medical Plan at the time of your death.

Employee and Retiree Couples

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

Verification of Dependent Status

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

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

If a Dependent Becomes Ineligible

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

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

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

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

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;
- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and
- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

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

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

Enrolling in the Medical Plan

When You Become Eligible

If you are an eligible retiree as described in the *Eligible Retirees* section above, you may elect retiree coverage under the Medical Plan when you retire. When your employment terminates, if you are an eligible retiree, you can choose to:

- begin Medical Plan coverage immediately or at a later date; or
- decline Medical Plan coverage.

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

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

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

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

By making your coverage election when you are first eligible, you are affirmatively representing that all information provided during enrollment including, but not limited to, the eligibility of any dependents for coverage, is true and correct. If Duke Energy discovers that any information you provide during enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of information, up to and including termination of Medical Plan coverage, and to take other appropriate action.

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

At a Later Date

If you are an eligible retiree and you do not immediately begin retiree coverage under the Medical Plan at your termination of employment, or if you subsequently discontinue your retiree coverage, you can elect to enroll during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

For example, if you are an eligible retiree covered as a dependent of a spouse enrolled as an active employee under the Duke Energy Active Medical Plan, you may elect retiree coverage under the Medical Plan during a future annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

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

During Annual Enrollment

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

By making (or not changing, as applicable) your coverage election during annual enrollment, you are affirmatively representing that all information provided during annual enrollment, including, but not limited to, the eligibility of any dependents for coverage, is true and correct. If Duke Energy discovers that any information you provide during annual enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of information, up to and including termination of Medical Plan coverage, and to take other appropriate action.

If You Are Rehired

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

Cost of Coverage

The cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option you elect and the eligible dependent(s) you choose to cover. The portion of the cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your termination, but remains subject to Duke Energy Corporation's right to amend, modify or terminate the Medical Plan, including termination of eligibility for Company contributions toward the cost of retiree medical coverage.

If you are eligible for a Company contribution toward the cost of retiree medical coverage, the Company contribution may be provided either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits, depending on your retiree group. If you have questions about your retiree group or the form of any subsidized monthly coverage for which you may be eligible, contact the Duke Energy myHR Service Center.

Information about contribution amounts is available through the YBR website.

Eligibility for Company Contributions toward the Cost of Retiree Medical Coverage

If your employment with Duke Energy and its affiliates ends on or after January 1, 2018 and you satisfy the eligibility criteria specified for your employment classification in the chart below, you may be eligible for a Company contribution toward the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements.

If your employment with Duke Energy and its affiliates ends on or after January 1, 2018 and you do not satisfy the eligibility criteria specified for your employment classification in the chart below or you do not satisfy all applicable requirements when your employment with Duke Energy and its affiliates ends, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and you will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan.

If your employment with Duke Energy and its affiliates ended before January 1, 2018, your eligibility for a Company contribution toward the cost of retiree medical coverage is governed by the eligibility rules in effect at that time.

EMPLOYMENT CLASSIFICATION	ELIGIBILITY CRITERIA
All Duke Energy Employees[2] except for Duke Energy Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA, IBEW SCU-8, IBEW 1902 and PPF 702	Hired before January 1, 2009*
All Legacy Progress Energy Employees[3], except for Legacy Progress Energy Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA, IBEW SCU-8, IBEW 1902 and PPF 702	Hired or rehired before January 1, 2002 and you either were at least age 40 or completed at least 5 years of retiree eligibility service by December 31, 2001
All Legacy Piedmont Employees, except for Legacy Piedmont Employees hired prior to January 1, 2008 (prior to January 1, 2009 for Legacy Piedmont Employees covered under the Nashville bargaining unit contract), except for Legacy Piedmont Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA and IBEW SCU-8	Hired before January 1, 2018*

[2]When used in this booklet, the term "Duke Energy Employee" refers to an individual who satisfies either of the following requirements:

- the individual (1) was employed by Duke Energy or its affiliates immediately prior to the merger of Duke Energy Corporation and Progress Energy, Inc. on July 2, 2012, (2) was hired following such merger but prior to January 1, 2014 by Duke Energy or a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy immediately prior to such merger or (3) was hired on or after January 1, 2014 by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan; or
- the individual (1) was employed by Duke Energy or its affiliates immediately prior to the acquisition of Piedmont Natural Gas Company Inc. and its subsidiaries (collectively, "Piedmont") by Duke Energy effective on October 3, 2016, (2) was hired following such acquisition but prior to 2018 by Duke Energy or a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy immediately prior to such acquisition or (3) was hired on or after January 1, 2018 by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan.

[3]When used in this booklet, the term "Legacy Progress Energy Employee" refers to an individual who (1) was employed by Progress Energy, Inc., Duke Energy Progress, Inc. f/k/a Progress Energy Carolinas, Inc., Duke Energy Florida, Inc. f/k/a Progress Energy Florida, Inc. and/or Progress Energy Service Company, LLC (collectively, "Progress Energy") immediately prior to the merger of Duke Energy Corporation and Progress Energy, Inc. on July 2, 2012 or (2) was hired by Progress Energy following such merger but prior to January 1, 2014.

Employees represented by IBEW 1347	Hired before January 1, 2010*
Employees represented by IBEW 1393	Hired before January 1, 2011*
Employees represented by USW 12049 & USW 5541-06	Hired before January 1, 2012*
Employees represented by UWUA	Hired before January 1, 2013*
Employees represented by IBEW SCU-8	Hired or rehired before January 1, 2009

**If you are an eligible retiree and you are rehired on or after the applicable date specified for your employment classification in the chart above you are eligible for access to retiree coverage under the Medical Plan. When you subsequently terminate your employment with Duke Energy and its affiliates, you may be eligible for a Company contribution toward the cost of retiree medical coverage only if, upon your previous termination of employment, you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of such termination of employment. If you did not satisfy the eligibility requirements in effect at the time of your previous termination, you will be treated as a new hire and will be responsible for paying the full cost of any retiree coverage you elect.*

Paying for Coverage as a Retiree

Initially, you will be billed directly for the monthly contribution for your medical coverage. There are several different options available to you for making payment, which are listed below.

- If you are billed directly each month, you will receive a statement that explains how to make your payments, when they are due and where they need to be sent.
- Rather than receiving a monthly bill, you may set up an automatic withdrawal from your checking or savings account for monthly contribution payments. If you choose this option, a *Direct Debit Authorization* must be completed and returned to the Duke Energy myHR Service Center.
- If you are receiving annuity payments under a Company-sponsored pension plan, you may elect to have your contributions deducted from your monthly pension check by contacting the Duke Energy myHR Service Center. However, if the amount of your contributions is or becomes greater than the amount of your pension annuity payment, you will be switched to a monthly billing arrangement.

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

If you elect coverage for a domestic partner and you are receiving a Company contribution toward the cost of retiree medical coverage in the form of subsidized monthly coverage, the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner is considered taxable (or imputed) income to you. This imputed income will be reported as income on a Form W-2 and will be subject to federal and state income tax (if applicable) as well as FICA and FUTA taxes. Please note that the Company does not provide tax advice, and you should consult with your tax advisor for information about the tax consequences of electing coverage for a domestic partner.

The Company is obligated to collect the applicable taxes on the imputed income created by the election of benefits for a domestic partner. Therefore, in addition to reporting the imputed income on your Form W-2, you will be billed for the amount of this tax liability. If you do not pay the bills for the tax liability in a timely manner, you may be subject to termination of any benefit coverage you elected for your domestic partner.

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

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

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

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

Any amounts owed in arrears at the time of a death or coverage change will continue to be billed and must be paid.

When Coverage and Contributions Begin

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

When you make your coverage elections during annual enrollment, coverage begins on January 1 of the following calendar year. Payments for your coverage begin as soon as administratively practicable following January 1 of the following calendar year.

Mid-Year Changes

Enrolling in Coverage Mid-Year

Once you have made your Medical Plan election for the year, you may not change your election during that year to enroll in coverage for yourself and/or your eligible dependents unless you have a work or life event for which a mid-year enrollment change is permitted and the work or life event results in the gain of eligibility for coverage. Specific information about these "work/life" events and allowable mid-year enrollment changes is available by calling the Duke Energy myHR Service Center. A "mid-year enrollment change" refers to any change made to

your coverage during a calendar year due to a work or life event that results in the gain of eligibility for coverage.

If you experience a work/life event for which mid-year enrollment changes are allowed, you have 31 calendar days from the date of the event (for example, your marriage date) to change your election. Otherwise, unless a subsequent work/life event which would allow you to enroll yourself and/or your eligible dependents in coverage occurs, you cannot elect to enroll yourself and/or your eligible dependents in Medical Plan coverage until annual enrollment.

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

Below is a list of some work/life events for which you may enroll yourself and/or your eligible dependents mid-year:

- You get married
- Your domestic partner becomes eligible for coverage
- The number of your eligible children changes
  - you have, or adopt, a child
  - you become the legal guardian of a child
  - a Qualified Medical Child Support Order (QMCSO) is received[4]
- Your dependent's benefit coverage changes because:
  - he or she loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
  - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You or your dependent loses Medicare or Medicaid
- You or your dependent loses coverage under a group health plan
- There is a significant increase in the cost of coverage under the employer plan in which your dependent participates
- Your period of temporary employment with the Company ends

Dropping Coverage Mid-Year

Once you have made your Medical Plan election for the year, you may elect to drop coverage for yourself and/or one or more covered dependents at any time, even if you do not experience a work/life event. An election to drop coverage for yourself and/or your covered dependents will be effective on a prospective basis only.

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

When Your Dependent Is No Longer Eligible

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

When You Enroll a Dependent Mid-Year

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

When Mid-Year Coverage and Contribution Changes Are Effective

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

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

individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

When You Reach Age 65

When you and your spouse or other dependent reach age 65, you and your spouse or other dependent will be able to purchase individual medical and prescription drug coverage through a Medicare exchange if you choose. The Medical Plan options available to retirees and their spouses and other dependents who have not yet reached age 65 are not available to retirees and their spouses and other dependents who are age 65 or older.

Once you and your spouse or other dependent reach age 65, you will receive additional information that describes your individual health plan choices, coverage costs and how to enroll in individual coverage for yourself and your eligible spouse/dependent.

If You Become Entitled to Medicare Before Age 65

If you become entitled to Medicare before age 65 due to disability or end stage renal disease, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare before age 65.

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

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

Termination of Coverage

When Coverage Ends

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

- the last day of the month prior to the month in which you reach age 65;

- the date that you are rehired as an active employee of Duke Energy or its affiliates (e.g., as a regular, fixed-term or temporary employee);
- the last day of the month in which you cease to be an eligible retiree or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, on the last day of the month prior to the month in which the dependent reaches age 65 or on the last day of the month in which the dependent otherwise loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms must be completed and received within 60 days of the event or notification, whichever is later.

If You Become Divorced or Your Domestic Partner Relationship Ends

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

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

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

COBRA Continuation Coverage

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

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

Continued Coverage for Your Dependents

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

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

Bankruptcy Proceeding

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

Procedures to Obtain Continued Coverage

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

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

- you become divorced;
- your domestic partner relationship ends; or
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan.

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

For other qualifying events, such as your death, it is the Company's responsibility to notify the COBRA administrator.

Election Period

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

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

Type of Coverage

If continued coverage is elected, the medical coverage will initially be the same coverage as was in effect on the day before the qualifying event. During the COBRA continuation period, any changes to the medical coverage of similarly situated retirees also will apply to the medical coverage elected as a COBRA qualified beneficiary. In addition, if the COBRA continuation period extends into a future plan year, the Medical Plan COBRA election may be changed for the following plan year during annual enrollment to the same extent that Medical Plan elections can be changed by other similarly situated retirees for the following plan year during annual enrollment.

Cost

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

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

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

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

Conversion Privilege

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

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

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

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

Your Role

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

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

You must notify the applicable Claims Administrator if a provider:

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

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

Other Important Information

Plan Sponsor

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

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

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Retiree Health & Welfare Benefit (Financed) Plans, plan number 503.

Funding

The following funding vehicles are, or may be, used to accumulate assets from which Medical Plan claims may be paid: (i) Section 401(h) medical account under the Duke Energy Retirement Cash Balance Plan, (ii) Section 401(h) medical account under the Duke Energy Legacy Pension Plan, (iii) Duke Energy Corporation Welfare Benefits Trust VEBA I, (iv) Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II, (v) Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Non-Bargaining Employees and/or (vi) Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Bargaining Unit Employees. Duke Energy also may provide benefits under the Medical Plan from its general assets.

The trustee for the Section 401(h) medical accounts is:

Duke Energy Corporation Master Retirement Trust
The Northern Trust Company, Trustee
50 South LaSalle Street
Chicago, IL 60675

The trustee for the VEBAs is:

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

The trustee for the Piedmont 501(c)(9) Trusts is:

Wells Fargo Institutional Retirement and Trust
1525 West W.T. Harris Blvd., 3C5
Charlotte, NC 28262-8522

Plan Administrator

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

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

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

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

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

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

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

Investment Committee

The named fiduciary for the maintenance and investment of the plan assets that are held in the Duke Energy Corporation Welfare Benefits Trust VEBA I, the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II, the Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Non-Bargaining Employees, the Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Bargaining Unit Employees and the 401(h) medical accounts under the Duke Energy Corporation Master Retirement Trust is the Duke Energy Investment Committee. The Board of Directors of Duke Energy Corporation appointed the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee. Any successor Chairman

of the Investment Committee is appointed by the Finance and Risk Management Committee of the Board of Directors of Duke Energy Corporation.

The Investment Committee may be contacted through the following address:

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

Plan Year

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

Service of Legal Process

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

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

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

Affiliated Employers of the Company That Have Adopted the Medical Plan

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

Claim Determination Procedures

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

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

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or

coverage option due to disputes regarding the cost of your Medical Plan coverage or (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity.

Claims for Medical Plan Benefits

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

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

Eligibility or Enrollment Claims

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

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

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

Initial Claim

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

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

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

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

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

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

Adverse Determination

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

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

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request; and
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to

the Claims Committee within 180 calendar days after receipt of the adverse determination. If your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

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

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

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

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

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

Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

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

Legal Action

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

Discretionary Authority

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

Right to Change or Terminate the Medical Plan

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

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

In the event of a complete termination of the Medical Plan, eligible claims for Medical Plan benefits will be paid by the Duke Energy Corporation Welfare Benefits Trust VEBA I, the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II and/or the Duke Energy Corporation Master Retirement Trust – 401(h) Account, as applicable, to the extent that funds are available.

Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

Keep Us Informed

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

A Final Note

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

documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

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Benefit Booklet

Duke Energy Retiree Medical Plan
Health Savings Plan 1 Option

Effective: January 1, 2018
Group Number: 729784

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SECTION 1 - WELCOME

Quick Reference Box

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

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

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

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

IMPORTANT

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

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

How To Use This Benefit Booklet

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

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

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

Accessing Benefits

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

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

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

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

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

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

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

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

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Network Providers

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

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

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

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

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

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

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

Designated Providers

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

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

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

Limitations on Selection of Providers

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

Eligible Expenses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Deductible

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

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

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

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

Coinsurance

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

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

Out-of-Pocket Maximum

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

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

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

If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in Section 4, *Plan Highlights* does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

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

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

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

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

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

Care Management

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

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

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

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

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

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share

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

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

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

Prior Authorization

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

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

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

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

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

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

The services that require prior authorization are:

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

- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication-assisted treatment programs for substance-related and addictive disorders;
- Surgery - sleep apnea surgeries;
- Therapeutic treatments as described in Section 5, Additional Coverage Details under Therapeutic Treatments - Outpatient;
- Transplants.

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

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

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

Special Note Regarding Medicare

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

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

SECTION 4 - PLAN HIGHLIGHTS

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

Plan Features	Network	Non-Network
Annual Deductible[1]		
■ Individual	$2,500	$5,000
■ Family (cumulative Annual Deductible[2])	$5,000	$10,000
Annual Out-of-Pocket Maximum[1]		
■ Individual	$5,000	$10,000
■ Family (cumulative Out-of-Pocket Maximum[3])	$10,000	$20,000
Lifetime Maximum Benefit[4] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

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

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

[3]If more than one person in a family is covered under the Plan, the individual coverage Out-of- Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

[4]Generally the following are considered to be essential Benefits:

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

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

<table>
<tr><th rowspan="2">Covered Health Services[1]</th><th colspan="2">Percentage of Eligible Expenses Payable by the Plan</th></tr>
<tr><th>Network</th><th>Non-Network</th></tr>
<tr><td>Acupuncture Services
Acupuncture services will be reviewed after 20 visits for medical necessity</td><td>80% after you meet the Annual Deductible</td><td>60% after you meet the Annual Deductible</td></tr>
<tr><td>Ambulance Services
■ Emergency Ambulance</td><td>80% after you meet the Annual Deductible</td><td>80% after you meet the Annual Deductible</td></tr>
<tr><td>■ Non-Emergency Ambulance</td><td>80% after you meet the Annual Deductible</td><td>60% after you meet the Annual Deductible</td></tr>
<tr><td>Cancer Resource Services (CRS)[2]
■ Hospital Inpatient Stay
See Cancer Resource Services (CRS) in Section 5, Additional Coverage Details.</td><td>80% after you meet the Annual Deductible</td><td>Not Covered</td></tr>
<tr><td>Clinical Trials
Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</td><td colspan="2">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.</td></tr>
</table>

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

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

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

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.	

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

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

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

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

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

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

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

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

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

Acupuncture Services

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

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

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

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

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

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

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

Ambulance Services

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

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

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

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

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

Cancer Resource Services (CRS)

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

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

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

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

- Physician's Office Services - Sickness and Injury.

- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

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

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

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*

- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

Congenital Heart Disease (CHD) Surgery Services

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

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

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

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

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

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

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

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

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

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

Dental Services - Accident Only

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

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

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

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

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

The Plan pays for treatment of accidental Injury only for:

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

Dental Services – Treatment of a Medical Condition

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

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

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

Dental Treatment Covered under Plan

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

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

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

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

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

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

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items	■ Insulin pumps and pump supplies for the management and treatment of diabetes based upon the medical needs of the Covered Person. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

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

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

Durable Medical Equipment (DME)

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

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

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

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the Health Resources and Services Administration (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;

- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets)for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, shoes/inserts made from a mold of a Covered Person's foot; Charges for custom built orthopedic shoes when medically necessary must be prescribed by a doctor and limited to two (2) pairs per calendar year;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

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

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

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

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

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

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

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

Emergency Health Services - Outpatient

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

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

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

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

Foot Care

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

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in this section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under the Plan's prescription drug benefit.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

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

  Female to Male:

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

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

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

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

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

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

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

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

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

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

Home Health Care

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

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

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

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

Hospice Care

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

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

Prior Authorization Requirement

For Non-Network Benefits for:

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

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

Kidney Resource Services (KRS)

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

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

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

You or a covered Dependent may:

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

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

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

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

Lab, X-Ray and Diagnostics - Outpatient

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

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

Benefits under this section include:

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

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

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

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

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

Benefits under this section include:

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

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

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

Mental Health Services

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

Benefits include the following levels of care:

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

Services include the following:

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

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

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

Prior Authorization Requirement
For Non-Network Benefits for:

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

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

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

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

Benefits include the following levels of care:

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

Services include the following:

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

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

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

Prior Authorization Requirement

For Non-Network Benefits for:

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

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

Nutritional Counseling

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

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

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

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

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

Obesity Surgery

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

The Plan covers surgical treatment of obesity provided by or under the direction of a

Physician if any of the following are true:

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

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

- you have any life threatening or serious medical condition that is weight induced;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

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

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

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

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

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

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

Orthotic Devices

Refer to the Durable Medical Equipment (DME) section above for details.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Pharmaceutical Products - Outpatient

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

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

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

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

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

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

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

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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

Pregnancy - Maternity Services

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

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

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

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

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

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Clinical Programs and Services*, for details.

Preventive Care Services

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

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

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

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

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

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

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

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

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

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Private Duty Nursing - Outpatient

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Private Duty Nursing – Outpatient visits. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

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

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

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

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

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

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

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

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses

Reconstructive Procedures

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

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

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

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

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

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

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

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

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

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.
- The services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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

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

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

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

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Rehabilitation services will be reviewed after 40 visits for medical necessity. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

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

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

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

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

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

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

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

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

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

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

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

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

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

Prior Authorization Requirement
For Non-Network Benefits for:

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

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

Spine and Joint Solution (SJS) Program MANDATORY

The Spine and Joint Solution (SJS) program is for eligible participants age 18 and older. SJS provides support before, during, and after surgery. Nurses help direct participants to high-quality facilities and provide them case management support.

In-scope procedures include:

- Spine Fusion Inpatient Surgery.
- Disc Inpatient Surgery.
- Total Hip Replacement Inpatient Surgery.
- Total Knee Replacement Inpatient Surgery.

If care involves a hospital admission, it may also require that surgery is performed at an SJS Center of Excellence (COE) facility (Designated Provider). To enroll in the program and find the closest COE provider call 1-877-214-2930 and ask to speak with an SJS Nurse.

You must enroll in the SJS Program to access benefit coverage for spine and joint procedures. Failure to enroll in the program may result in no coverage for your spine & joint procedure.

Enhanced travel benefits may be available to participants who enroll in this program and utilize a Center of Excellence (COE) facility (Designated Provider) for their eligible surgery. See *Travel and Lodging* for details.

As part of the SJS program, most facilities will cover costs related to complications that result from the surgery for a period of 90 days after the surgery. Claims incurred during this period of time will be reviewed to determine if they were a complication related to the surgery or a readmission to the COE and, as a result, if this feature applies.

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

Please remember Non-Network Benefits for inpatient spine and joint surgery are not available.

Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

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

Services include the following:

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

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

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

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as soon as is reasonably possible.

- In addition, for Non-Network Benefits you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

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

Surgery - Outpatient

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

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

Benefits under this section include:

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

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

- pain or dysfunction is moderate or severe.

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

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

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

Therapeutic Treatments - Outpatient

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

*Non-Network dialysis is *not* covered under the Plan.

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

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

Benefits under this section include:

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

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.
If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

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

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

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

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

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

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

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

Prior Authorization Requirement
For Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Provider, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

For Non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging Assistance Program

Travel and Lodging assistance is available under the Plan for you or your eligible family member only if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is more than 50 miles from your home address. Eligible Expenses

are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The SJS services program provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.

- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

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

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. Benefits under this section are not available for services to treat a condition that does not meet the definition of Urgent Care.

Virtual Visits

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

Vision Examinations

The Plan pays Benefits for:

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

Wigs

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

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

SECTION 6 - CLINICAL PROGRAMS AND SERVICES

What this section includes:
Health and well-being resources available to you, including:

- Condition Management Services; and
- Telephonic Wellness Coaching.

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

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

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

NurseLine℠

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

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

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

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

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

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

Decision Support

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

This program offers:

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

Conditions for which this program is available include:

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

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

UnitedHealth Premium® Program

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

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

www.myuhc.com

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

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

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

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

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

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

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

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

Condition Management Services

Cancer Support Program

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

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

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

Condition Management Services

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

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

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

*HealtheNotes*SM

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

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

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

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

Telephonic Wellness Coaching

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

Tobacco Cessation Program

A tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support throughout the quitting process for up to one year via toll-free phone and live chat.
- Nicotine replacement therapy (patch, lozenge or gum) sent to you in conjunction with your quit date.

- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in the Quit For Life® program, or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

Stress Management Program

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

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

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

Nutrition Management Program

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

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

Exercise Management Program

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

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

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.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

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

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:
  - systolic BP = >/=140 or Diastolic BP = ./=90
  - high Blood Pressure and is on medication
  - cholesterol = 240 or HDL < 40
  - indicates has high cholesterol & is on medication
  - high LDL
  - indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.

- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Coinsurance or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

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

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

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

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

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

What this section includes:

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

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

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

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

Alternative Treatments

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

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative/chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

Dental

1. Dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under Dental Treatment Covered under Plan in Section 5, *Additional Coverage Details*.

2. Treatment for the following conditions:
   - injury related to chewing or biting;
   - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
   - periodontal disease or cavities and disease due to infection or tumor.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

For information on your dental coverage, contact your Dental Plan provider.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities;

2. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

4. The replacement of lost or stolen prosthetic devices;

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details;*

6. Oral appliances for snoring;

7. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your CVS Caremark Prescription Drug Benefit Booklet for information about the Plan's prescription drug benefit);

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting;

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office;

4. Over-the-counter drugs and treatments;

5. Growth hormone therapy;

6. Clomiphine (e.g., Clomid®), menotropins (e.g., Repronex®), or other drugs associated with conception by artificial means.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet;
   - Applying skin creams in order to maintain skin tone;
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes;

2. Treatment of flat feet;

3. Treatment of subluxation of the foot;

4. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty;
   - Blepharoplasty;
   - Breast enlargement, including augmentation mammoplasty and breast implants;
   - Body contouring, such as lipoplasty;
   - Brow lift;
   - Calf implants;
   - Cheek, chin, and nose implants;
   - Injection of fillers or neurotoxins;
   - Face lift, forehead lift, or neck tightening;
   - Facial bone remodeling for facial feminizations;
   - Hair removal;
   - Hair transplantation;
   - Lip augmentation;
   - Lip reduction;
   - Liposuction;
   - Mastopexy;
   - Pectoral implants for chest masculinization;
   - Rhinoplasty;
   - Skin resurfacing;
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple);
   - Voice modification surgery;
   - Voice lessons and voice therapy;

2. Reversal of tubal ligation or vasectomy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - Compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details;*
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details;*

- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details;*

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. The replacement of lost or stolen Durable Medical Equipment;

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act;*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods);

2. Food of any kind. Foods that are not covered include:

   - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - Oral vitamins and minerals;
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay;
   - Other dietary and electrolyte supplements;

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television;

2. Telephone;

3. Beauty/barber service;

4. Guest service;

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details;*

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation;

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of $500 per Covered Person per lifetime;

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback;

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. Rehabilitation services and Manipulative/Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

4. Speech therapy to treat stuttering, stammering, or other articulation disorders;

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details;*

6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty;

8. Psychosurgery (lobotomy);

9. Treatment of tobacco dependency, excluding screenings and counseling;

10. Chelation therapy, except to treat heavy metal poisoning;

11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details,* are satisfied;.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis);

15. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;

16. Breast reduction surgery that is determined to be a Cosmetic Procedure;

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details;*

17. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;

2. Services performed by a provider with your same legal residence;

3. Services ordered or delivered by a Christian Science practitioner;

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

6. Services and supplies provided at Cancer Treatment Centers of America are not covered under the Plan.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment;

   This exclusion does not apply to services required to treat or correct underlying causes of infertility;
2. Surrogate parenting, donor eggs, donor sperm and host uterus;
3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
4. The reversal of voluntary sterilization;
5. The reversal of tubal ligation or vasectomy;
6. In vitro fertilization regardless of the reason for treatment;
7. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
8. 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);
9. Services provided by a doula (labor aide);
10. 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.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services;

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 12, *Glossary;*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services;

5. Private Duty Nursing received on an inpatient basis;

4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details;*

5. Rest cures;

8. Services of personal care attendants;

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants);

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;

4. Eye exercise or vision therapy;

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse;

2. Charges for:

    - Missed appointments.
    - Room or facility reservations.
    - Completion of claim forms.
    - Record processing;

3. Charges prohibited by federal anti-kickback or self-referral statutes;

4. Diagnostic tests that are:

    - Delivered in other than a Physician's office or health care facility.
    - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. Expenses for health services and supplies:

    - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
    - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.

- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
- That exceed Eligible Expenses or any specified limitation in this Benefit Booklet
- For which a non-Network provider waives the Annual Deductible or Coinsurance amounts;

6. Foreign language and sign language services;

7. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service;

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type;

10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

11. Health services and supplies that do not meet the definition of a Covered Health Service – as defined in Section 12, *Glossary.* Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Benefit Booklet under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights.*
    - Not otherwise excluded in this Benefit Booklet under this Section 7, *Exclusions and Limitations.*

SECTION 8 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Retiree.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits.*

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- the specific reason or reasons for the denial;
- 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 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 adverse benefit determination and any time limits for filing such a civil action;
- 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; and
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims.

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 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 claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

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:

- the specific reason or reasons for the adverse determination of your appeal;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination and any time limits for filing such a civil action, and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request; and
- 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.

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: 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 legal action.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	
Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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 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 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 henefit.

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 henefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term "allowable expense" is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims hy updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee or retiree pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Only expenses normally paid by the Plan will be paid under COB
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Retiree under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan may pay an additional amount.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If this Plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- individuals with end-stage renal disease, for a limited period of time; and
- participants not actively working and receiving long-term disability benefits for up to six months.

After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare.

If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

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.

This cross-over process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the

overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been contributed to or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not

have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.

- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for

any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 12 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible. The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Retirees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations.*

Covered Person – the Retiree or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6. *Clinical Programs and Services*, "Covered Person" means all domestic Retired Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works.*

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employer - Duke Energy Corporation.

EOB - see Explanation of Benefits (EOB).

ERISA – the Employee Retirement Income Security Act of 1974 (ERISA), the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by the Plan Administrator who provides or

arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions and Limitations.*

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights* and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights* and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Health Savings Plan 1 Option under the Duke Energy Retiree Medical Plan and/or the Duke Energy Retiree Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retiree – a former employee of the Company who is eligible for benefits under the Plan as described in the General Information Booklet.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan Coinsurance and Deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.

- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through 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.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive

standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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ATTACHMENT I - NOTICES

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏇ ᎩᏢ ᏗᏟᏃᎮᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎸᏓ ᏣᏤᏢ ᎪᎯ ᎩᎡ ᏗᎫᎪᏗ ᎠᏟᏍᏓᏗ ᏆᎾᏲᏍᏗᎢ, ᏧᏭᏬᏍᏓᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 [illegible].TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێرێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو نای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສຳລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bą́ąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yiníkeedgo, ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wɛ̈rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711

Language	Translated Taglines
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	[illegible] TTY 711. 0
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

Prescription Drug Program Guide for the Duke Energy Retiree Medical Plan

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SECTION 1 – WELCOME

The Duke Energy Retiree 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) Option

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option[1].

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

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

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

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

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

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

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

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

Using the CVS Caremark Maintenance Choice™ Program

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

Fill limit for long-term medications

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

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

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

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

Process for Mail Order Medications
There are several methods you may use to fill your newly prescribed long-term medications through the CVS Caremark Mail Service Pharmacy.

- **Option 1**: Ask your doctor to select the CVS Caremark Mail Service Pharmacy using their provider ePrescribing tools, or your physician may call 800.378.5697.

- **Option 2**: Use the CVS Caremark mobile app for your smart phone to photograph your prescription order and submit the new prescription electronically to the CVS Caremark Mail Service Pharmacy.

- **Option 3**: Get started using the CVS Caremark Mail Service Pharmacy with FastStart®. Log on to www.caremark.com/faststart to provide the requested information, and CVS Caremark will contact your doctor for the 90-day prescription you need. You also can call FastStart® toll-free at 800.875.0867 for assistance.

- **Option 4**: Alternatively, you can complete the mail order form, which is available at www.Caremark.com, and send it with your new prescription order and payment method for any applicable prescription drug annual deductible and co-insurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Please note: Once you fill a prescription through the CVS Caremark Mail Service for the first time, you then have the option to use the automated refill service for future refills by CVS Caremark. Visit www.Caremark.com for more information on the Auto Refill process.
Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

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

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

Covered Expenses

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

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

Excluded Expenses

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

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)

- Blood or blood plasma products (covered as a medical expense under the Medical Plan)
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Retiree Dental Plan)

Medical Plan and Health Savings Account

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

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.

Refer to the prescription drug program summary of benefits on page 19 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 <u>without</u> 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 <u>without</u> trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

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

Maximum Drug Limitation Program

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

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

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

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved

therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

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

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

Drug Utilization Reviews

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

SECTION 5 – COORDINATION OF BENEFITS

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

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

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

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

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2018, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2019 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable deductible and coinsurance, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2018 would have 45 days (until February 14, 2018) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

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

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

Reviews & Appeals

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

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

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

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

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

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

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

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

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

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

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

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

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

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's review procedures, 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 adverse benefit determination on appeal and any time limits for filing such a civil action;
- 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; and
- 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.

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.

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:

- 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 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 adverse benefit determination and any applicable time limits for bringing such a civil action;
- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge; and
- 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.

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."

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 claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority
The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to 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 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 Retiree 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)
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.

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

Retiree Medical Plan

Standard PPO option

January 2018

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

Duke Energy Retiree Medical Plan General Information

(Pre-65 Retirees)

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Retiree Medical Plan ("Medical Plan") provides information that is applicable to all Medical Plan coverage options available to retirees who are not yet age 65 and their eligible dependents who are not yet age 65. This booklet addresses eligibility for coverage under the Medical Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered dependents may be able to continue coverage if it ends. It also contains information such as who provides coverage, who administers the Medical Plan, who decides claims for benefits, ERISA rights and Duke Energy Corporation's right to amend or terminate the Medical Plan.

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

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

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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 and disease management benefits.

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

Duke Energy myHR™ Service Center

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

Eligibility

Eligible Retirees

If your employment terminates on or after January 1, 2018, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must be:

- employed by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the "Company," as applicable) offering access to retiree coverage under the Medical Plan;
- at least age 50 and credited with at least 5 years of retiree eligibility service; and
- under age 65.

Note: You are not eligible for coverage under the Medical Plan if you are a current employee of Duke Energy or its affiliates. If you are a current employee of Duke Energy or its affiliates and eligible for coverage, you must enroll in the Duke Energy Active Medical Plan for medical coverage, even if you are a rehired retiree or an under age 65 eligible dependent of another Company retiree who might otherwise be eligible for coverage under the Medical Plan if you weren't a current employee of Duke Energy or its affiliates.

You also are not eligible for coverage under the Medical Plan, if you are a Legacy Piedmont Employee[1] hired prior to January 1, 2008 (prior to January 1, 2009, if you are a Legacy Piedmont Employee covered under the Nashville bargaining unit contract).

[1] When used in this booklet, the term "Legacy Piedmont Employee" refers to an individual who (1) was employed by Piedmont Natural Gas Company Inc. and its subsidiaries (collectively, "Piedmont") immediately prior to the acquisition of Piedmont by Duke Energy Corporation effective on October 3, 2016 or (2) was hired by Piedmont following such acquisition but prior to 2018.

Other Retiree Eligibility Information

If your employment with Duke Energy and its affiliates terminated before January 1, 2018, your eligibility for retiree coverage is governed by the eligibility rules in effect at that time.

If you enroll for coverage for yourself, you may be able to elect coverage under the Medical Plan for your eligible spouse/domestic partner and/or child(ren) who are under age 65. Please refer to the sections *Enrolling in the Medical Plan* and *Mid-Year Changes* for additional information. Your eligible spouse/domestic partner and/or child(ren) who are age 65 or older may be able to elect individual medical and prescription drug coverage through a Medicare exchange available to eligible retirees who are age 65 or older. Additional information about the individual medical and prescription drug coverage available through the Medicare exchange will be provided to your eligible spouse/domestic partner and/or child(ren) when they reach age 65.

Duke Energy Corporation reserves the right to amend, modify or terminate retiree coverage offered under the Medical Plan at any time, including termination of eligibility.

Eligible Dependents

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

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

In order to be eligible for coverage under the Medical Plan, your eligible dependent must be under age 65. Under age 65 eligible dependents of eligible retirees who are age 65 or older are eligible for coverage under the Medical Plan. Your eligible dependents age 65 or older are eligible for individual medical and prescription drug coverage through a Medicare exchange. Additional information about the individual medical and prescription drug coverage available through the Medicare exchange will be provided to your eligible dependent(s) when they reach age 65.

Spouse Eligibility

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

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

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

You must immediately report any spouse who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your spouse's loss of eligibility is not reported

within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible spouse, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your spouse after your spouse ceases to be eligible will be considered a misrepresentation of your spouse's eligibility.

Domestic Partner Eligibility

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

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

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

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

Child Eligibility

Your child is:

- your biological child, up to age 26; **or**
- your legally adopted child, including a child placed in your home for legal adoption by you as long as the child remains in your home and the adoption procedure has not been terminated, and whether or not the adoption has become final, up to age 26; **or**
- your stepchild, up to age 26; **or**
- your foster child, up to age 26; **or**
- your domestic partner's biological child, legally adopted child (including a child placed in your home for legal adoption by your domestic partner as long as the child remains in your home and the adoption procedure has not been terminated, whether or not the

adoption has become final), stepchild or foster child, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**

- any other child for whom you, your spouse or your domestic partner has legal guardianship, full or joint legal custody or managing conservatorship under a valid court decree, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26.

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

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

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

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

Surviving Spouse, Domestic Partner and Child Eligibility

If you die while you and your spouse/domestic partner are covered under the Medical Plan, your surviving spouse/domestic partner may continue Medical Plan coverage by making contribution payment arrangements with the Duke Energy myHR Service Center. This coverage can be continued until the earliest of your spouse's remarriage, your domestic partner's establishment of a new domestic partner relationship, your spouse's/domestic partner's attainment of age 65, the death of your spouse/domestic partner and the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan).

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

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

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

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage. If coverage under the Medical Plan is declined or ends, your covered dependents may be eligible for continued coverage under COBRA for up to 36 months in certain situations.

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

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

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Medical Plan at the time of your death.

Employee and Retiree Couples

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

Verification of Dependent Status

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

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

If a Dependent Becomes Ineligible

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

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

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

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

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;
- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and
- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

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

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

Enrolling in the Medical Plan

When You Become Eligible

If you are an eligible retiree as described in the *Eligible Retirees* section above, you may elect retiree coverage under the Medical Plan when you retire. When your employment terminates, if you are an eligible retiree, you can choose to:

- begin Medical Plan coverage immediately or at a later date; or
- decline Medical Plan coverage.

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

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

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

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

By making your coverage election when you are first eligible, you are affirmatively representing that all information provided during enrollment including, but not limited to, the eligibility of any dependents for coverage, is true and correct. If Duke Energy discovers that any information you provide during enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of information, up to and including termination of Medical Plan coverage, and to take other appropriate action.

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

At a Later Date

If you are an eligible retiree and you do not immediately begin retiree coverage under the Medical Plan at your termination of employment, or if you subsequently discontinue your retiree coverage, you can elect to enroll during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

For example, if you are an eligible retiree covered as a dependent of a spouse enrolled as an active employee under the Duke Energy Active Medical Plan, you may elect retiree coverage under the Medical Plan during a future annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

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

During Annual Enrollment

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

By making (or not changing, as applicable) your coverage election during annual enrollment, you are affirmatively representing that all information provided during annual enrollment, including, but not limited to, the eligibility of any dependents for coverage, is true and correct. If Duke Energy discovers that any information you provide during annual enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of information, up to and including termination of Medical Plan coverage, and to take other appropriate action.

If You Are Rehired

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

Cost of Coverage

The cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option you elect and the eligible dependent(s) you choose to cover. The portion of the cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your termination, but remains subject to Duke Energy Corporation's right to amend, modify or terminate the Medical Plan, including termination of eligibility for Company contributions toward the cost of retiree medical coverage.

If you are eligible for a Company contribution toward the cost of retiree medical coverage, the Company contribution may be provided either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits, depending on your retiree group. If you have questions about your retiree group or the form of any subsidized monthly coverage for which you may be eligible, contact the Duke Energy myHR Service Center.

Information about contribution amounts is available through the YBR website.

Eligibility for Company Contributions toward the Cost of Retiree Medical Coverage

If your employment with Duke Energy and its affiliates ends on or after January 1, 2018 and you satisfy the eligibility criteria specified for your employment classification in the chart below, you may be eligible for a Company contribution toward the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements.

If your employment with Duke Energy and its affiliates ends on or after January 1, 2018 and you do not satisfy the eligibility criteria specified for your employment classification in the chart below or you do not satisfy all applicable requirements when your employment with Duke Energy and its affiliates ends, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and you will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan.

If your employment with Duke Energy and its affiliates ended before January 1, 2018, your eligibility for a Company contribution toward the cost of retiree medical coverage is governed by the eligibility rules in effect at that time.

EMPLOYMENT CLASSIFICATION	ELIGIBILITY CRITERIA
All Duke Energy Employees[2] except for Duke Energy Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA, IBEW SCU-8, IBEW 1902 and PPF 702	Hired before January 1, 2009*
All Legacy Progress Energy Employees[3], except for Legacy Progress Energy Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA, IBEW SCU-8, IBEW 1902 and PPF 702	Hired or rehired before January 1, 2002 and you either were at least age 40 or completed at least 5 years of retiree eligibility service by December 31, 2001
All Legacy Piedmont Employees, except for Legacy Piedmont Employees hired prior to January 1, 2008 (prior to January 1, 2009 for Legacy Piedmont Employees covered under the Nashville bargaining unit contract), except for Legacy Piedmont Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA and IBEW SCU-8	Hired before January 1, 2018*

[2]When used in this booklet, the term "Duke Energy Employee" refers to an individual who satisfies either of the following requirements:

- the individual (1) was employed by Duke Energy or its affiliates immediately prior to the merger of Duke Energy Corporation and Progress Energy, Inc. on July 2, 2012, (2) was hired following such merger but prior to January 1, 2014 by Duke Energy or a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy immediately prior to such merger or (3) was hired on or after January 1, 2014 by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan; or
- the individual (1) was employed by Duke Energy or its affiliates immediately prior to the acquisition of Piedmont Natural Gas Company Inc. and its subsidiaries (collectively, "Piedmont") by Duke Energy effective on October 3, 2016, (2) was hired following such acquisition but prior to 2018 by Duke Energy or a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy immediately prior to such acquisition or (3) was hired on or after January 1, 2018 by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan.

[3]When used in this booklet, the term "Legacy Progress Energy Employee" refers to an individual who (1) was employed by Progress Energy, Inc., Duke Energy Progress, Inc. f/k/a Progress Energy Carolinas, Inc., Duke Energy Florida, Inc. f/k/a Progress Energy Florida, Inc. and/or Progress Energy Service Company, LLC (collectively, "Progress Energy") immediately prior to the merger of Duke Energy Corporation and Progress Energy, Inc. on July 2, 2012 or (2) was hired by Progress Energy following such merger but prior to January 1, 2014.

Employees represented by IBEW 1347	Hired before January 1, 2010*
Employees represented by IBEW 1393	Hired before January 1, 2011*
Employees represented by USW 12049 & USW 5541-06	Hired before January 1, 2012*
Employees represented by UWUA	Hired before January 1, 2013*
Employees represented by IBEW SCU-8	Hired or rehired before January 1, 2009

**If you are an eligible retiree and you are rehired on or after the applicable date specified for your employment classification in the chart above you are eligible for access to retiree coverage under the Medical Plan. When you subsequently terminate your employment with Duke Energy and its affiliates, you may be eligible for a Company contribution toward the cost of retiree medical coverage only if, upon your previous termination of employment, you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of such termination of employment. If you did not satisfy the eligibility requirements in effect at the time of your previous termination, you will be treated as a new hire and will be responsible for paying the full cost of any retiree coverage you elect.*

Paying for Coverage as a Retiree

Initially, you will be billed directly for the monthly contribution for your medical coverage. There are several different options available to you for making payment, which are listed below.

- If you are billed directly each month, you will receive a statement that explains how to make your payments, when they are due and where they need to be sent.
- Rather than receiving a monthly bill, you may set up an automatic withdrawal from your checking or savings account for monthly contribution payments. If you choose this option, a *Direct Debit Authorization* must be completed and returned to the Duke Energy myHR Service Center.
- If you are receiving annuity payments under a Company-sponsored pension plan, you may elect to have your contributions deducted from your monthly pension check by contacting the Duke Energy myHR Service Center. However, if the amount of your contributions is or becomes greater than the amount of your pension annuity payment, you will be switched to a monthly billing arrangement.

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

If you elect coverage for a domestic partner and you are receiving a Company contribution toward the cost of retiree medical coverage in the form of subsidized monthly coverage, the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner is considered taxable (or imputed) income to you. This imputed income will be reported as income on a Form W-2 and will be subject to federal and state income tax (if applicable) as well as FICA and FUTA taxes. Please note that the Company does not provide tax advice, and you should consult with your tax advisor for information about the tax consequences of electing coverage for a domestic partner.

The Company is obligated to collect the applicable taxes on the imputed income created by the election of benefits for a domestic partner. Therefore, in addition to reporting the imputed income on your Form W-2, you will be billed for the amount of this tax liability. If you do not pay the bills for the tax liability in a timely manner, you may be subject to termination of any benefit coverage you elected for your domestic partner.

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

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

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

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

Any amounts owed in arrears at the time of a death or coverage change will continue to be billed and must be paid.

When Coverage and Contributions Begin

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

When you make your coverage elections during annual enrollment, coverage begins on January 1 of the following calendar year. Payments for your coverage begin as soon as administratively practicable following January 1 of the following calendar year.

Mid-Year Changes

Enrolling in Coverage Mid-Year

Once you have made your Medical Plan election for the year, you may not change your election during that year to enroll in coverage for yourself and/or your eligible dependents unless you have a work or life event for which a mid-year enrollment change is permitted and the work or life event results in the gain of eligibility for coverage. Specific information about these "work/life" events and allowable mid-year enrollment changes is available by calling the Duke Energy myHR Service Center. A "mid-year enrollment change" refers to any change made to

your coverage during a calendar year due to a work or life event that results in the gain of eligibility for coverage.

If you experience a work/life event for which mid-year enrollment changes are allowed, you have 31 calendar days from the date of the event (for example, your marriage date) to change your election. Otherwise, unless a subsequent work/life event which would allow you to enroll yourself and/or your eligible dependents in coverage occurs, you cannot elect to enroll yourself and/or your eligible dependents in Medical Plan coverage until annual enrollment.

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

Below is a list of some work/life events for which you may enroll yourself and/or your eligible dependents mid-year:

- You get married
- Your domestic partner becomes eligible for coverage
- The number of your eligible children changes
  - you have, or adopt, a child
  - you become the legal guardian of a child
  - a Qualified Medical Child Support Order (QMCSO) is received[4]
- Your dependent's benefit coverage changes because:
  - he or she loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
  - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You or your dependent loses Medicare or Medicaid
- You or your dependent loses coverage under a group health plan
- There is a significant increase in the cost of coverage under the employer plan in which your dependent participates
- Your period of temporary employment with the Company ends

Dropping Coverage Mid-Year

Once you have made your Medical Plan election for the year, you may elect to drop coverage for yourself and/or one or more covered dependents at any time, even if you do not experience a work/life event. An election to drop coverage for yourself and/or your covered dependents will be effective on a prospective basis only.

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

When Your Dependent Is No Longer Eligible

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

When You Enroll a Dependent Mid-Year

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

When Mid-Year Coverage and Contribution Changes Are Effective

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

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

individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

When You Reach Age 65

When you and your spouse or other dependent reach age 65, you and your spouse or other dependent will be able to purchase individual medical and prescription drug coverage through a Medicare exchange if you choose. The Medical Plan options available to retirees and their spouses and other dependents who have not yet reached age 65 are not available to retirees and their spouses and other dependents who are age 65 or older.

Once you and your spouse or other dependent reach age 65, you will receive additional information that describes your individual health plan choices, coverage costs and how to enroll in individual coverage for yourself and your eligible spouse/dependent.

If You Become Entitled to Medicare Before Age 65

If you become entitled to Medicare before age 65 due to disability or end stage renal disease, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare before age 65.

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

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

Termination of Coverage

When Coverage Ends

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

- the last day of the month prior to the month in which you reach age 65;

- the date that you are rehired as an active employee of Duke Energy or its affiliates (e.g., as a regular, fixed-term or temporary employee);
- the last day of the month in which you cease to be an eligible retiree or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, on the last day of the month prior to the month in which the dependent reaches age 65 or on the last day of the month in which the dependent otherwise loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms must be completed and received within 60 days of the event or notification, whichever is later.

If You Become Divorced or Your Domestic Partner Relationship Ends

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

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

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

COBRA Continuation Coverage

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

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

Continued Coverage for Your Dependents

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

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

Bankruptcy Proceeding

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

Procedures to Obtain Continued Coverage

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

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

- you become divorced;
- your domestic partner relationship ends; or
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan.

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

For other qualifying events, such as your death, it is the Company's responsibility to notify the COBRA administrator.

Election Period

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

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

Type of Coverage

If continued coverage is elected, the medical coverage will initially be the same coverage as was in effect on the day before the qualifying event. During the COBRA continuation period, any changes to the medical coverage of similarly situated retirees also will apply to the medical coverage elected as a COBRA qualified beneficiary. In addition, if the COBRA continuation period extends into a future plan year, the Medical Plan COBRA election may be changed for the following plan year during annual enrollment to the same extent that Medical Plan elections can be changed by other similarly situated retirees for the following plan year during annual enrollment.

Cost

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

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

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

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

Conversion Privilege

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

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

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

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

Your Role

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

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

You must notify the applicable Claims Administrator if a provider:

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

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

Other Important Information

Plan Sponsor

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

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

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Retiree Health & Welfare Benefit (Financed) Plans, plan number 503.

Funding

The following funding vehicles are, or may be, used to accumulate assets from which Medical Plan claims may be paid: (i) Section 401(h) medical account under the Duke Energy Retirement Cash Balance Plan, (ii) Section 401(h) medical account under the Duke Energy Legacy Pension Plan, (iii) Duke Energy Corporation Welfare Benefits Trust VEBA I, (iv) Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II, (v) Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Non-Bargaining Employees and/or (vi) Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Bargaining Unit Employees. Duke Energy also may provide benefits under the Medical Plan from its general assets.

The trustee for the Section 401(h) medical accounts is:

Duke Energy Corporation Master Retirement Trust
The Northern Trust Company, Trustee
50 South LaSalle Street
Chicago, IL 60675

The trustee for the VEBAs is:

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

The trustee for the Piedmont 501(c)(9) Trusts is:

Wells Fargo Institutional Retirement and Trust
1525 West W.T. Harris Blvd., 3C5
Charlotte, NC 28262-8522

Plan Administrator

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

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

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

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

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

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

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

Investment Committee

The named fiduciary for the maintenance and investment of the plan assets that are held in the Duke Energy Corporation Welfare Benefits Trust VEBA I, the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II, the Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Non-Bargaining Employees, the Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Bargaining Unit Employees and the 401(h) medical accounts under the Duke Energy Corporation Master Retirement Trust is the Duke Energy Investment Committee. The Board of Directors of Duke Energy Corporation appointed the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee. Any successor Chairman

of the Investment Committee is appointed by the Finance and Risk Management Committee of the Board of Directors of Duke Energy Corporation.

The Investment Committee may be contacted through the following address:

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

Plan Year

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

Service of Legal Process

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

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

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

Affiliated Employers of the Company That Have Adopted the Medical Plan

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

Claim Determination Procedures

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

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

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or

coverage option due to disputes regarding the cost of your Medical Plan coverage or (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity.

Claims for Medical Plan Benefits

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

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

Eligibility or Enrollment Claims

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

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

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

Initial Claim

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

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

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

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

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

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

Adverse Determination

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

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

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request; and
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to

the Claims Committee within 180 calendar days after receipt of the adverse determination. If your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

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

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

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

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

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

Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

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

Legal Action

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

Discretionary Authority

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

Right to Change or Terminate the Medical Plan

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

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

In the event of a complete termination of the Medical Plan, eligible claims for Medical Plan benefits will be paid by the Duke Energy Corporation Welfare Benefits Trust VEBA I, the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II and/or the Duke Energy Corporation Master Retirement Trust – 401(h) Account, as applicable, to the extent that funds are available.

Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

Keep Us Informed

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

A Final Note

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

documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

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Benefit Booklet

Duke Energy Retiree Medical Plan
Standard PPO Option

Effective: January 1, 2018
Group Number: 729784

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SECTION 1 - WELCOME

Quick Reference Box

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

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

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

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

IMPORTANT

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

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

How To Use This Benefit Booklet

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

SECTION 2 - HOW THE PLAN WORKS

What this section includes:
- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

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

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

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

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

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

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

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 12, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

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

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

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

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

Network Providers

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

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

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

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

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular

Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

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

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30 mile radius of your home zip code.You can check a provider's Network status by visiting **www.myuhc.com** or by calling UnitedHealthcare at the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Designated Providers

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

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

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

Limitations on Selection of Providers

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

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

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

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare determines the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the Benefit Booklet.

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

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

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

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

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

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

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

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

Annual Deductible

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

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

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible but Copays do count toward the Out-of-Pocket-Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

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

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

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate medical and prescription drug Out-of-Pocket Maximums for the Plan's Standard PPO Option. If your eligible out-of-pocket expenses in a calendar year exceed the applicable annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The medical Copays and Coinsurance amounts are applied toward the Plan's annual ***medical*** Out-of-Pocket Maximums. This means that once you satisfy your applicable annual ***medical*** Out-of-Pocket Maximums, you do not have to pay any further Copays or Coinsurance amounts for Covered Health Services that are medical expenses. However, if you satisfy the Plan's separate annual ***prescription drug*** Out-of-Pocket Maximums, but have not yet satisfied your applicable annual ***medical*** Out-of-Pocket Maximums, you still have to pay any applicable Copay or Coinsurance amount for Covered Health Services which are medical expenses until you satisfy your applicable annual ***medical*** Out-of-Pocket Maximums.

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

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

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

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

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

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

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

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefit Booklet, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share

important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

The Plan requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 5, *Additional Coverage Details.*

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services listed below as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services for which they fail to obtain prior authorization as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator prior to receiving a service.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator as shown in Section 5, *Additional Coverage Details* before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if you do not obtain prior authorization from the Claims Administrator prior to receiving a service..

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

The services that require prior authorization are:

- Ambulance - non-emergent air;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including breast pumps and diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria treatment as described under *Gender Dysphoria* in Section 5 *Additional Coverage Details;*
- Genetic testing- Breast Cancer Susceptibility Gene (BRCA);
- Home health care for nutritional foods and skilled nursing;
- Hospice care – inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services-inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- Private Duty Nursing – outpatient;
- Prosthetic devices;

- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication-assisted treatment programs for substance-related and addictive disorders;
- Surgery - sleep apnea surgeries;
- Therapeutic treatments as described in Section 5, *Additional Coverage Details* under *Therapeutic Treatments - Outpatient*;
- Transplants.

For notification timeframes and any reductions in Benefits that apply if you do not obtain prior authorization or notify Personal Health Support, see Section 5, *Additional Coverage Details*.

Notification to Personal Health Support is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

(Applicable only to Medicare enrollees who have Plan coverage under COBRA or due to the receipt of long-term disability benefits under a Company-sponsored long-term disability plan).

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to obtain prior authorization before receiving Covered Health Services. Since Medicare pays Benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB)*.

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network	Non-Network
Copays[1]		
■ Emergency Health Services	$150	$150
■ Physician's Office Services – Primary Physician	$40	60% after you meet the Annual Deductible
■ Physician's Office Services - Specialist	$50	60% after you meet the Annual Deductible
■ Urgent Care Center Services	$50	$50
■ Virtual Visits		Not Applicable
- Primary Physician	$40	
- Specialist Physician	$50	
Annual Deductible[2]		
■ Individual	$800	$1,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$2,400	$3,000
Annual Out-of-Pocket Maximum[2]		
■ Individual	$3,300	$6,000
■ Family(not to exceed the applicable Individual amount per Covered Person)	$7,400	$10,000
Lifetime Maximum Benefit[3]		
There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1] In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services and Urgent Care Center Services, a Copay does not apply when you visit a non-Network provider.

[2]Copays do not apply toward the Annual Deductible. Copays do apply toward the medical Out-of-Pocket Maximum. The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services.

[3]Generally the following are considered to be essential Benefits.

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Acupuncture Services (Copay is per visit) Acupuncture services will be reviewed after 20 visits for medical necessity	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Ambulance Services		
■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay See *Cancer Resource Services (CRS)* in Section 5, *Additional Coverage Details*.	80% after you meet the Annual Deductible	Not Covered
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgery Services[2]	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only (Copay is per visit)	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition (Copay is per visit)	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Dental Treatment Covered under Plan (Copay is per visit)	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section.	
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Emergency Health Services – Outpatient (Copay is per visit) If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. Benefits for an Inpatient Stay in a Network Hospital will apply instead.	100% after you pay a $150 Copay	100% after you pay a $150 Copay
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your CVS Caremark Prescription Drug Benefit Booklet	
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
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	*Physician's office* 100% *All other locations* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient. (Copay is per visit)	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient. (Copay is per visit)	100% after you pay a $50 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
Nutritional Counseling (Copay is per visit) Up to 6 visits per condition per calendar year		
■ Primary Physician	100% after you pay a $40 Copay	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Obesity Surgery[2] (The Plan pays Benefits only for Covered Health Services provided through BRS)		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $50 Copay	Not Covered
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	Not Covered
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	Not Covered
Orthotic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Physician's Office Services - Sickness and Injury (Copay is per visit)		
■ Primary Physician	100% after you pay a $40 Copay	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $50 Copay	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

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment		
■ Cardiac & Pulmonary Rehabilitation Services	100% for Office Visits	60% after you meet the Annual Deductible
■ All other services (Copay is per visit)		
- Primary Physician	100% after you pay a $40 Copay	60% after you meet the Annual Deductible
- Specialist Physician	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits		
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Spine and Joint Surgeries MANDATORY In order to receive Spine and Joint Surgeries Benefits at a Designated Provider you must contact a Spine and Joint Solution (SJS) Nurse and enroll in the SJS Program prior to surgery. An SJS Nurse may be reached by calling 1-877-214-2930.	80% after you meet the Annual Deductible when you use a Designated Provider	Not covered
Substance-Related and Addictive Disorders Services		
■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient - (Copay is per visit)	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services (Copay is per visit) Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	100% after you pay a $50 Copay	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Note: Non-Network dialysis is not covered under the Plan.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Provider and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing transplant, obesity surgery, Spine and Joint surgery services, cancer treatment or Congenital Heart Disease treatment	
Urgent Care Center Services (Copay is per visit)	100% after you pay a $50 Copay	100% after you pay a $50 Copay
Virtual Visits (Copay is per visit) Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	*Primary Physician* 100% after you pay a $40 Copay *Specialist Physician* 100% after you pay a $50 Copay	Not Covered
Vision Examinations (Copay is per visit)	Routine Vision Examination: 100% Non-Routine Vision and refraction eye examination:	
■ Primary Physician	100% after you pay a $40 Copay	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $50 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
Wigs Up to a $500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 3, *Personal Health Support and Prior Authorization* to receive full Benefits for certain Covered Health Services. See Section 5, *Additional Coverage Details* for further information. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from the Claims Administrator before you receive certain Covered Health Services. See Section 5, *Additional Coverage Details*, for further information.

[2]These Benefits are for Covered Health Services provided through BRS, CRS, CHD and KRS at a Designated Provider. For oncology services not provided through CRS or for congenital heart disease surgery services not provided through CHD, or for kidney services not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*. The Plan does not pay any Benefits for obesity surgery not provided through the BRS program.

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 4, *Plan Highlights.*

While the table in Section 4 *Plan Highlights* provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions and Limitations.*

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Acupuncture services will be reviewed after 20 visits for medical necessity.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed services or if goals have previously been met.

Did you know…
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 12, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 12, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.

- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as determined by UnitedHealthcare, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*

  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgery Services

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD surgery services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) surgery services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD surgery services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you should contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD surgery services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Accident only dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for accidental Injury for children. Timing of when the Covered Services will be rendered is determined by the Physician.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental Services – Treatment of a Medical Condition

The Plan covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental treatment required as a result of a medical condition, but which is not an integral component of the treatment of that condition, is not covered (examples include decayed teeth due to dry mouth from medication or disease, or treatment of disease).

Dental Treatment Covered under Plan

The Plan provides Benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure is related to one of the following conditions:

- Congenital deformity, including cleft lip and cleft palate; and
- Removal of:
  - Tumors;
  - cysts which are not related to teeth or associated by dental procedures; and
  - exostoses for reasons other than preparation of dentures.

The Plan provides Benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

In addition, Benefits may be provided for dentures and orthodontic braces if used to treat congenital deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, Benefits for surgery will be subject to a Covered Health Service review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, Benefits are only provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This Benefit is only available to dependent children below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items	Insulin pumps and pump supplies for the management and treatment of diabetes based upon the medical needs of the Covered Person. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as monitors, syringes, test strips, and lancets are covered under the Plan's prescription drug benefit.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the Health Resources and Services Administration (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;

- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay*, *Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets)for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, shoes/inserts made from a mold of a Covered Person's foot; Charges for custom built orthopedic shoes when medically necessary must be prescribed by a doctor and limited to two (2) pairs per calendar year;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every five calendar years.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the five year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works.*

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Foot Care

The Plan covers hygienic and preventive maintenance foot care; cutting or removal of corns and calluses, nail trimming, cutting, or debriding only if the treatment is a Covered Health Service and related to a medical condition.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in this section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under the Plan's prescription drug benefit.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris).
  - Labiaplasty (creation of labia).
  - Orchiectomy (removal of testicles).
  - Penectomy (removal of penis).
  - Urethroplasty (reconstruction of female urethra).
  - Vaginoplasty (creation of vagina).

  Female to Male:

  - Bilateral mastectomy or breast reduction.
  - Hysterectomy (removal of uterus).
  - Metoidioplasty (creation of penis, using clitoris).
  - Penile prosthesis.
  - Phalloplasty (creation of penis).
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
  - Scrotoplasty (creation of scrotum).
  - Testicular prosthesis.
  - Urethroplasty (reconstruction of male urethra).
  - Vaginectomy (removal of vagina).
  - Vulvectomy (removal of vulva).

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.

- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 12, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization for nutritional foods and skilled nursing, from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) services provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 12, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography, including 3D mammograms (breast tomosynthesis) for screening or diagnosis of breast cancer.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management, you must obtain prior authorization for Non-Network Benefits before services are received.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to six individual sessions per calendar year for each medical condition.

Obesity Surgery

(The Plan pays Benefits only for Covered Health Services provided through BRS.)

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician if any of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea, hypertension, cardiopulmonary condition or diabetes) directly related to, or exacerbated by, obesity.

In addition to meeting the above criteria the following must also be true:

- you have any life threatening or serious medical condition that is weight induced;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Coverage of surgical treatment of morbid obesity is limited to adults who are 18 years old or older.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 12, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling the toll-free number on the back of your ID card.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for obesity surgery are not available.

Orthotic Devices

Refer to the Durable Medical Equipment (DME) section above for details.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient.*

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your Benefit Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay

is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Clinical Programs and Services,* for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Examples of preventive care services include routine physical examinations, well-baby and well-child care, immunizations, screening mammograms and prostate screenings. Preventive

care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement also include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- Human papillomavirus testing in women with normal cytology results beginning at age 30 and no more frequently than once every three years;
- Annual counseling for sexually transmitted infections;
- Annual counseling and screening for human immune-deficiency virus;
- Comprehensive lactation support and counseling in conjunction with each birth, by a trained provider during pregnancy and/or in the postpartum period;
- All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a doctor; and
- Annual screening and counseling for interpersonal and domestic violence.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prior Authorization Requirement

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Private Duty Nursing – Outpatient visits. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.

- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.
- The services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Rehabilitation services will be reviewed after 40 visits for medical necessity. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services.*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Spine and Joint Solution (SJS) Program MANDATORY

The Spine and Joint Solution (SJS) program is for eligible participants age 18 and older. SJS provides support before, during, and after surgery. Nurses help direct participants to high-quality facilities and provide them case management support.

In-scope procedures include:

- Spine Fusion Inpatient Surgery.
- Disc Inpatient Surgery.
- Total Hip Replacement Inpatient Surgery.
- Total Knee Replacement Inpatient Surgery.

If care involves a hospital admission, it may also require that surgery is performed at an SJS Center of Excellence (COE) facility (Designated Provider). To enroll in the program and find the closest COE provider, call 1-877-214-2930 and ask to speak with an SJS Nurse.

You must enroll in the SJS Program to access benefit coverage for spine and joint procedures. Failure to enroll in the program may result in no coverage for your spine & joint procedure.

Enhanced travel benefits may be available to participants who enroll in this program and utilize a Center of Excellence (COE) facility (Designated Provider) for their eligible surgery. See *Travel and Lodging* for details.

As part of the SJS program, most facilities will cover costs related to complications that result from the surgery for a period of 90 days after the surgery. Claims incurred during this period of time will be reviewed to determine if they were a complication related to the surgery or a readmission to the COE and, as a result, if this feature applies.

Benefits are available for spine and joint services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for inpatient spine and joint surgery are not available.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services

must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/ Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food*

and Drug Administration (FDA)-approved TMJ implants only when all other treatment has failed.

Any combination of Network Benefits and Non-Network Benefits for oral appliances and associated expenses is limited to a $1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis* (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

*Non-Network dialysis is *not* covered under the Plan.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement

For Non-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

The Plan pays Benefits for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement

For Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Provider, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). For Non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging Assistance Program

Travel and Lodging assistance is available under the Plan for you or your eligible family member only if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is more than 50 miles from your home address. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The SJS services program provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.

- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. Benefits under this section are available for services to treat a condition that does not meet the definition of Urgent Care.

Virtual Visits

The Plan provides Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.
- Non routine vision exam and refraction eye exam –(Vision Exam - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. Refractive eye exam – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accomodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND SERVICES

What this section includes:
Health and well-being resources available to you, including:

- Condition Management Services; and
- Telephonic Wellness Coaching.

The Company believes in giving you the tools you need to be an educated health care consumer. To that end, the Company has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the Company has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine[SM] is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine[SM] any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are available when you log onto **www.myuhc.com**;
- search for Network providers available in your Plan through the online provider directory;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanations of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Covered Persons who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS).*

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a condition management program at no cost to you. The heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition. These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the condition management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes[SM]

UnitedHealthcare provides a service called HealtheNotes to help educate Covered Persons and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 12, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Telephonic Wellness Coaching

The following provides a description of and the eligibility criteria for each Wellness Coaching program:

Tobacco Cessation Program

A tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support throughout the quitting process for up to one year via toll-free phone and live chat.
- Nicotine replacement therapy (patch, lozenge or gum) sent to you in conjunction with your quit date.

- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in the Quit For Life® program, or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

Stress Management Program

UnitedHealthcare's stress management program will provide you with information to help you manage stress through positive behavioral changes.

UnitedHealthcare will identify Covered Persons who are eligible for the stress management program based on the following criteria:

- Covered Persons who feel tense, anxious, or depressed often and stress has had a noticeable impact on health a lot over the past year.

Nutrition Management Program

UnitedHealthcare's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, and setting dietary goals, and making lifestyle changes. UnitedHealthcare will identify Covered Persons eligible for the nutrition management program based on the following criteria:

- Covered Persons having a BMI of greater than or equal to 25 and less than 30 and 5-6 servings of high cholesterol food per day. BMI greater than or equal to 30 is prioritized to the weight management program.

Exercise Management Program

UnitedHealthcare's exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. UnitedHealthcare will also provide exercise educational materials. UnitedHealthcare will identify Covered Persons eligible for the exercise management program based on the following criteria:

- Covered Persons with a BMI of greater than or equal to 25 and less than 30 and have physical activity less than one time per week. BMI greater than or equal to 30 is prioritized to the weight management program.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

The heart health lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise. The identification/stratification criteria for the heart health lifestyle management program are as follows:

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:
  - systolic BP = >/=140 or Diastolic BP = ./=90
  - high Blood Pressure and is on medication
  - cholesterol = 240 or HDL < 40
  - indicates has high cholesterol & is on medication
  - high LDL
  - indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Diabetes Lifestyle Management Program

The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/management and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication. The identification/stratification criteria for the diabetes lifestyle management program are as follows:

- Covered Persons who indicate they have diabetes and self-report excess weight with a BMI > 25. BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.

- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

If you are pregnant and enrolled in the Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefit Booklet says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefit Booklet specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.*

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative /chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

Dental

1. Dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under Dental Treatment Covered under Plan in Section 5, *Additional Coverage Details.*

2. Treatment for the following conditions:
   - injury related to chewing or biting;
   - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
   - periodontal disease or cavities and disease due to infection or tumor.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

For information on your dental coverage, contact your Dental Plan provider.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

4. The replacement of lost or stolen prosthetic devices

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

6. Oral appliances for snoring.

7. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details.*

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your CVS Caremark Prescription Drug Benefit Booklet for information about the Plan's prescription drug benefit).
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Clomiphine (e.g., Clomid®), menotropins (e.g., Repronex®), or other drugs associated with conception by artificial means.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.

4. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

2. Reversal of tubal ligation or vasectomy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - Compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details.*

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Food of any kind. Foods that are not covered include:

   - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details.*

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of $500 per Covered Person per lifetime.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.
2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).
3. Rehabilitation services and Manipulative/Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Speech therapy to treat stuttering, stammering, or other articulation disorders.
5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details.*
6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
8. Psychosurgery (lobotomy).
9. Treatment of tobacco dependency, excluding screenings and counseling.
10. Chelation therapy, except to treat heavy metal poisoning.
11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies.
12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
13. The following treatments for obesity:
    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details,* are satisfied.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis).

15. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

16. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

17. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

6. Services and supplies provided at Cancer Treatment Centers of America are not covered under the Plan.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).
4. The reversal of voluntary sterilization.
5. The reversal of tubal ligation or vasectomy.
6. In vitro fertilization regardless of the reason for treatment.
7. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
8. 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.
9. Services provided by a doula (labor aide).
10. 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.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services;

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 12, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*.

5. Rest cures.

8. Services of personal care attendants.

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3 Eye exercise or vision therapy.

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

5. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
   - That exceed Eligible Expenses or any specified limitation in this Benefit Booklet
   - For which a non-Network provider waives the Copayment, 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.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

11. Health services and supplies that do not meet the definition of a Covered Health Service as defined in Section 12, *Glossary.* Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Benefit Booklet under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights.*
    - Not otherwise excluded in this Benefit Booklet under this Section 7, *Exclusions and Limitations.*

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible, Coinsurance or Copay, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Retiree.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where

Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- the specific reason or reasons for the denial;
- 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 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 adverse benefit determination and any time limits for filing such a civil action;
- 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; and
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims.

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 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 claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

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:

- the specific reason or reasons for the adverse determination of your appeal;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination and any time limits for filing such a civil action and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request; and
- 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.

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: 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 legal action.

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.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required

UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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 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 appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9- COORDINATION OF BENEFITS (COB)

What this section includes:
- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term "allowable expense" is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee or retiree pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Only expenses normally paid by the Plan will be paid under COB.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Retiree under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan may pay an additional amount.

You will be responsible for any Deductible, Coinsurance or Copay payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If this Plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- individuals with end-stage renal disease, for a limited period of time; and
- participants not actively working and receiving long-term disability benefits for up to six months.

After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare.

If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

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.

This cross-over process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are

payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been contributed to or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not

have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for

any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 12 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible. The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Retirees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations.*

Covered Person – the Retiree or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6, *Clinical Programs and Services*, "Covered Person" means all domestic Retired Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or

- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works.*

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employer - Duke Energy Corporation.

EOB - see Explanation of Benefits (EOB).

ERISA – the Employee Retirement Income Security Act of 1974 (ERISA), the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Sickness, Injury, Mental Illness, substance related and addictive disorder disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions and Limitations.*

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights,* and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights,* and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay for Covered Health Services every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health

Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Standard PPO Option under the Duke Energy Retiree Medical Plan and/or the Duke Energy Retiree Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may

suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retiree – a former employee of the Company who is eligible for benefits under the Plan as described in the General Information Booklet.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan Coinsurance and Deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through 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.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted

randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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ATTACHMENT I - NOTICES

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT II – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT III – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏫ ᎲᏢ ᏗᏣᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎠᏆᏯ ᏛᏓ ᏩᏴᏢ ᏁᎯ ᎲᏒ ᏗᎫᎪᏁᏗ ᎠᏓᏍᏁᏗ ᏆᎾᏲᏍᏗᎤ, ᏧᏠᏫᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 [illegible].TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەومت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕیکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bąąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik1 1' b44sh bee hane'7 t'1 1 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wɛ̈rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveţi dreptul de a obţine gratuit ajutor şi informaţii în limba dumneavoastră. Pentru a cere un interpret, sunaţi la numărul de telefon gratuit care se găseşte pe cardul dumneavoastră de sănătate, apăsaţi pe tasta 0. TTY 711

Language	Translated Taglines
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	[illegible] TTY 711. 0
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל, דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láìsanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

Prescription Drug Program Guide for the Duke Energy Retiree Medical Plan

2018

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SECTION 1 – WELCOME

The Duke Energy Retiree Medical Plan ("Medical Plan") options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation ("Duke Energy") (individually or collectively referred to with its affiliated companies as the "Company," as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 64,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at **www.Caremark.com** to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

- CVS Caremark employees follow detailed ethical standards and a comprehensive Code of Conduct regarding your personal health information.
- CVS Caremark pharmacists follow a professional Code of Ethics.

SECTION 2 – HOW THE PROGRAM WORKS

Filling Your Prescription at a Pharmacy Participating in the CVS Caremark Retail Network

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay the applicable prescription drug co-pay or coinsurance amount.

- If you don't identify yourself to the pharmacist as a CVS Caremark participant, or if you go to a pharmacy that is not participating in the CVS Caremark retail network, you will have to pay the full price when you pick up the prescription and then submit a paper claim to CVS Caremark for reimbursement. You will be reimbursed based on the CVS Caremark negotiated price for the medication, less any required co-pay or coinsurance amount. Retail pharmacies that participate in the CVS Caremark retail network fill prescriptions at an agreed upon discounted price. When you fill prescriptions at a non-participating retail pharmacy, or do not identify yourself as a CVS Caremark participant, you may be charged a price higher than the negotiated price and the result is a higher cost prescription to you.
- If you make a prescription drug purchase at a pharmacy that is participating in the CVS Caremark retail network, do not identify yourself as a CVS Caremark participant by presenting your CVS Caremark prescription ID card and are required to pay full price for the prescription drug purchase, generally, you have up to 14 days from the time your prescription was purchased to return to the pharmacy, present your CVS Caremark prescription ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm at the time you make your purchase that you can return to have your purchase re-processed. You may be entitled to a refund for the difference between the full price and your applicable co-pay or coinsurance amount. This process will eliminate your need to submit a paper claim to CVS Caremark for reimbursement.

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. Under CVS Caremark's Maintenance Choice program, if you are taking a long-term medication, you must choose to receive 90-day supplies through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you. Whether you choose delivery or pick-up, you will pay the same applicable co-pay or coinsurance amount.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply co-pay or coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS

retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

If you will be obtaining your own prescription, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum).

The list of long-term medications that are part of the Maintenance Choice program is subject to change at any time. Visit **www.Caremark.com** to find out whether your medication is considered a long-term medication and whether it is affected by any Medical Plan limits, or you may call CVS Caremark directly for more information.

Process for Mail Order Medications
There are several methods you may use to fill your newly prescribed long-term medications through the CVS Caremark Mail Service Pharmacy.

- **Option 1**: Ask your doctor to select the CVS Caremark Mail Service Pharmacy using their provider ePrescribing tools, or your physician may call 800.378.5697.

- **Option 2**: Use the CVS Caremark mobile app for your smart phone to photograph your prescription order and submit the new prescription electronically to the CVS Caremark Mail Service Pharmacy.

- **Option 3**: Get started using the CVS Caremark Mail Service Pharmacy with FastStart®. Log on to www.caremark.com/faststart to provide the requested information, and CVS Caremark will contact your doctor for the 90-day prescription you need. You also can call FastStart® toll-free at 800.875.0867 for assistance.

- **Option 4**: Alternatively, you can complete the mail order form, which is available at www.Caremark.com, and send it with your new prescription order and payment method for any applicable copayment to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service for the first time, you then have the option to use the automated refill service for future refills by CVS Caremark. Visit www.Caremark.com for more information on the Auto Refill process.

Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

Using Mail Order if you have an Immediate Medication Need
If you will be using the CVS Caremark Mail Service Pharmacy, but need to begin taking a long-term medication immediately, have your doctor write two prescriptions:

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.

- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

The following are covered expenses under the Medical Plan unless listed as excluded below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (100% covered with no co-pay or coinsurance)
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes 100% covered with no co-pay or coinsurance)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% covered after standard co-pay, if applicable, up to $2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime, 100% covered with no co-pay or coinsurance)
- Anti-obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)

- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Retiree Dental Plan)

Medical Plan Annual Deductibles and Out-of-Pocket Maximums

Except as otherwise noted below for the Medical Plan's Catastrophic option, the prescription drug program co-pays and coinsurance amounts are not subject to or applied toward your Medical Plan annual deductibles or ***medical*** out-of-pocket maximums, if applicable. This means that the prescription drug program under the Medical Plan provides applicable benefits for covered prescription drug expenses even before you satisfy your annual deductible, if applicable.

Except as otherwise noted below for the Medical Plan's Catastrophic option, the prescription drug program co-pays and coinsurance amounts are applied toward your Medical Plan annual ***prescription drug*** out-of-pocket maximums, if applicable. This means that once you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums, you do not have to pay any further co-pays or coinsurance amounts for covered prescription drugs. Please note that the Medical Plan has separate annual ***medical*** out-of-pocket maximums. If you satisfy the Medical Plan's separate annual ***medical*** out-of-pocket maximums, but have not yet satisfied your applicable annual ***prescription drug*** out-of-pocket maximums, you still have to pay any applicable co-pay or coinsurance amount for covered prescription drugs until you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums.

Catastrophic Option

Under the Medical Plan's Catastrophic option, prescription drug program co-pays and coinsurance amounts do apply toward your Medical Plan annual deductibles, if applicable.

In addition, the prescription drug program co-pays and coinsurance amounts also are applied toward your Medical Plan's applicable annual out-of-pocket maximums. For the Medical Plan's Catastrophic option, the annual prescription drug and annual medical deductible and out-of-pocket maximums are combined. This means that once you satisfy your applicable annual out-of-pocket maximums, you do not have to pay any further co-pays or coinsurance amounts for covered prescription drugs or medical expenses.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your co-pay and/or coinsurance amounts for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at **www.Caremark.com** or call CVS Caremark Customer Service at 888-797-8912.

Refer to the prescription drug benefit summary on page 19 for more information about applicable co-pays and/or coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and
- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)
- Influenza (Fluzone)

- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

Please Note: Not all local pharmacies are staffed to provide immunizations and some may require a prescription to administer the vaccine based on requirements of particular states. Check with your local pharmacy for vaccine availability before you go.

CVS Caremark Specialty Medications and Specialty Guideline Management

Duke Energy participates in the CVS Caremark Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. Under your prescription drug program, some specialty medications may only be covered when ordered through CVS Caremark's specialty care pharmacy. CVS Caremark is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Certain specialty medications such as treatments for Growth Hormone and related disorders, Hepatitis C, Multiple Sclerosis and Anemia will have additional management that ensures that the specialty medication continues to have appropriate lab testing and data reviewed to help ensure utilization of these specialty medications to be:

- clinically appropriate;
- safe; and
- effective for the patient throughout the duration of therapy.

For continued treatment with one of these specialty drugs, a periodic clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review.

The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or to your doctor's office
- Medicine- and disease-specific education and counseling
- Online support through **www.Caremark.com/specialty**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also

require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

All specialty medications undergo external review of the program guidelines by clinical experts to ensure the program is unbiased and consistent with current standards of care and practice.

To answer any questions you may have about specialty medications or to find out what medications are considered to be specialty medications for purposes of the Medical Plan, you may contact CVS Caremark Specialty Pharmacy Services directly at 800-237-2767.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30 or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have, except for Medicare as described below. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a deductible and coinsurance, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

Please Note: CVS Caremark <u>does</u> coordinate benefits for Medicare Part B coverage for participants with that coverage. Please see the section titled "Medicare Part B Medications" below for more details.

Medicare Part B Medications

(Applicable only to Medicare Part B enrollees)

If you have Medicare Part B coverage, you will be able to fill prescriptions as described below:

Take your prescription to a Medicare Part B retail pharmacy. If you choose to use a Medicare Part B retail pharmacy for your Medicare Part B medication or supply needs, you will be asked to present your Medicare ID card.

- The participating Medicare Part B retail pharmacy will work with you to bill Medicare on your behalf.
- Most independent pharmacies and national chains are Medicare Part B providers. If you want to locate a retail pharmacy that is a Medicare Part B provider, visit the Medicare website at **www.medicare.gov**.

Medicare Part B allows only 30 days worth of medication except for Diabetic Supplies. For Diabetic Supplies, you can receive up to a 90-day supply; however, you can only test up to 3 times a day. If you test more than 3 times a day, you will need to provide further documentation as to why it is necessary for you to test so often. Further documentation can include the results of blood tests conducted by your physician's office.

All prescriptions must be in writing; CVS Caremark cannot take a verbal prescription over the phone. However, CVS Caremark can accept a faxed copy.

Call CVS Caremark at 888-797-8912 to find out what types of drugs or supplies are covered by Medicare Part B.

CVS Caremark needs to have an original Assignment of Benefits (AOB) form filled out before your Medicare Part B prescriptions can be filled at mail order. If the AOB form is not filled out,

CVS Caremark will divert those prescriptions and make an outbound call to obtain a copy of the AOB form. An AOB form will also be included in each order; however, you only have to fill out an original once each year. To obtain an AOB form, call CVS Caremark Customer Service at 888-797-8912.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable co-pay or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required co-pay or coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2018, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2019 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable co-pay or coinsurance amount, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2018 would have 45 days (until February 14, 2018) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CVS Caremark sends such a notice of missing information, and the determination period will resume on the date you respond to the notice. You will have at least 45 days to respond to the request for information.

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)

In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims

If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's review procedures, 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 adverse benefit determination on appeal and any time limits for filing such a civil action;
- 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; and
- 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.

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.

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:

- 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 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 adverse benefit determination and any applicable time limits for bringing such a civil action;
- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge; and
- 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.

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."

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 claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority
The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to 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 benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable co-pays, coinsurance and plan limits, please call CVS Caremark Customer Service or visit ***www.Caremark.com****. For more detailed information on the Medical Plan, refer to the Duke Energy Retiree 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:
Certain contraceptive medications and routine vaccines	**$0**	**$0**
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	Lower of **$10** or the cost of the medication*	Lower of **$25** or the cost of the medication*
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	**25%** of the cost of the medication up to a maximum of **$50***	**25%** of the cost of the medication up to a maximum of **$125***
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	**50%** of the cost of the medication up to a maximum of **$100***	**50%** of the cost of the medication up to a maximum of **$250***
***Prescription Drug Out-of-Pocket Maximum** These amounts apply to only the prescription drug out-of-pocket maximum	$2,000 per year for individual coverage / $4,000 per year for family coverage	

Maintenance Choice® is a registered mark of Caremark, LLC.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-041

REQUEST:

Provide detailed descriptions of all early retirement plans or other staff reduction programs Duke Kentucky has offered or intends to offer its employees during either the base period or the forecasted test period. Include all cost-benefit analyses associated with these programs.

RESPONSE:

While the Company seeks continuous improvement to address evolving business needs, the Company does not anticipate early retirement or staff reduction programs at this time for the forecasted test year. As businesses need to meet O&M targets, there are some tools under which employees have left or are leaving under during the base period; however, none of those employees leaving were in the Duke Energy Kentucky payroll company. Those tools which have been applied to employees in other jurisdictions are described in STAFF-DR-01-041(a) through (c) Attachments.

PERSON RESPONSIBLE: Renee H. Metzler

Management Toolkit

Performance Transition Plan (PTP)

November 2015

IMPORTANT: This document contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with applicable plan documents, the plan documents shall 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, shall be considered a contract for future employment.

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Performance Transition Program (PTP) Overview

As part of our workforce planning and performance management efforts, the Company is now offering a program designed to address poor performers and provide an option to exit a poorly performing employee in lieu of placing the employee on a formal Performance Improvement Plan (PIP).

This Management Toolkit provides an overview of the process to help facilitate the potential application of the PTP, understand the appropriate use of the PTP and determine employee eligibility.

With approval by the responsible Executive Leadership Team member and the business unit HR Business Partner Director, management may offer a choice to an employee with documented poor performance to either exit the Company under the PTP or to pursue a PIP, under the following conditions:

1. The employee has documented poor performance, including but not limited to: an overall rating of Partially Meets Expectations/Needs Improvement or lower on his or her most recent mid-year or annual performance appraisal; or
2. The employee has not yet had a performance appraisal and has demonstrated serious performance deficiencies; or
3. The employee has met expectations on his or her most recent performance appraisal but whose performance has deteoriated rapidly, or successfully completed a PIP in the past but demonstrated a subsequent decline in performance; AND
4. Management has concerns that the employee may not be successful on a Performance Improvement Plan or has identified other factors supporting a decision to offer the employee an alternative to a PIP.

Employees generally will not be offered a choice when they are subject to termination for misconduct, including but not limited to, theft, harassment, violations of Company policy, or other similar misconduct, or when they have failed to successfully complete a PIP within the previous twelve months.

Employees who choose to separate under the PTP in lieu of a PIP will be eligible for a transition payment, health care supplement, and outplacement services as described below, if they meet certain requirements, including separating from employment when designated by management, and signing and not revoking a waiver and release of claims acceptable to the Company. Those benefits are:

1. Transition payment provided as a lump sum payment equivalent to the amount of 12 weeks of the employee's regular base pay, and

2. Health care supplement provided as a lump sum payment equivalent to the premium cost of three months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by the Company in its sole discretion.

3. Six (6) months of outplacement services through a vendor selected by the Company in accordance with the Company's policies in effect from time to time as of his or her separation from Duke Energy.

When management has obtained appropriate approvals to offer this alternative, the employee should be provided with the "PIP With PTP Option" template included in this Toolkit instead of the PIP standard template.

PTP Process

The following describes the process to pursue this option:

Steps	Description	Objectives
1	Gather Information	• Identify employees that are not performing in accordance with previously communicated expectations • Gather and review documentation relating to the employee's poor performance, including prior performance appraisals.
2	Decide whether to offer PIP with PTP Option and seek approvals.	• Determine (i) the likelihood of success on a PIP and (ii) risk to the Company if the PTP is not offered. • Decide whether to seek approval to offer the PTP Option. • Obtain required approvals.
3	Meet with employee to offer the Performance Transition Program	• Offer the PTP Option to the employee using the standard script provided below.
4	Implement the PIP (if chosen by employee) or separate under PTP	• Employee selects between PIP or PTP Option • If PIP selected, employee continues under terms of the PIP • If a PTP is selected, the employee terminates under the PTP provisions

Manager Script for 1-on-1 Meeting w/ Employee to Offer Proposed PIP with PTP Option

This script should be used to offer poor performers the choice between continuing their employment under the terms of a PIP, or separating from employment under the PTP Option. The completed form should be returned to your HR Business Partner.

Employee ID: ____________ **Employee Name:** ____________________

Date: ____________ **Employee Job Title:** ____________________ **Department:** __________

- Thank you for taking the time to meet with me today.
- Over the past several months, there has been a decline in your performance and I'd like to discuss with you how we can address this. *(Add specific examples of poor performance here.)*
- When there are performance concerns, the Company typically offers the employee a Performance Improvement plan or PIP. The PIP is a tool to assist an employee with improving and sustaining personal performance to a satisfactory level in areas that are critical to meeting the demands of his/her position.
- A PIP is a joint effort involving a written understanding between an employee and a supervisor/manager regarding specific ways to improve less than satisfactory performance in a specific time period.
- In this case, we would place you on a PIP for 90 days.
- The PIP is not corrective action; however, your failure to adhere to the expectations outlined in the PIP may result in corrective action up to and including discharge.
- Upon successful completion of a PIP, you are expected to sustain a level of satisfactory performance for 12 months or you could be removed from your position pending an investigation.
- **At times, the Company also may offer a second option** to consider if you do not feel that you will be successful in the PIP program. The second option would involve your separation from the Company under a Performance Transition Program in lieu of a PIP.
- The PTP Program offers an opportunity for a transition payment, health care supplement, and outplacement services if all program requirements are met.
  - The Transition payment would be provided as a lump sum payment equivalent to the amount of12 weeks of your regular base pay, and
  - The health care supplement would be a second payment equivalent to (ii) three (3) months of the cost of medical/dental/vision coverage under COBRA for you and your covered dependents, based on your existing coverage as of your release date which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion.
  - The PTP Program also offers six (6) months of outplacement services through a vendor selected by the Company in accordance with the Company's policies in effect from time to time.

- To participate in the PTP Program in lieu of a PIP, you would be required to separate from your employment when released, and sign and not revoke a Waiver and Release of Claims against the Company.

- *(Provide the employee with a copy of the completed PIP document and PTP Program Overview here).*

- This is an important decision, and I understand if you need more time to think it over. Let's plan to reconvene in a few days so that we can agree on a decision and discuss next steps.

- *Manager/Supervisor to take the action item to schedule the follow up discussion.*

Performance Improvement Plan with PTP Option - EXAMPLE

Employee Name: ____________________ **Employee Job Title:** ____________________

Date: __________________ **Supervisor Name:** ____________________________________

As previously discussed on <insert date/s>, there are a number of performance areas you need to immediately improve in order to meet the requirements of your role of <Title>. You have not met the expectations of a <Title> role in the following areas including, but not limited to:

<include explanation of how the employee has not met the requirements; for example.:
- Work Execution
- Communication
- Interpersonal Skills

In order to meet the requirements of the position you currently hold, you are being placed on a Performance Improvement Plan (PIP) and you are expected to achieve the following performance standards:

Improvement Area	Performance Standard	Improvement Measure	Deadline
Work Execution	Work activities will be efficiently performed in a quality manner, demonstrating commitment and effective follow-through.	• Produce quality work by ensuring that the schedule is accurately and adequately developed to 80% loaded prior to weekly commitment meeting. • Use priority work list, such as 1s, 2s, and 3s and/or the ranked list of work from the scheduling application. • Make note of those items discussed in the daily and weekly meetings and include them in the schedule. • Reduce time spent on personal activities, such as phone calls and internet usage, in order to focus more time on work-related responsibilities. • Keep supervision informed on a weekly basis of work activities/situations	
Communication	Verbal communications will improve to an effective level.	• Communicate schedule to all team members in a timely and on-going manner. Team members include: (list titles) • Ensure that schedule has been communicated to Operations between (specify times) on a daily basis. • Encourage (titles) to complete their assigned tasks based on the schedule and in a timely and positive manner. • Improve the weekend schedules for all	

		groups in order to reflect productive work.	
Interpersonal Skills	Establish positive relationships with team members.	• Be receptive to feedback by actively listening with the intent to understand. • Increase interaction with (titles) in order to improve relationships.	

It is your responsibility to successfully manage your job performance in order to meet the expectations of your PIP. To support your efforts, I will continue to meet with you on a regular basis to provide feedback regarding your performance against these performance standards. Unless prevented by business circumstances, our meetings will be held ________________**<insert: weekly or bi-weekly >**. The goal of these meetings is to monitor your PIP progress and ensure your continued understanding of Duke Energy's expectations for your performance as a ____________ **<Title>**.

You will also be required to complete the following formal training as part of the PIP: _______________ **<insert training>**. During the period of time that you are on a PIP, you are generally not permitted to transfer to another position, subject to any local law requirements.

If you have any questions or are not clear regarding these expectations, please do not hesitate to ask for clarification. Significant progress against these performance standards is expected on an immediate and sustained basis with full correction of the deficiencies noted above by the end of the PIP's 90 day duration, on __________**<PIP end date>**.

If at any time it appears that you are not making significant progress, further action, up to and including the termination of your employment, will follow in accordance with applicable law. It is expected that once satisfactory performance is achieved, it will be maintained during the course of your employment. Please be aware that notwithstanding the PIP, your employment with Duke Energy continues to be terminable in accordance with applicable law and the terms and conditions of your employment.

You are encouraged to contact the Company's Employee Assistance Program provider, at _____(name)_______, at ________(phone number) for assistance with any personal issues that may be impacting work.

Employee Acknowledgement

I have discussed this plan with my supervisor and manager and I understand the expectations as described. I understand that the intent of this plan is to assist me with being successful in my current position; however, if my performance does not improve and does not result in sustained acceptable performance, management will determine the appropriate corrective action, up to and including termination at any time during or following the performance improvement plan.

_________________________________ _________________________

(Employee's signature) (Date)

_________________________________ _________________________

(Supervisor's signature) (Date)

Performance Transition Program Option. In the event that you do not believe you will complete this PIP successfully or otherwise do not desire to pursue a PIP, you are eligible for an alternate option called the Performance Transition Program (PTP). Accordingly, you may elect to separate from your employment in lieu of a PIP with a transition payment and outplacement services, as described below, if you meet certain requirements, including separating from employment when designated by management, and signing and not revoking a waiver and release of claims acceptable to the Company. The PTP benefits are fully described in the attached Letter Agreement. As a brief overview, those benefits include the following:

1. Transition payment in the amount of 12 weeks of the employee's regular base pay, and
2. A health care supplement equivalent to the premium cost of 3 months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by the Company in its sole discretion.
3. Six (6) months of outplacement services through a vendor selected by the Company in accordance with the Company's policies in effect from time to time (including the Duke Energy Corporation 409A Policy).

Please complete the attached "Letter Agreement" form to communicate your decision whether to pursue a PIP or to separate from employment under the PTP.

PTP LETTER AGREEMENT TEMPLATE

(place on Company letterhead)

[INSERT DATE]

Dear ____________________**[INSERT EMPLOYEE NAME]** **Empid** __________________

As an alternative to acknowledging the terms of the Performance Improvement Plan "PIP" provided to you on ______ **[INSERT DATE], [INSERT APPLICABLE PAYROLL COMPANY]** (the "Company") is offering you the opportunity to separate from employment with the Company and its affiliates (collectively, "Duke Energy") on ___________ **[INSERT DATE]** (the "Separation Date") under the Performance Transition Program (PTP) and receive the following benefits if you agree to the terms of this Letter Agreement, separate under the PTP on your Separation Date in accordance with this Letter Agreement and sign and do not revoke a waiver of claims against the Company and certain other entities and individuals substantially in the form attached hereto as Attachment I (the "Waiver");

1. Separation Pay. In addition to the amounts set forth below, if you separate under the PTP in accordance with the terms of this Letter Agreement, the Company agrees to pay you:

   a. A transition payment provided as a lump sum cash payment equal to $______________ **[INSERT TRANSITION PAYMENT AMOUNT]** (the "Transition Payment").; and

   b. A health care supplement payment provided as a lump sum cash payment equal to $_________ **[INSERT HEALTH CARE SUPPLEMENT AMOUNT]**, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion.

   Payment will be made within 60 days after the Separation Date, provided that you have first executed, returned and not revoked the attached Waiver. You will not be eligible to receive the payment described above if you fail to complete these actions regarding the Waiver within the stated 60-day period. The Company will have the right to deduct from any payment made to you pursuant to this Letter Agreement such taxes as are, in the reasonable opinion of the Company, required to be withheld with respect to such payment, as well as any other deductions required by law, such as those made in order to comply with any court or administratively ordered wage garnishments. No amounts paid to you pursuant to this Letter Agreement will be considered when determining your benefits under the Company's other benefit plans (e.g., 401(k) plan, defined benefit pension plan, etc.).

2. Outplacement Services. If you separate under the PTP in accordance with the terms of this Letter Agreement, the Company will make outplacement services available to you for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

3. Benefits after Separation. Following your Separation Date, you will not be entitled to any other benefits or compensation from the Company, any of its affiliates or any of their respective benefit plans or arrangements, other than as expressly set forth below:

   a. Base Salary and Vacation Pay. Within 30 days of your Separation Date, the Company agrees to pay you your base salary for services through the Separation Date and for all of your unused, accrued vacation for the calendar year in which your Separation Date occurs.

b. Retirement Benefits. Your rights with respect to retirement benefits will be determined pursuant to the terms of the Duke Energy Retirement Savings Plan and/or the Duke Energy Retirement Cash Balance Plan, each as amended from time to time.

c. Welfare Benefits. Your rights with respect to welfare benefits (e.g., COBRA and/or retiree healthcare coverage) will be determined pursuant to the terms of the Duke Energy Active Health & Welfare Benefit (Financed) Plans, the Duke Energy Active Health & Welfare Benefit Plans, the Duke Energy Retiree Health & Welfare Benefit (Financed) Plans and the Duke Energy Retiree Health & Welfare Benefit Plans, each as amended from time to time.

Nothing herein shall modify or otherwise affect such benefit plans or arrangements.

I. Election

Please select from the following:

☐ I would like to proceed with the PIP. I have discussed the PIP with my management and I understand the expectations as described in the PIP. I understand that the intent of the PIP is to assist me with being successful in my current position; however, if my performance does not improve and does not result in sustained acceptable performance, management will determine the appropriate corrective action, up to and including termination of my employment at any time during or following the PIP. I also acknowledge that I will not be eligible for a transition payment if I am not successful on the PIP.

☐ I would like to separate under the PTP. I understand this will result in my separation from employment with **[INSERT APPLICABLE PAYROLL COMPANY]** and its affiliates on the Separation Date specified above and that this election is irrevocable. This election is entirely voluntary.

______________________________ ______________________
(Employee's signature) (Date)

______________________________ ______________________
(Supervisor's signature) (Date)

Note: Please return completed forms to the HRBP

SAMPLE WAIVER AND RELEASE OF CLAIMS

UNDER THE DUKE ENERGY PERFORMANCE TRANSITION PROGRAM

This Waiver and Release of Claims (the "Release"), delivered on ____________, is entered into by and between Duke Energy Corporation and its subsidiaries and affiliates and any predecessors and successors thereto (individually and collectively referred to as the "Company"), and __________________________ ("Employee") pursuant to the Performance Transition Program (the "Program") with the mutual exchange of promises as consideration.

WHEREAS, Employee is eligible to separate from employment on ______________ (the "Separation Date") and receive severance benefits described below provided Employee enters into and does not revoke this Release; and

WHEREAS, the Company is willing to provide the Employee the severance benefits described below, provided Employee enters into and does not revoke this Release.

THEREFORE, the Company and Employee agree as follows:

1. Program Benefits. In exchange for Employee separating from employment with the Company on his or her Separation Date in accordance with the Program and entering into and not revoking this Release, the Company agrees to provide the Employee the following:

   a. Transition Payment. A lump sum cash payment equal to $__________ less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Release.

   b. Health Care Supplement. A lump sum cash payment equal to $_________, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Release.

   c. Outplacement Services. Outplacement services for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy.

2. Basis for Entitlement. Employee acknowledges and agrees that Employee would not be entitled to the benefits described in Paragraph 1 absent Employee's separation from employment on his or her Separation Date and execution and non-revocation of this Release in accordance with the Program. Employee further acknowledges that he or she is not entitled to a pension enhancement under the Program.

3. Adequate Consideration. Employee acknowledges and agrees that this Release provides good, valuable and sufficient consideration for Employee's obligations under this Release.

4. Release by Employee. Employee, of the Employee's own free will, voluntarily waives and releases the Company, its employee benefit, pension, welfare, and other plans or programs (including any and all fiduciaries thereof), and any of the Company's respective current or former officers, directors, agents, employees, attorneys, insurers, plan administrators, predecessors, successors or assigns from any and all rights or claims that Employee has, or may have, as of the date of the execution of this Release, based on or arising out of the

employment relationship or the termination of the employment relationship, other than those rights or claims set forth below in Paragraph 5. The rights and claims so waived and released shall include, but not be limited to:

a. Those arising under any federal, state or local statute, ordinance, common law (including, but not limited to, claims of breach of promise, breach of contract, promissory estoppel, intentional or negligent infliction of emotional distress, defamation, tortious interference with a business relationship or contract and wrongful discharge), or claims in equity or public policy; and
b. Those arising under any law based on any protected status or employment, including but not limited to, sex, age, race, color, religion, handicap or disability, national origin, pregnancy, discrimination, retaliation, or whistleblower (including, but not limited to, any rights or claims arising under Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1991, the Americans with Disabilities Act, the Rehabilitation Act, the Older Workers Benefits Protection Act of 1990, the Equal Pay Act of 1963, the Employee Retirement Income Security Act of 1974, the Age Discrimination in Employment Act of 1967, the Family and Medical Leave Act, the Genetic Information Nondiscrimination Act, the Equal Pay Act of 1963, the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Indiana Discrimination on Account of Age Act, the Indiana Civil Rights Statute, the Kentucky Civil Rights Statute, the Ohio Civil Rights Statute, the North Carolina Equal Employment Practices Act, the North Carolina Persons with Disabilities Protection Act, the North Carolina Retaliatory Employment Discrimination Act, the South Carolina Human Affairs Law, the Florida Civil Rights Act, the Florida Whistleblower Act, the Texas Labor Code Chapter 21, and every other local, state, or federal law, regulation, or other legal authority concerning employment rights or claims); and
c. Those arising under the civil rights laws of any state or municipality; and
d. Any claim for compensatory damages, punitive damages, attorneys' fees, expenses and litigation costs; and
e. Any grievance, charge or other claim arising under the applicable collective bargaining agreement, National Labor Relations Act, or other similar labor laws, regulations, and authority.

Employee acknowledges that he or she has been paid for all hours worked during his or her employment with the Company and has received all other payments owed to him or her by the Company as of his or her Separation Date. In addition, Employee acknowledges that he or she has received all leave to which he or she may have been entitled to under the Family and Medical Leave Act or applicable state law during his or her employment with the Company.

5. Claims Not Waived. Notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release any workers' compensation or unemployment compensation claims filed prior to the date of execution of this Release, or claims against the Company arising out of possible exposure to asbestos during Employee's employment with the Company at a facility or facilities owned by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release Employee's rights or claims to accrued or vested benefits under an employee benefit plan or program maintained by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release claims that may arise after the date of execution of this Release, including, but not limited to, claims that may arise under an employee benefit plan or program maintained by the Company.

6. Acknowledgement of No Interference with Reporting and Compliance Rights. Employee acknowledges and agrees that it is the policy of the Company to comply with all applicable federal, state and local laws and regulations. Employee affirms that he or she has reported all compliance issues and violations of federal, state and local law or regulation or Company policy of which he or she had knowledge during the term of his or her employment, if any. Employee represents and acknowledges that he or she has no further or additional knowledge or information regarding compliance issues or possible violations of federal, state or local law or regulations or Company policy other than what Employee may have previously reported, if any, including, but not limited to, any and all outstanding nuclear safety concerns Employee has involving any nuclear power plant owned or operated by the Company. Nothing in this Release shall be construed to prohibit, restrict or otherwise discourage Employee from participating in "protected activity" as defined in 10 CFR 50.7 and Section 211 of the Energy Reorganization Act of 1974, including, but not limited to reporting any suspected instance of illegal activity of any nature, any nuclear safety concern, any workplace safety concern, any public safety concern, or any other matter within the United States Nuclear Regulatory Commission's ("NRC") regulatory responsibilities to the NRC, the United States Department of Labor, or any other federal or state governmental agency. This Agreement further does not prohibit Employee from participating in any way in any state or federal administrative, judicial, or legislative proceeding or investigation. Further, nothing in this Agreement prevents Employee from filing a charge or complaint, with or from participating in an investigation or proceeding conducted by the Equal Opportunity Commission ("EEOC"), National Labor Relations Board ("NLRB"), Securities and Exchange Commission ("SEC"), or any other federal, state or local agency charged with the enforcement of any laws, or from exercising rights under Section 7 of the NLRA to engage in joint activity with other employees, although by signing this Agreement, Employee acknowledges that the Release waives Employee's right to individual relief based on claims asserted in a such a charge or complaint, regardless if such claim is brought individually or as part of a class or collective action, except where such waiver of individual relief is otherwise legally prohibited.

7. Promise Not to Sue. Employee agrees not to institute a lawsuit against the Company asserting any of the claims that are released in Paragraph 4 of this Release. **Employee acknowledges that signing this Release means that Employee has waived not only his or her right to recover in a lawsuit, claim or other action brought by him or her as described herein, but also in any claim, lawsuit or other action brought on his or her behalf (including any claim of age discrimination) against the Company based on or arising out of the employment relationship or the termination of the employment relationship up to the date this Agreement is signed. This does not mean that Employee is precluded from filing a charge of discrimination with EEOC, or other state commission or otherwise participating in proceedings before the EEOC or those commissions; however, if Employee does file such a charge, he or she shall be entitled to no monies, pay, compensation or relief of any type from the Company as a result of the charge.**

8. Confidentiality. Employee shall not, at any time, directly or indirectly, use any trade secrets or confidential information of the Company for Employee's benefit or the benefit of any other person or, directly or indirectly, disclose any such trade secrets or confidential information of the Company to any other person. The Company and Employee agree to keep the terms and conditions of this Agreement confidential except to the extent the terms and conditions are required to be disclosed by any judicial or administrative federal, state or local agency. Employee may also disclose the terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Employee may also disclose the terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to

be bound by this same pledge of confidentiality. Notwithstanding any provisions of this Agreement to the contrary the Employee may be entitled to immunity and protection from retaliation under the Defend Trade Secrets Act of 2016 for disclosing a trade secret under limited circumstances, as set forth in the Company's Innovations and Intellectual Properties Policy.

9. Cooperation with Litigation. Upon the Company's request, Employee agrees to render reasonable assistance to the Company in connection with any litigation or investigation relating to the Company's business. Such assistance shall include, but not be limited to, providing information, attending meetings, assisting with discovery, giving depositions and making court appearances. Employee agrees to promptly notify the Chief Legal Officer of the Company of any requests for information or testimony that Employee receives in connection with any litigation or investigation relating to the Company's business; provided however, that this reporting requirement will not apply in the context of "protected activity", as defined in Paragraph 6 of this Release.

10. Consultation with Attorney Advised. **Employee is advised to consult with an attorney prior to executing this Agreement.** Employee acknowledges being given that advice. Employee represents that he or she has read and fully understands all of the provisions of this Agreement. Employee represents that he or she is voluntarily signing this Agreement.

11. Due Care - Time Frame for Acceptance. **Employee acknowledges that he or she has received a copy of this Release and has been given a period of twenty-one (21) days from his or her Separation Date within which to freely and voluntarily consider and sign this Release.**
    a. To enter into this Agreement, Employee must execute it by signing, dating and returning it to the **Employee Relations Control Center, Attn: Cathy Edwards, DEC37B, 550 South Tryon, Charlotte, North Carolina 28202**.

    b. Employee acknowledges that if Employee has signed this Agreement it is because Employee freely chose to do so.

    c. Employee has **seven (7) calendar days** after he or she signs this Agreement within which to revoke it. To be effective, a revocation must be communicated in writing to the **Employee Relations Control Center, Attn: Cathy Edwards, DEC37B, 550 South Tryon, Charlotte, North Carolina 28202**, and delivered no later than 5:00 p.m. Eastern Time on the final day of the seven (7) day period.

12. Governing Law. This Agreement shall be interpreted, enforced and governed under the laws of the State of North Carolina.

13. No Admission of Liability. This Agreement shall not in any way be construed as evidence or as an admission of any liability or wrongdoing by the Company.

14. Binding Effect of Agreement. This Agreement will be binding upon and shall operate for the benefit of the heirs, executors, administrators, assigns, and successors in interest of Employee and the Company.

15. Severability. If any portion of this Agreement should be unenforceable for any reason, the parties agree that the remaining portions will continue in effect.

16. Effective Date. This Agreement shall become effective and enforceable upon the expiration of the revocation period established in Paragraph 11 (the "Effective Date").

AGREED TO BY:

______________________________ ________________________
Employee Date

THE COMPANY

By: __________________________ ________________________
Stan Sherrill Date
Vice President, Employee Relations
and Labor Relations

DUKE ENERGY
SEVERANCE PLAN
(Plan No. 587)

SUMMARY PLAN DESCRIPTION

Effective November 1, 2016

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I. INTRODUCTION

The purpose of the Duke Energy Severance Plan (the "DESP") is to provide severance benefits to Eligible Employees of Duke Energy Corporation and its participating affiliates, including Piedmont Natural Gas Company, Inc. ("Piedmont Natural Gas") (individually and collectively, the "Company"). The DESP provides a lump sum severance payment, certain continued health benefits and outplacement assistance (collectively, "DESP Benefits") to Eligible Employees who separate under the DESP.

This document is a Summary Plan Description for the DESP as in effect on November 1, 2016 that describes the eligibility criteria and DESP Benefits available to Eligible Employees who are separated from employment with the Company and its affiliates under circumstances in which the provision of severance benefits is appropriate, as determined by the Company, in its sole discretion. The eligibility criteria for any voluntary window offered under the DESP, as well as the DESP Benefits available to Eligible Employees who request and are approved for separation under any such voluntary window, will be described in a separate Summary Plan Description.

You must read each provision of this Summary Plan Description as a part of the whole summary. A single statement, read out of context, may be misleading. The DESP is intended to be a "welfare plan" subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), and is effective as of November 1, 2016.

II. ELIGIBILITY

A. Eligibility Criteria

You are an Eligible Employee for purposes of the DESP only if you are an active employee of the Company and the Company, in its sole discretion, designates you as an Eligible Employee. The Company may designate you as an Eligible Employee in such circumstances as the Company, in its sole discretion, determines make the provision of severance benefits appropriate.

You will not be an Eligible Employee if any of the following applies to you: (i) you are employed in a position governed by a collective bargaining agreement; (ii) you are in temporary, seasonal or fixed-term employment status; (iii) you are an executive officer of the Company; (iv) you are eligible for severance protection under another active severance plan or agreement sponsored by Duke Energy Corporation ("Duke Energy") or a Duke Energy affiliate including, but not limited to, the Piedmont Natural Gas Company, Inc. Severance Plan; (v) you are not designated as an Eligible Employee by the Company or (vi) you are selected for and accept a position with the Company after being designated as an Eligible Employee, but prior to your Release Date, as determined by the Company, in its sole discretion.

B. Requirements for Receiving DESP Benefits

If you are designated as an Eligible Employee you will be eligible to receive DESP Benefits only if each of the following applies to you:

- you separate from employment in accordance with the terms of the DESP on the Release Date (as defined below) established by the Company for you;
- you sign and do not revoke a waiver of claims against the Company and certain others which becomes effective and irrevocable no later than 53 days following the date you receive such waiver; and
- you meet all other requirements of the DESP.

You will not be eligible to receive DESP Benefits if (i) you voluntarily separate from employment prior to your Release Date, as determined by the Company, in its sole discretion; (ii) your employment is terminated for cause, as determined by the Company, in its sole discretion, prior to your Release Date;

(iii) you are removed from service prior to your Release Date and subsequently terminated for cause, as determined by the Company, in its sole discretion; (iv) you separate and become entitled to severance benefits pursuant to another severance plan or agreement sponsored by Duke Energy or its affiliates, as determined by the Company, in its sole discretion; or (v) you are selected for and accept a position with the Company after being designated as an Eligible Employee, but prior to your Release Date, as determined by the Company, in its sole discretion.

C. Release Date

Your "Release Date" is the date on which you must separate from employment with Duke Energy and its affiliates in order to receive DESP Benefits. Release Dates will be designated by the Company, in its sole discretion, and generally will be no later than 12 months following the date of the notification informing you that you have been designated as an Eligible Employee under the Plan.

III. DESP BENEFITS

As described in more detail below, DESP Benefits include a lump sum severance payment, certain continued health benefits and outplacement assistance.

A. Severance Payment

If you are designated as an Eligible Employee and separate under the DESP in accordance with the terms of the DESP, you will receive a Severance Payment ("Severance Payment") as described below.

1. Formula

The Severance Payment is calculated as of your Release Date in accordance with the following formula:

- two weeks of your Annual Base Pay for each Year of Service (including partial Years of Service).

Your Severance Payment will not be less than 12 weeks of your Annual Base Pay and will not be more than 52 weeks of your Annual Base Pay.

2. Payment

If you separate under the DESP in accordance with the terms of the DESP, you will receive the Severance Payment in the form of a lump sum via check following your Release Date as follows:

- if your Release Date occurs on or before October 31 of a calendar year, you will receive the lump sum payment within 21 calendar days after your waiver becomes effective and irrevocable; and
- if your Release Date occurs after October 31 of a calendar year, you will receive the lump sum payment within 21 calendar days after the later of (i) January 1 of the immediately following calendar year, or (ii) the date that your waiver becomes effective and irrevocable (but no later than 53 days following the date you receive such waiver).

Your Severance Payment is subject to all applicable state and Federal tax withholdings, as well as any other deductions required by law, such as those made in order to comply with any court or administratively ordered wage garnishments.

3. *Definitions*

For purposes of calculating the amount of the Severance Payment,

"Annual Base Pay" means the following:

- if you are an Eligible Employee paid on a salaried basis, your annual base pay as in effect on your Release Date, excluding any allowances, premiums, bonuses, overtime, benefits or other forms or types of compensation; and

- if you are an Eligible Employee paid on an hourly basis, your hourly base rate of pay as in effect on your Release Date, excluding any allowances, premiums, bonuses, overtime, benefits or other forms of types of compensation, multiplied by (A) 2080 if you are a full-time employee as of your Release Date, as determined by the Company, in its sole discretion or (B) if you are a part-time employee as of your Release Date, as determined by the Company, in its sole discretion, the number of hours you were scheduled to work during the 12-month period ending on your Release Date (which number of hours will be annualized if such period of employment is less than 12 months).

"Year of Service" means the following:

- if you were employed by Duke Energy and its affiliates immediately prior to the merger of Duke Energy and Piedmont Natural Gas contemplated by the Agreement and Plan of Merger dated as of October 24, 2015 (the "Merger"), or you were hired following the Merger by a Company that was affiliated with Duke Energy immediately prior to the Merger, your period of employment with Duke Energy and its affiliates (including the Company) beginning on your most recent date of hire with the Company, or adjusted service date, if earlier, and ending on your Release Date, calculated to the nearest number of full months, divided by 12 and rounded up to the nearest full year (i.e., partial Years of Service are recognized for purposes of the DESP), all as determined in accordance with uniform procedures prescribed by the Company, in its sole discretion, which procedures will be interpreted to avoid duplicative counting of service and will exclude any service with Piedmont Natural Gas and its affiliates before the Merger; and

- if you were employed by Piedmont Natural Gas and its affiliates immediately prior to the Merger, or you were hired following the Merger by a Company that was affiliated with Piedmont Natural Gas immediately prior to the Merger, your period of employment with Piedmont Natural Gas and its affiliates prior to the Merger and with Duke Energy and its affiliates (including the Company) on and after the Merger, beginning on your most recent date of hire with Piedmont Natural Gas and its affiliates, or adjusted service date, if earlier, and ending on your Release Date, calculated to the nearest number of full months, divided by 12 and rounded up to the nearest full year (i.e., partial Years of Service are recognized for purposes of the DESP), all as determined in accordance with uniform procedures prescribed by the Company, in its sole discretion, which procedures will be interpreted to avoid duplicative counting of service and will exclude any service with Duke Energy and its affiliates before the Merger.

If you previously received severance benefits under another severance benefits plan of Duke Energy or any of its affiliates, you will have your "Years of Service" determined beginning with your most recent date of rehire with the Company.

4. *An Example – Severance Payment*

Here is a closer look at how the Severance Payment will be calculated. Assume you are an Eligible Employee, your Annual Base Pay is $70,000 and you have 22 Years of Service.

1.	Annual Base Pay	$70,000
2.	One week of Annual Base Pay ($70,000/52 weeks)	$1,346.15
3.	Formula benefit for Years of Service 22 x 2 = 44 weeks x $1,346.15	$59,230.60
4.	Minimum Severance Payment ($1,346.15 x 12)	$16,153.80
5.	**Final Severance Payment (greater of lines 3 or 4, but not higher than 52 weeks of Annual Base Pay)**	**$59,230.60**

In this example, your Severance Payment is $59,230.60. You would receive a lump sum payment equal to $59,230.60 (less taxes and other withholdings) following your Release Date as described above.

B. Medical, Dental and Vision Benefits

If you are designated as an Eligible Employee and you separate under the DESP in accordance with the terms of the DESP, continued medical, dental and/or vision coverage under the Company-sponsored medical, dental and/or vision plan in which you are enrolled on your Release Date, as applicable, will be provided during the 6-month period following the termination of your active coverage (the "COBRA Subsidy Period") pursuant to the Federal law known as COBRA for you and your eligible dependents covered on your Release Date at no premium cost to you if you satisfy the following requirements:

you are enrolled in the medical, dental and/or vision plan coverage, as applicable, on your Release Date; and

you elect to continue such coverage following the termination of your active coverage in accordance with COBRA.

For these purposes, your eligible dependents are determined in accordance with the terms and provisions of the medical, dental and/or vision plan in which you are enrolled, as applicable. You and your eligible dependents are eligible for COBRA coverage only under the health care plans in which you and your eligible dependents are enrolled on your Release Date.

If you make any changes to your COBRA coverage during the COBRA Subsidy Period during annual enrollment or as a result of a work/life event for which changes are permitted, modified COBRA coverage will be provided at no premium cost to you for the remainder of the COBRA Subsidy Period.

If you are designated as an Eligible Employee and you die before your Release Date, and your eligible dependents enrolled in Company-sponsored medical dental and/or vision coverage at the time of your death elect to continue such coverage following your death under COBRA, COBRA coverage will be provided at no premium cost to your eligible dependents for the COBRA Subsidy Period. If you are receiving Company-provided COBRA coverage under the DESP and you die prior to the expiration of the COBRA Subsidy Period, COBRA coverage will be provided to your eligible dependents covered at the time of your death at no premium cost for the remainder of the COBRA Subsidy Period. You or your eligible dependents will be responsible for paying the applicable premium or portion thereof for any COBRA coverage continued after the expiration of the COBRA Subsidy Period, as the Company will not pay any portion of the premium cost for such period.

C. Outplacement Assistance

If you are designated as an Eligible Employee and you separate under the DESP in accordance with the terms of the DESP, the Company will provide you with up to 6 months of outplacement assistance through a vendor selected by Duke Energy, in accordance with its policies in effect from time to time.

D. Special Rehire Severance Payment

If you previously separated and received severance benefits under a severance plan or agreement sponsored by Duke Energy, Piedmont Natural Gas or their affiliates, but you were later rehired by Duke Energy, Piedmont Natural Gas or their affiliates and repaid all or a portion of those severance benefits, and you separate under the DESP in accordance with the terms of the DESP, you may be eligible to receive an additional rehire severance payment (the "Rehire Severance Payment"). The Rehire Severance Payment is in addition to the Severance Payment provided for under the DESP. If you believe that you are eligible for a Rehire Severance Payment, you may contact the Plan Administrator for additional information, including details regarding the amount and payment of the Rehire Severance Payment.

E. Maximums

The sum of your Severance Payment and any Rehire Severance Payment will not be more than 2 times the amount set forth in Box 5 of your Form W-2 for the year immediately preceding the year in which your Release Date occurs (which amount will be annualized if you did not work a full year in the prior year).

IV. OTHER CONSIDERATIONS

A. Other Plans

If you separate under the DESP in accordance with the terms of the DESP, you will be treated as having been involuntarily terminated without cause solely for purposes of determining your rights to a payment under any annual incentive plan sponsored by the Company or its affiliates in which you are participating during the year in which your Release Date occurs.

B. Reemployment and Contingent Worker Assignments

Separation from employment and receipt of benefits under the DESP does not preclude your subsequent rehire. However, Duke Energy, the Company and their affiliates generally will not rehire anyone who separates under the DESP for 12 months after their Release Date. You do not have any right to reemployment or any preferential rights for rehire. Employees who separate under a Company-sponsored severance program, including the DESP, generally are not eligible for staff augmentation contingent worker assignments to the Company for 12 months following their separation from employment.

C. Tax Information

Your Severance Payment and any Rehire Severance Payment are taxable to you as ordinary income. This document is only a summary. It is not intended to be a complete description of the tax consequences of the DESP. You are urged to consult with your personal tax advisor before making any decisions. The Company will withhold from any payment of DESP Benefits such Federal and state tax withholdings and other deductions reasonably determined to be required by law, such as those made in order to comply with any court or administratively ordered garnishments from certain DESP Benefits. A limited number of executives could be subject to a 6-month delay in the payment of their Severance Payment and any Rehire Severance Payment to comply with the Internal Revenue Code.

D. Employment Issues

The DESP does not constitute inducement or consideration for the employment of any employee, nor is it a contract between any employee and Duke Energy, the Company or their affiliates. The DESP does not give any employee the right to continued employment. Duke Energy, the Company and their affiliates have the right to hire and terminate any employee at any time, with or without cause, as if the DESP had never been established. The DESP does not provide Eligible Employees with any right not expressly granted by its provisions, and does not provide any benefit without the execution of the waiver and release(s) required in Section II(B).

APPENDIX A

This Appendix A includes important information that is required by Federal regulations to be included in the Summary Plan Description for the DESP.

Inquiries and Claims

To file a claim, follow the procedures described here.

Inquiries and questions about the DESP may be addressed to the Plan Administrator at the address provided below under the "DESP Administration" section. If you disagree with your benefits under the DESP, you must file a claim within 12 months of the date your first payment would have been due under the DESP. Any legal action for benefits under the DESP must be brought within 1 year following a final denial of an appeal brought in accordance with the DESP's claims procedures.

Situations That Can Affect Your DESP Benefits

Some situations could cause a loss or delay of your DESP Benefits.

The DESP is designed to provide DESP Benefits to Eligible Employees. Some situations could affect DESP Benefits. These situations include the following:

- Eligibility for the DESP is limited to those Eligible Employees designated by the Company. You may be in a position such that you are not designated as eligible for the DESP. If you are not designated as an Eligible Employee, you will not be eligible for DESP Benefits.
- Eligibility for the Rehire Severance Payment described in Section III(D) is conditioned on your satisfying the eligibility requirements for the Rehire Severance Payment described in that Section. If you do not satisfy the eligibility requirements, you will not be eligible for the Rehire Severance Payment.
- Eligibility for DESP Benefits is subject to strict deadlines. If you do not meet the deadlines, you will not be eligible for DESP Benefits.
- Eligibility for DESP Benefits is conditioned on your signing and not revoking a valid waiver and separating from employment on a specified date (i.e., your Release Date) in the manner determined by the Company. If you do not comply with these requirements, you will not be eligible for DESP Benefits.
- If you voluntarily separate from employment prior to your Release Date, you will not be eligible for DESP Benefits.
- If you are designated as an Eligible Employee under the DESP but are terminated for cause prior to your Release Date, as determined by the Company in its sole discretion, you will not be eligible for DESP Benefits.
- If you are designated as an Eligible Employee under the DESP but are removed from service prior to your Release Date and subsequently terminated for cause, as determined by the Company in its sole discretion, you will not be eligible for DESP Benefits.
- If you separate and become entitled to severance benefits pursuant to another severance plan or agreement sponsored or agreed to by the Company or its affiliates, as determined by the Company, in its sole discretion, you will not be eligible to receive DESP Benefits.
- If you are selected for and accept a position with the Company after being designated as an Eligible Employee, but prior to your Release Date, as determined by the Company, in its sole discretion, you will not be eligible to receive DESP Benefits.

Other Important Information About the DESP

- Your DESP Benefits are paid from the general assets of Duke Energy and the Company.
- Your DESP Benefits may not be sold, assigned, transferred or pledged under most circumstances.
- The DESP is intended to be a welfare plan for purposes of ERISA. Your DESP Benefits may be limited to retain the DESP's status as a welfare plan.
- Your DESP Benefits may be limited so as to not be subject to taxation under Section 409A of the Internal Revenue Code.
- If you die before any Severance Payment and/or Rehire Severance Payment under the DESP is paid, such payment(s) will be paid to your estate upon the execution of an effective waiver and release by your estate's representative.
- The DESP may be amended or terminated at any time.
- Any overpayments from the DESP may be recouped from future payments or by other means permitted by law.
- Nothing in the DESP is a commitment of continued employment. Your employment is at-will. Duke Energy's, the Company's and their affiliates' right to terminate or change the terms of your employment remains the same as if the DESP had not been adopted.
- DESP Benefits are paid only if the Plan Administrator or its delegate determines, in its sole discretion, that you are entitled to benefits under the provisions of the DESP.
- As a participant in the DESP, you have certain rights under ERISA. Information about your rights and other important information can be found in the DESP Administration section.
- If you disagree with your DESP Benefits, you must file a claim and provide any required information with the claim before DESP Benefits can be paid. See "Claim Review Process" in the DESP Administration section for information on claim submissions and the review process.
- Any claim for benefits under the DESP must be filed within 12 months of the date your first payment would have been due under the DESP.
- Any legal action for benefits under the DESP must be brought within 1 year following the denial of an appeal brought in accordance with the DESP's claims procedures.

Changes to the DESP

Duke Energy does not expect to continue the DESP indefinitely. Further, Duke Energy reserves the right to amend, modify, eliminate, suspend, or terminate all or part of the DESP (and/or any of its other plans) at any time in its sole discretion.

DESP Administration

Here are details about how the DESP is administered:

Plan Name

The DESP's name is the Duke Energy Severance Plan.

DESP Sponsor

Duke Energy Corporation is the sole sponsor of the DESP. The company address, telephone number and employer identification number (EIN) are:

Duke Energy Corporation
550 South Tryon Street
Charlotte, North Carolina 28202
980-373-8649
EIN: 20-2777218

Plan Number

The plan number assigned to the DESP is 587.

Funding

The DESP is not funded and no contributions are made to the DESP. Benefits under the DESP are paid from the general assets of Duke Energy and the Company.

Administrator and Administration

The Plan Administrator for the DESP is the Duke Energy Benefits Committee (the "Benefits Committee"). The Benefits Committee has responsibility and authority to control and manage the operation and administration of the DESP, except to the extent delegated or assigned to others.

The Benefits Committee may assign or delegate any of its authority or duties to others. Duke Energy Human Resources is appointed to serve as the Benefits Committee's delegate with respect to the review of initial claims for DESP Benefits. The Benefits Committee has appointed the Duke Energy Claims Committee (the "Claims Committee") to serve as Denied Claim Reviewer for DESP Benefits. The Benefits Committee and the Claims Committee may be contacted as follows:

Duke Energy Benefits Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, North Carolina 28202
(704) 382-4703

Duke Energy Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, North Carolina 28202
(704) 382-4703

The Benefits Committee (and any delegate thereof) and the Claims Committee, each within its area of authority and responsibility, have the power and discretion to construe and interpret the DESP and to make factual determinations. Benefits under the DESP are paid only if the Benefits Committee or its delegate decides in its sole discretion that the applicant is entitled to benefits under the provisions of the DESP.

Plan Year

The DESP is operated on a calendar-year basis, beginning January 1 and ending December 31.

Agent for Service of Legal Process

The person designated for service of legal process upon the DESP is:

Corporate Secretary
Duke Energy Corporation
550 South Tryon Street
Charlotte, North Carolina 28202

Legal process may also be served upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the DESP

Contact the Plan Administrator for information regarding affiliates of Duke Energy that have adopted and are participating in the DESP.

Type of Plan

The DESP is a welfare plan for purposes of ERISA. The DESP provides severance benefits.

Claim Review Process

The DESP has a claim review process that is followed whenever you submit a claim for DESP Benefits.

Initial Decision

When you file a claim, Duke Energy Human Resources reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You will receive a written notice of the claim decision within a reasonable period of time - generally not later than 90 days after receipt of your claim. In some situations, Duke Energy Human Resources may need an extension of time to make a decision (for example, if it needs additional information). If special circumstances require an extension, the period to make a decision may be extended for an additional 90 days. You'll be notified of the extension within the initial 90-day period following receipt of your claim.

If Your Claim is Denied

If your request or claim is denied, in whole or in part, you will receive a written notice that explains:

- the specific reasons for the denial;
- the DESP provisions on which the denial is based;
- a description of any additional material or information needed and an explanation of why it is necessary; and
- an explanation of the DESP's claim review procedures, applicable time limits and your rights to bring a civil action under Section 502(a) of ERISA following a denial on review.

Request for Review if Your Claim is Denied

After receiving the notice, you, your beneficiary, or your legal representative may ask for a full and fair review of the decision by writing to the Claims Committee. You must make this request within 60 days of the date you receive notice of the denied claim. During the 60-day period, you or your authorized representative will be given reasonable access to all documents and information related to the claim, and you may request copies free of charge. You also can submit written comments, documents, records, and other information to the Claims Committee.

Final Decision

The Claims Committee or its delegate then will review the claim and make a decision based on all comments, documents, records, and other information you've submitted. You'll receive the Claims Committee's final decision within a reasonable period of time - generally not later than 60 days after the Claims Committee receives your request for review. If necessary, the period may be extended for an additional 60 days.

If your request on review is denied, in whole or in part, you will receive a written notice that explains:

- the specific reasons for the denial;
- the DESP provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relating to your claim; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

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 claims review process. You may not initiate a legal action against the DESP, Duke Energy, the Company, affiliates of Duke Energy or the Company, the Benefits Committee or the Claims Committee until you have completed the claims review process. No legal action may be brought more than 1 year following a denial of an appeal brought in accordance with the DESP's claims procedures. 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 under the DESP and denied claims on review under the DESP includes the full power and discretion to interpret DESP provisions and to make factual determinations, with the decisions, interpretations and factual determinations made by the Claims Committee controlling. Requests for information regarding individual claims, or review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim or to decide the denied claim on review, as applicable.

Your Rights Under ERISA

As a participant in the DESP, you are entitled to certain rights and protections under ERISA, which are listed below:

Receive Information About Your Plan and Benefits

As a participant in the DESP, you have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the DESP and a copy of the latest annual report (Form 5500 Series) filed by the DESP 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 DESP and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for DESP participants, ERISA imposes duties upon the people who are responsible for the operation of the DESP. The people who operate the DESP, called "fiduciaries" of the DESP, have a duty to do so prudently and in the interest of you and other DESP participants and beneficiaries. No one, including Duke Energy, the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Claim Review

If your claim for DESP Benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial -- all within certain time schedules. For more information on claim review, see the "Claim Review Process" section above.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of DESP documents or the latest annual report from the DESP 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 DESP Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court once you have completed the claims review process.

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 DESP, 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.

Legal Documents as Final Authority

Although this summary plan description describes the principal features of the DESP that are generally applicable, it is only a summary. The complete provisions of the DESP are set forth in the legal plan document, which is available upon request by contacting the Duke HR Control Center during regular office hours. Descriptions of DESP Benefits should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. In the event of a conflict between this summary plan description or any other communication regarding the DESP and the plan document, the plan document controls. Remember, the DESP may be amended only by proper corporate action and not by oral or written communications about benefits under the DESP.

Management Toolkit

Duke Energy
Retirement Transition Program (RTP)

Nov. 2015, Rev. Feb. 2016, Oct. 2016

This document 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.

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RETIREMENT TRANSITION PROGRAM (RTP)

Purpose and Overview

As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or knowledge who are eligible to retire (i.e., more than 55 years old with at least 10 years of service) to address the potential risk of losing their critical skills or knowledge. In many instances, knowledge transfer plan(s) are incomplete or clear successors may not be identified or known for those employees.

The Retirement Transition Program (RTP) is an optional retention program designed to retain, for a specified period of time, certain employees with critical skills to ensure knowledge transfer in an orderly manner before retirement. It also provides the Company with the ability to have clarity around an employee's retirement date for planning purposes. The RTP is not a severance program, but is designed to be management-initiated, although participation in the RTP is based on mutual agreement between management and the employee.

This Management Toolkit provides an overview of the process to help facilitate the identification and review of employees with critical skills or knowledge and also help managers with planning for the future. "Retirement-eligible" refers to an employee who is at least 55 years old with 10 years of service. "Critical skills" generally refers to those skills essential for continued operations and not replaceable without significant notice or transition time. Additional detail is provided on the "Definitions" page of this Toolkit.

Program Phases

Phase	Description	Objective
1	Identify risk of losing retirement-eligible employees with critical skills via manager script for a 1-on-1 meeting or through use of a survey.	Determine critical skilled employees' intent and timing for retirement. The same information is designed to be obtained regardless of whether the employee takes the survey or the manager meets with them one-on-one.
2	Gather additional information from employees identified in Phase 1 performing a critical role using a manager script.	Gather more specific information from employees performing critical roles who have shared an intent to retire, and begin discussing a knowledge transfer plan. Determine if knowledge transfer plan can be implemented through business-as-usual or if employee's retirement plans creates a business risk.
3	Obtain approvals and conduct a follow-up meeting with the employee to present options if knowledge transfer plan is not yet developed and/or no clear successor is identified (*e.g.,*	Obtain approvals (*by the business unit Senior Management Committee member and HRBP Director*), and meet with employee to present options for retaining the employee.

	cannot transition business-as-usual).	

It is important to note that although there are three potential phases in the RTP process, situations may vary and it may not be necessary to go through all three phases. For example, if the business decides not to do the survey in Phase 1, and they have already identified their retirement eligible employees performing critical roles, then they may go straight to Phase 2 to gather more detailed information before determining whether to utilize the RTP for certain employees.

Phase 1 and 2 are only for gathering information to help in management discussion with the HR Business Partner to determine next steps. This will ensure consistent administration of the RTP and allow time for necessary approvals prior to presenting any RTP options as described in Phase 3.

Prior to embarking on Phase 3 of the RTP process, managers should work with their HR Business Partner to determine if their employee would be eligible for possible transition benefits or reduced schedule with premium pay. Eligibility for the RTP must be approved by the business unit Senior Management Committee member and HRBP Director.

In situations where the RTP option is presented to a designated employee, the HRBP should provide the relevant information to the ER Control Center (Cathy Edwards or her designee) for purposes of tracking and administration. Updated information should be provided to the ER Control Center once the employee declines or accepts the RTP option. This will permit us to track and report RTP letter agreements and signed waivers, and ensure timely administration of payments and other benefits.

Program Options

There are two options within the RTP. Eligible employees who meet all program requirements have the opportunity to either receive transition benefits upon retirement, or to participate in a reduced work schedule with premium pay and a separation bonus, as described below.

Option 1: Transition Benefits

1. Transition Payments. The Transition Payments will consist of the following:

    a. Transition Bonus. The amount of the Transition Bonus depends on the length of time the employee remains employed with the Company (called the "Transition Period") under the terms of the RTP Program. The Transition Bonus will be (i) equal the sum of two weeks of regular base pay for each full month of the Transition Period, but never less than 6 weeks, or more than 48 weeks, of the employee's final rate of regular base pay, and (ii) provided as a lump sum payment.

    b. Health Care Supplement. The Health Care Supplement will be (i) equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion, and (ii) provided as a lump sum payment.

2. Outplacement. The Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

3. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

Option 2: Reduced Work Schedule

1. Premium Pay: During the time an eligible employee remains employed in a reduced work schedule under the RTP, the employee will receive his or her regular base wages/ salary reduced proportionately based on their reduced hours, plus a "Salary Premium" equivalent to 50% of their newly calculated regular base wages/ salary.

   The work schedule will be determined by mutual agreement between the eligible employee and his or her manager. Hours worked on a weekly basis will be tracked by the employee and monitored by the manager to ensure the work schedule is consistent with the reduced schedule. For example, the employee and manager may agree that in certain weeks the employee may work more hours than the schedule provides, as long as the employee reduces hours worked in a subsequent week.

2. Separation Bonus. In addition, eligible employees on a reduced work schedule who meet all program requirements will receive a Separation Bonus, in the form of a lump cash payment equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion, provided as a lump sum payment

3. Outplacement. In addition to the opportunity to earn the Separation Bonus, the Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

4. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

General Provisions

1. Approvals Required. Eligibility must be approved by the Senior Management Committee member and business unit HRBP Director. The RTP is management initiated, but based on mutual agreement regarding the employee's participation in the program, the transition period and the retirement date.

2. Relationship to other Benefits. The benefits of RTP participants will be determined based on their compensation and work schedule as in effect from time to time under the terms of the applicable plans. For example, employees participating in the reduced schedule option under the RTP will be treated as part-time employees. The annual base salary of an employee on a reduced work schedule will be his or her regular base wages/salary in effect immediately prior to the commencement of the reduced work schedule, reduced proportionately based on his or her reduced hours (i.e., if his or her hours are reduced by 50%, his or her regular base wages/salary will be reduced by 50%) for purposes of determining his or her benefits under the Company's benefit plans and programs, including, but not limited to, the Company's life, accidental death & dismemberment, business travel accident and long-term disability insurance plans. Any unused, accrued vacation provided to a RTP participant who participated in the reduced schedule option under the RTP upon separation in accordance with the RTP will be based on the RTP participant's annual base salary in effect immediately prior to the commencement of the Transition Period.

   The 401(k) and pension benefits of RTP participants will be determined pursuant to the applicable plan documents based on the amount of compensation the RTP participants actually receive, and neither the Transition Payments, Salary Premium nor Separation Bonus, as applicable, will be considered eligible or credited compensation, and, therefore, these items will not be taken into consideration when determining benefits under the 401(k) and pension plans. Solely for purposes determining their rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, RTP participants will be treated as having been separated without cause.

3. Changes in Employment.

   (i) If Employment Ends During the Transition Period. If the employment of an eligible employee with the Company ends before the end of the Transition Period due to voluntary resignation or involuntary termination by the Company with cause, RTP Program benefits will not be provided. If, however, the Company terminates the employee involuntarily without cause or due to changing business conditions, the employee will be eligible to receive severance benefits under the Company's applicable severance plan in lieu of any RTP benefits.

   (ii) If an Authorized Leave is Taken During the Transition Period. Eligible employees remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, the Company may determine that the Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

   (iii) If an RTP Participant Obtains Another Internal Position. If a RTP participant accepts another internal position with the Company before separating in accordance with the RTP , Program benefits will not be provided.

4. Timing of Payment; No Severance Benefits Available. If eligible employees meet the conditions for earning the Transition Payments or the Separation Bonus, as described above, the applicable payment(s) (less applicable taxes) will be provided in a cash

payment(s) as soon as administratively practicable (not more than 60 days) after termination of employment. Please note that if payment of the Transition Payments or Separation Bonus are/is received, the employee will not be considered eligible for any benefits under any applicable severance plan that otherwise covers the employee.

RTP FORMS

PHASE 1: Manager Script for 1-on-1 Meeting (In Lieu of Survey) to Identify Risk of Losing Retirement-Eligible Employees with Critical Skills

A survey can be conducted to determine the risk of losing employees with critical skills or knowledge who are eligible to retire (e.g., at least 55 years old with 10 years of service). In lieu of a survey, this script/ form can be used to gather information from retirement-eligible employees. The completed form should be returned to your HR Business Partner.

Employee ID: ____________ **Employee Name:** ____________________

Date: ______________ **Employee Job Title:** ____________________

Department: ______________

Background

As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or knowledge who are eligible to retire. Some of these employees do not have clear successors, and also may not have plans in place to ensure knowledge transfer in an orderly manner before they leave.

A survey or in person meeting is being conducted for certain retirement-eligible employees in our group to assess their intent and timing on their departure.

Introduction

Use the information below as talking points during the meeting with your employee. Once you have the information, please return this document to your HR Business Partner.

- As part of our workforce planning, this survey is being conducted to help identify the unique knowledge and skills of employees eligible to retire that may be lost to the Company if not transitioned properly. Please be assured that the information provided will be used solely for knowledge transfer purposes, if and when needed.

- I value your contributions and would like your input in our workforce planning process. I have a few questions I would like to ask you, which will help in this process.

What do you believe are the top three areas of your role that require knowledge transfer?

1.
2.
3.

How long do you believe it would take to transfer this knowledge to others?

	Less than 6 months
	6 to 12 months
	12 to 18 months
	18 to 24 months
	Greater than 24 months

If you are anticipating retirement, how long do you plan to continue working for the company?

	Less than 6 year
	6–12 months
	12-18 months
	18-24 months
	> 24 months
	I'm thinking about retirement but not sure about the timeframe

If asked, would you consider staying at the Company for a longer time period to help with knowledge transfer? If yes, would you be willing to stay?

	Less than 1 year
	1 year
	2 years or more

I would like to thank you for being candid with me about your intentions over the next several years. This has been very helpful as we continue to work on our workforce planning.

RTP FORMS

PHASE 2: Management Script for Meeting to Gather Information from Retirement Eligible Employees with Critical Skills

This script is used to gather specific information from retirement-eligible employees who have been identified as having critical skills and knowledge for purposes of workforce planning and to evaluate potential eligibility for the RTP.

Background

As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or knowledge who are eligible to retire. Some of these employees do not have clear successors, and also may not have plans in place to ensure knowledge transfer in an orderly manner before they leave.

This script should be used to meet with retirement eligible employees who have been identified as having critical skills and knowledge (e.g., essential for continued operations and not replaceable without significant notice). The objectives of the meeting are to:

(1) Help facilitate discussion in order to allow efficient knowledge transfer and/or the advancement of highly engaged employees;
(2) Gain a better understanding of an employee's retirement intentions
(3) Assist in determining potential eligibility for the Retirement Transition Program (RTP)

Introduction

Use the information below as talking points during the meeting with your employee.

- As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or unique knowledge who are eligible to retire. Some of these employees don't have a clear successor and we're concerned about the impact of ineffective knowledge transfer if we have to endure a sudden retirement.

- You have been identified as having critical skills and being eligible to retire.

  (Manager can add more details here about the nature of those critical skills as appropriate.)

- I value your contributions and would like your input in our workforce planning process. The goal here is to identify options for effective knowledge transfer for certain employees like yourself that may be planning to leave the Company.

- I was hoping you could share with me what your current thinking is around your future here at Duke.

  - Let's talk about your critical skills and how you think we may need to approach knowledge transfer.

  - Can you provide me with additional details on your employment status within the next two years? *(If the employee has critical knowledge but not likely to retire within next 2*

years, no Retirement Transition Program (RTP) is offered, consider the development of a knowledge transfer plan)

- If you do not anticipate changes in your employment status at this time, would you be willing to provide us with notice if you do decide to make a change and, if so, how much?

Based on the answers to the questions above, consider whether there is time to capture knowledge and transfer skills with a business as usual approach, or whether eligibility might be appropriate for the Retirement Transition Program (e.g. transition payment, reduced work schedule, etc.). Refer to table below.

Potential additional talking points may include:

- If retirement likely in the next six months
  - ☐ Would you consider staying longer to complete knowledge transfer?
  - ☐ Would you want to consider a reduced work schedule to transition into retirement?
  - ☐ Let's discuss developing a knowledge transfer plan.
- Retirement likely in the next 12 months
  - ☐ Would you want to consider a reduced work schedule to transition into retirement?
  - ☐ Let's discuss developing a knowledge transfer plan.
- Retirement likely in the next 24 months
  - ☐ Would you want to consider a reduced work schedule to transition into retirement?
  - ☐ Let's discuss developing a knowledge transfer plan

Do you think there is anything else I need to know in planning for the future of this work that you perform?

I would like to thank you for being candid with me about your career intentions. This has been very helpful as we continue to work on our workforce planning.

RTP FORMS

PHASE 3: Management Script for Meeting with Employees Eligible for the RTP

Background

Prior to any offers or discussions with the Employee, approval of eligibility for the RTP should be obtained from the Senior Management Committee (SMC) member or designee and HRBP Director.

Use this script to discuss the Retirement Transition Program if you have an employee identified as having critical skills or knowledge who is planning to leave relatively shortly and needs to be retained for purposes of knowledge transfer, which cannot be handled in a business-as-usual manner.

During this conversation, be prepared to present the employee with the following documents:

1. *Retirement Transition Program (RTP) Overview*
2. *RTP Letter Agreement- for either a Transition Benefits or Reduced Schedule Option*
3. *Sample of the Waiver and Release Form*

The employee ***must*** *voluntarily agree to sign and return the Letter Agreement in order to enter the RTP Program. The Waiver and Release form should not be signed until after the employee's release date if the employee wants to participate.*

Introduction

Use the information below as talking points during the meeting with your employee.

- As you know from our prior discussions, you have been identified as having critical skills and knowledge and you have indicated an intent to retire in the relatively near future. *(Manager can add more details here about the nature of those critical skills as appropriate.)*
- I'd like for you to consider whether you are willing to work with me on an agreement to transfer your knowledge before you retire.
- Toward that end, I would like to discuss the Retirement Transition Program options with you and offer you the opportunity to participate in this program. This is a voluntary program that offers two options to choose from: (1) Transition Benefits at the end of employment; or (2) Reduced Work Schedule with Premium Pay and Separation Bonus. Under both options, we would agree on a firm retirement date so we will have certainty around the timing of your transition.
- I'm giving you an **RTP Letter Agreement** for you to review and consider. If you are interested in participating in the RTP, please sign and return the Letter Agreement to me. I'm sure you will need time to read and think about this, so let's plan to meet again in a few days to continue this discussion.

- Let me emphasize that participation in the RTP is voluntary, and based on mutual agreement.
- I appreciate your consideration of the RTP option, and I look forward to working through these issues with you.
- If you have any questions, please let me know or feel free to contact our HR Business Partner.

Definitions

Critical Role: The following chart is used during the knowledge risk phase to classify the level of knowledge loss risk associated with strategic/critical positions.

Value	Definition	Criteria
High	Very difficult to replace	1. Critical and unique knowledge and skills 2. Mission critical knowledge and skills with limited duplication and documentation 3. Duke Energy specific knowledge 4. Key contact for strategic relationships that are difficult to establish 5. Requires at least 2-4 years of core training and experience 6. Critical knowledge that is unique to one employee and generally requires 5+ years of core training or experience 7. No replacements readily available
Medium	Difficult to replace	1. Important knowledge and skills 2. Documentation exists or other employees possess similar knowledge and skills 3. Key contact for relationships that can be transferred orderly 4. Replacements generally available and can be trained within 1-2 years
Low	Easy to replace	1. Possess procedural or non-mission critical knowledge and skills or common knowledge and skills 2. Up to date documentation exists 3. Training programs are current and effective and can be completed in less than 1 year 4. External hires possessing the knowledge and skills are readily available and require minimal training

FORMS

Retirement Transition Program (RTP) Overview

The Retirement Transition Program (RTP) is a voluntary program designed to facilitate business continuity and work transition when employees designated by management as having critical skills plan to leave the Company without a clear successor or existing knowledge transfer plan.

Eligible employees who decide to voluntarily participate and meet all program requirements have the opportunity to either receive transition benefits, or to participate in a reduced work schedule with premium pay and a separation bonus, as described below.

Option 1: Transition Benefits

1. Transition Payments. The Transition Payments will include of the following:

   a. Transition Bonus. The amount of the Transition Bonus depends on the length of time the employee remains employed with the Company (called the "Transition Period") under the terms of the RTP Program. The Transition Bonus will be (i) equal the sum of two weeks of regular base pay for each full month of the Transition Period, but never less than 6 weeks, or more than 48 weeks, of the employee's final rate of regular base pay, and (ii) provided as a lump sum payment.

   b. Health Care Supplement. The Health Care Supplement will be (i) equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion, and (ii) provided as a lump sum payment.

2. Outplacement. The Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

3. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

Option 2: Reduced Work Schedule

1. Premium Pay. During the time an eligible employee remains employed in a reduced work schedule under the RTP, the employee will receive his or her regular base wages/ salary reduced proportionately based on their reduced hours, plus a "Salary Premium" equivalent to 50% of their newly calculated regular base wages/ salary.

   The work schedule will be determined by mutual agreement between the eligible employee and his or her manager. Hours worked on a weekly basis will be tracked and monitored to ensure the work schedule is consistent with the reduced schedule. For example, the

employee and manager may agree that in certain weeks the employee may work more hours than the schedule provides, as long as the employee reduces hours worked in a subsequent week.

2. Separation Bonus. In addition, eligible employees on a reduced work schedule who meet all program requirements will receive a Separation Bonus, in the form of a lump cash payment equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion.

3. Outplacement. In addition to the opportunity to earn the Separation Bonus, the Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies as in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

4. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

General Provisions

1. Relationship to other Benefits. The benefits of RTP participants will be determined based on their compensation and work schedule as in effect from time to time under the terms of the Company's applicable plans. For example, employees participating in the reduced schedule option under the RTP will be treated as part-time employees. The annual base salary of an employee on a reduced work schedule will be his or her regular base wages/salary in effect immediately prior to the commencement of the reduced work schedule, reduced proportionately based on his or her reduced hours (i.e., if his or her hours are reduced by 50%, his or her regular base wages/salary will be reduced by 50%) for purposes of determining his or her benefits under the Company's benefit plans and programs, including, but not limited to, the Company's life, accidental death & dismemberment, business travel accident and long-term disability insurance plans. Any unused, accrued vacation provided to a RTP participant who participated in the reduced schedule option under the RTP upon separation in accordance with the RTP will be based on the RTP participant's annual base salary in effect immediately prior to the commencement of the Transition Period.

   The 401(k) and pension benefits of RTP participants will be determined pursuant to the applicable plan documents based on the amount of compensation the RTP participants actually receive, and neither the Transition Payments, Salary Premium nor Separation Bonus, as applicable, will be considered eligible or credited compensation, and, therefore, these items will not be taken into consideration when determining benefits under the 401(k) and pension plans. Solely for purposes determining their rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, RTP participants will be treated as having been separated without cause.

2. Changes in Employment. If the employment of an eligible employee with the Company ends before the end of the Transition Period due to voluntary resignation or involuntary termination by the Company with cause, RTP Program benefits will not be provided. Similarly, if a RTP participant accepts another position with the Company before separating in accordance with the RTP, RTP Program benefits will not be provided. If, however, the Company terminates the employee involuntarily without cause or due to changing business conditions, the employee will be eligible to receive severance benefits under the Company's applicable severance plan in lieu of RTP benefits. Eligible employees remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, the Company may determine that the Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

3. Timing of Payment; No Severance Benefits. If eligible employees meet the conditions for earning the Transition Payments or Separation Bonus, as described above, the applicable payment(s) (less applicable taxes) will be provided in a cash payment(s) as soon as administratively practicable (not more than 60 days) after termination of employment. Please note that payment of the Transition Benefits or Separation Bonus will be in lieu of and, the employee will not be considered eligible for any benefits under any applicable severance plan that otherwise covers the employee.

[On Duke Energy Letterhead]

[Date]

Re: Retirement Transition Program -- Transition Benefits Opportunity

Dear Participant:

Duke Energy ("we" or "us") is offering you the opportunity to voluntarily participate in our Retirement Transition Program (the "Program"), in order to encourage business continuity, work transition and knowledge transfer as you near the end of your career with us.

If you agree to participate in the Program, you will have an opportunity to earn special compensation awards -- called "Transition Benefits" – provided you remain employed in good standing with us for a "Transition Period" described below and otherwise meet the conditions described in this letter. The following describes the Transition Benefits opportunity:

1. Transition Period. Your Transition Period will begin on [starting date] and end on [ending date]. We may in our sole discretion shorten the Transition Period or, subject to your agreement, extend it. Your employment with us will end on the last day of the Transition Period, unless we mutually agree otherwise.

2. Transition Payments.

    a. Transition Bonus. The amount of the Transition Bonus depends on the length of your Transition Period. The Transition Bonus will be (i) equal the sum of two weeks of regular base pay for each full month of the Transition Period, but never less than 6 weeks, or more than 48 weeks, of your final rate of regular base pay, and (ii) provided as a lump sum payment.

    b. Health Care Supplement. The Health Care Supplement will be (i) equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which you and your eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by Duke Energy in its sole discretion, and (ii) provided as a lump sum payment.

3. Other Transition Benefits. In addition to the opportunity to earn the Transition Payments, we will make outplacement services available to you for a period of up to six months through a vendor selected by us, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

4. Conditions to Payment. To earn the Transition Benefits described above, you must meet each of the following conditions:

    a. You must remain employed in your current position and in good standing with us through the end of the Transition Period.

    b. As of the date of your termination of employment with us at the end of the Transition Period, you must sign a waiver of claims within 45 days after your termination of

employment and not revoke such waiver within 7 days after its execution. The form of the waiver will be based on our standard form used at the time of your termination. The current form is attached to this letter as Exhibit A.

5. Relationship to other Benefits. Solely for purposes determining your rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, you will be treated as having been separated without cause.

6. Changes in Employment. If your employment with Duke Energy ends before the end of the Transition Period due to voluntary resignation or involuntary termination by Duke Energy with cause, RTP Program benefits will not be provided. Similarly, if you accept another position with Duke Energy before separating in accordance with the RTP, RTP Program benefits will not be provided. If, however, Duke Energy terminates your employment involuntarily without cause, you will be eligible to receive severance benefits under Duke Energy's generally applicable severance plan for involuntary severances of similarly-situated employees in lieu of RTP Program benefits. You will remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, Duke Energy may determine that your Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

7. Timing of Payment; No Severance Benefits. If you meet the conditions to earn the Transition Payments, as described above, you will be paid the Transition Payments (less applicable taxes) in a cash payment(s) as soon as administratively practicable (not more than 60 days) after your termination of employment. Please note that if you receive payment of the Transition Benefits, you will not be considered eligible for any benefits under any applicable severance plan that otherwise covers you.

To be eligible to receive the RTP Program benefits, please sign and date a copy of this letter and return it to our HR Business Partner, [insert name] by no later than [date]. Of course, you also are free to choose not to participate in the RTP.

This letter in all events will govern and control your rights with respect to the Transition Benefits and may be changed or modified only in writing signed by both parties. See Exhibit B for certain additional terms and conditions. If you have any questions, please contact our HR Business Partner.

Sincerely,

[Supervisor Name and Title]

Accepted and Agreed To:

By:____________________________

Print Name:________________________

Date:___________________________

[On Duke Energy Letterhead]

[Date]

Re: Retirement Transition Program -- Reduced Work Schedule and Separation Bonus Opportunity

Dear Participant:

Duke Energy ("we" or "us") is offering you the opportunity to voluntarily participate in our Retirement Transition Program (the "Program"), in order to encourage business continuity, work transition and knowledge transfer as you near the end of your career with us.

If you agree to participate in the Program, you will provide services to us on a reduced work schedule for a "Transition Period" with your base wage/ salary adjusted and increased by a 50% "premium" as described below. In addition, you will have an opportunity to earn a special compensation award -- called a "Separation Bonus" -- if you remain employed in good standing with us for the Transition Period and otherwise meet the conditions described in this letter. The following describes these Program benefits:

1. Transition Period. Your Transition Period will begin on [starting date] and end on [ending date]. We may in our sole discretion shorten the Transition Period or, subject to your agreement, extend it. Your employment with us will end on the last day of the Transition Period, unless we mutually agree otherwise.

2. Reduced Work Schedule and Salary Premium. During the Transition Period, your work schedule will be at [___%] of your regular work schedule, which equates to [___] hours per week or [____] hours per month.[1] We will track your hours worked on a weekly basis, and you and your manager will coordinate to ensure that your work schedule is consistent with this reduced schedule. For example, you and your manager may agree that in certain weeks you may work more hours than the schedule above provides, as long as you reduce your work schedule accordingly in a subsequent week or weeks.

   In exchange for your agreement to work on a reduced schedule, you will receive your regular base wages/ salary reduced proportionately based on your reduced hours, plus a "Salary Premium" equivalent to 50% of your newly calculated regular base wages/ salary.

3. Amount of Separation Bonus. Your Separation Bonus will be a lump cash payment equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which you and your eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by Duke Energy in its sole discretion, provided as a lump sum payment

4. Other Program Benefits. In addition, we will make outplacement services available to you for a period of up to six months through a vendor selected by us, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

[1] These blanks should be filled in based depending on the employee's individual circumstances.

5. Conditions to Payment. To earn the RTP Program benefits described above, you must meet each of the following conditions:

   a. You must remain employed in your current position and in good standing with us through the end of the Transition Period.

   b. As of the date of your termination of employment with us at the end of the Transition Period, you must sign a waiver of claims within 45 days after you receive the waiver of claims and not revoke such waiver within 7 days after its execution. The form of the waiver will be based on our standard form, and will be provided no later than your date of separation. The current form is attached to this letter as Exhibit A.

6. Relationship to other Benefits. During the Transition Period, your benefits will be determined based on your compensation and work schedule as in effect from time to time under the terms of Duke Energy's applicable plans. For example, in light of your reduced work schedule, you will be treated as part-time employee. Your annual base salary will be your regular base wages/salary in effect immediately prior to the commencement of the reduced work schedule, reduced proportionately based on your reduced hours (i.e., if your hours are reduced by 50%, your regular base wages/salary will be reduced by 50%) for purposes of determining your benefits under Duke Energy's benefit plans and programs, including, but not limited to, Duke Energy's life, accidental death & dismemberment, business travel accident and long-term disability insurance plans. Any unused, accrued vacation provided to you upon separation in accordance with the RTP will be based on your annual base salary in effect immediately prior to the commencement of the Transition Period. Your 401(k) and pension benefits will be determined pursuant to the applicable plan documents based on the amount of compensation you actually receive, and neither the Salary Premium nor the Separation Bonus will be considered eligible or credited compensation, and, therefore, these items will not be taken into consideration when determining benefits under the 401(k) and pension plans. Solely for determining your rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, you will be treated as having been separated without cause.

7. Changes in Employment. If your employment with Duke Energy ends before the end of the Transition Period due to voluntary resignation or involuntary termination by Duke Energy with cause, RTP Program benefits will not be provided. Similarly, if you accept another position with Duke Energy before separating in accordance with the RTP, RTP Program benefits will not be provided. If, however, Duke Energy terminates your employment involuntarily without cause, you will be eligible to receive severance benefits under Duke Energy's generally applicable severance plan for involuntary severances of similarly-situated employees in lieu of RTP benefits. You remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, Duke Energy may determine that your Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

8. Timing of Payment; No Severance Benefits. If you meet the conditions described above, you will be paid the Separation Bonus in a single cash payment as soon as administratively practicable (not more than 60 days) after your termination of employment. Please note that if you receive payment of the Separation Bonus, you will not be considered eligible for any benefits under any applicable severance plan that otherwise covers you.

To be eligible to receive reduced work schedule with RTP benefits, please sign and date a copy of this letter and return it to our HR Business Partner, [insert name] by no later than [date]. Of course, you are free to decline to participate in the RTP. This letter in all events will govern and control your rights with respect to the reduced work schedule with RTP benefits and may be changed or modified only in writing signed by both parties. See Exhibit B for certain additional terms and conditions. If you have any questions, please contact our HR Business Partner.

Sincerely,

[Supervisor Name and Title]

Accepted and Agreed To:

By:______________________________

Print Name:__________________________

Date:________________________________

Exhibit A
SAMPLE WAIVER AND RELEASE OF CLAIMS
UNDER THE DUKE ENERGY RETIREMENT TRANSITION PROGRAM (OPTION 1)

This Waiver and Release of Claims (the "Release"), delivered on ____________, is entered into by and between Duke Energy Corporation and its subsidiaries and affiliates and any predecessors and successors thereto (individually and collectively referred to as the "Company"), and ________________________ ("Employee") pursuant to the Retirement Transition Program (the "Program") with the mutual exchange of promises as consideration.

WHEREAS, Employee is eligible to separate from employment on _____________ (the "Separation Date") and receive severance benefits described below provided Employee enters into and does not revoke this Release; and

WHEREAS, the Company is willing to provide the Employee the severance benefits described below, provided Employee enters into and does not revoke this Release.

THEREFORE, the Company and Employee agree as follows:

1. Program Benefits. In exchange for Employee remaining employed and in good standing with the Company and separating employment from the Company on his or her Separation Date in accordance with the Program and entering into and not revoking this Release, the Company agrees to provide the Employee the following:

    a. Transition Payments. Transition Payments consisting of the following:

        i. Transition Bonus. A lump sum cash payment equal to $_________ less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Release.

        ii. Health Care Supplement. A lump sum cash payment equal to $________, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Release.

    b. Outplacement Services. Outplacement services for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

2. Basis for Entitlement. Employee acknowledges and agrees that Employee would not be entitled to the benefits described in Paragraph 1 absent Employee's separation from employment on his or her Separation Date and execution and non-revocation of this Release in accordance with the Program. Employee further acknowledges that he or she is not entitled to a pension enhancement under the Program.

3. Adequate Consideration. Employee acknowledges and agrees that this Release provides good, valuable and sufficient consideration for Employee's obligations under this Release.

4. Release by Employee. Employee, of the Employee's own free will, voluntarily waives and releases the Company, its employee benefit, pension, welfare, and other plans or programs

(including any and all fiduciaries thereof), and any of the Company's respective current or former officers, directors, agents, employees, attorneys, insurers, plan administrators, predecessors, successors or assigns from any and all rights or claims that Employee has, or may have, as of the date of the execution of this Release, based on or arising out of the employment relationship or the termination of the employment relationship, other than those rights or claims set forth below in Paragraph 5. The rights and claims so waived and released shall include, but not be limited to:

a. Those arising under any federal, state or local statute, ordinance, common law (including, but not limited to, claims of breach of promise, breach of contract, promissory estoppel, intentional or negligent infliction of emotional distress, defamation, tortious interference with a business relationship or contract and wrongful discharge), or claims in equity or public policy; and
b. Those arising under any law based on any protected status, including but not limited to, sex, age, race, color, religion, handicap or disability, national origin, pregnancy, discrimination, retaliation, or whistleblower (including, but not limited to, any rights or claims arising under Title VII of the Civil Rights Act of 1964, as amended, the Civil Rights Act of 1991, the Americans with Disabilities Act, the Rehabilitation Act, the Older Workers Benefits Protection Act of 1990, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Family and Medical Leave Act, the Genetic Information Nondiscrimination Act, the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Indiana Discrimination on Account of Age Act, the Indiana Civil Rights Statute, the Kentucky Civil Rights Statute, the Ohio Civil Rights Statute, the North Carolina Equal Employment Practices Act, the North Carolina Persons with Disabilities Protection Act, the North Carolina Retaliatory Employment Discrimination Act, the South Carolina Human Affairs Law, the Florida Civil Rights Act, the Florida Whistleblower Act, the Texas Labor Code Chapter 21, and every other local, state, or federal law, regulation, or other legal authority concerning employment rights or claims); and
c. Those arising under the Employee Retirement Income Security Act of 1974; and
d. Those arising under the civil rights laws of any state or municipality; and
e. Any claim for compensatory damages, punitive damages, attorneys' fees, expenses and litigation costs; and
f. Any grievance, charge or other claim arising under the applicable collective bargaining agreement, National Labor Relations Act, or other similar labor laws, regulations, and authority.

Employee acknowledges that he or she has been paid for all hours worked during his or her employment with the Company and has received all other payments owed to him or her by the Company as of his or her Separation Date. In addition, Employee acknowledges that he or she has received all leave to which he or she may have been entitled to under the Family and Medical Leave Act or applicable state law during his or her employment with the Company.

5. Claims Not Waived. Notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release any workers' compensation or unemployment compensation claims filed prior to the date of execution of this Release, or claims against the Company arising out of possible exposure to asbestos during Employee's employment with the Company at a facility or facilities owned by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release Employee's rights or claims to accrued or vested benefits under an employee benefit plan or program maintained by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release claims that may arise after the date of execution of this Release,

including, but not limited to, claims that may arise under an employee benefit plan or program maintained by the Company.

6. Acknowledgement of No Interference with Reporting and Compliance Rights. Employee acknowledges and agrees that it is the policy of the Company to comply with all applicable federal, state and local laws and regulations. Employee affirms that he or she has reported all compliance issues and violations of federal, state and local law or regulation or Company policy of which he or she had knowledge during the term of his or her employment, if any. Employee represents and acknowledges that he or she has no further or additional knowledge or information regarding compliance issues or possible violations of federal, state or local law or regulations or Company policy other than what Employee may have previously reported, if any, including, but not limited to, any and all outstanding nuclear safety concerns Employee has involving any nuclear power plant owned or operated by the Company. Nothing in this Release shall be construed to prohibit, restrict or otherwise discourage Employee from participating in "protected activity" as defined in 10 CFR 50.7 and Section 211 of the Energy Reorganization Act of 1974, including, but not limited to reporting any suspected instance of illegal activity of any nature, any nuclear safety concern, any workplace safety concern, any public safety concern, or any other matter within the United States Nuclear Regulatory Commission's ("NRC") regulatory responsibilities to the NRC, the United States Department of Labor, or any other federal or state governmental agency. This Agreement further does not prohibit Employee from participating in any way in any state or federal administrative, judicial, or legislative proceeding or investigation. Further, nothing in this Release prevents Employee from filing a charge or complaint, with or from participating in an investigation or proceeding conducted by the Equal Opportunity Commission ("EEOC"), National Labor Relations Board ("NLRB"), Securities and Exchange Commission ("SEC"), or any other federal, state or local agency charged with the enforcement of any laws, or from exercising rights under Section 7 of the NLRA to engage in joint activity with other employees, although by signing this Release, Employee acknowledges that the Release waives Employee's right to individual relief based on claims asserted in a such a charge or complaint, regardless if such claim is brought individually or as part of a class or collective action, except where such waiver of individual relief is otherwise legally prohibited.

7. Promise Not to Sue. Employee agrees not to institute a lawsuit against the Company asserting any of the claims that are released in Paragraph 4 of this Release. **Employee acknowledges that signing this Release means that Employee has waived not only his or her right to recover in a lawsuit, claim or other action brought by him or her as described herein, but also in any claim, lawsuit or other action brought on his or her behalf (including any claim of age discrimination) against the Company based on or arising out of the employment relationship or the termination of the employment relationship up to the date this Agreement is signed. This does not mean that Employee is precluded from filing a charge of discrimination with the Equal Employment Opportunity Commission ("EEOC"), or other state commission or otherwise participating in proceedings before the EEOC or those commissions; however, if Employee does file such a charge, he or she shall be entitled to no monies, pay, compensation or relief of any type from the Company as a result of the charge.**

8. Confidentiality. Employee shall not, at any time, directly or indirectly, use any trade secrets or confidential information of the Company for Employee's benefit or the benefit of any other person or, directly or indirectly, disclose any such trade secrets or confidential information of the Company to any other person. The Company and Employee agree to keep the terms and conditions of this Agreement confidential except to the extent the terms and conditions are required to be disclosed by any judicial or administrative federal, state or local agency. Employee may also disclose the terms and conditions of this Agreement to Employee's

spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Employee may also disclose the terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Notwithstanding any provisions of this Release to the contrary the Employee may be entitled to immunity and protection from retaliation under the Defend Trade Secrets Act of 2016 for disclosing a trade secret under limited circumstances, as set forth in the Company's Innovations and Intellectual Properties Policy.

9. Cooperation with Litigation. Upon the Company's request, Employee agrees to render reasonable assistance to the Company in connection with any litigation or investigation relating to the Company's business. Such assistance shall include, but not be limited to, providing information, attending meetings, assisting with discovery, giving depositions and making court appearances. Employee agrees to promptly notify the Chief Legal Officer of the Company of any requests for information or testimony that Employee receives in connection with any litigation or investigation relating to the Company's business; provided however, that this reporting requirement will not apply in the context of "protected activity", as defined in Paragraph 6 of this Release.

10. Consultation with Attorney Advised. **Employee is advised to consult with an attorney prior to executing this Agreement.** Employee acknowledges being given that advice. Employee represents that he or she has read and fully understands all of the provisions of this Agreement. Employee represents that he or she is voluntarily signing this Agreement.

11. Due Care - Time Frame for Acceptance. **Employee acknowledges that he or she has received a copy of this Release and has been given a period of forty-five (45) days from receipt within which to freely and voluntarily consider and sign this Release.**

    a. To enter into this Release, Employee must execute it by signing, dating and returning it to the **Employee Relations Control Center, Attn: Cathy Edwards, DEC37B, 550 South Tryon, Charlotte, North Carolina 28202**.

    b. Employee acknowledges that if Employee has signed this Release it is because Employee freely chose to do so.

    c. Employee has **seven (7) calendar days** after he or she signs this Release within which to revoke it. To be effective, a revocation must be communicated in writing to the **Employee Relations Control Center, Attn: Cathy Edwards, DEC37B, 550 South Tryon, Charlotte, North Carolina 28202**, and delivered no later than 5:00 p.m. Eastern Time on the final day of the seven (7) day period.

12. Governing Law. This Agreement shall be interpreted, enforced and governed under the laws of the State of North Carolina.

13. No Admission of Liability. This Agreement shall not in any way be construed as evidence or as an admission of any liability or wrongdoing by the Company.

14. Binding Effect of Agreement. This Agreement will be binding upon and shall operate for the benefit of the heirs, executors, administrators, assigns, and successors in interest of Employee and the Company.

15. Severability. If any portion of this Agreement should be unenforceable for any reason, the parties agree that the remaining portions will continue in effect.

16. Receipt of Required Disclosures. To the extent applicable, the job classifications and the birth dates of all individuals in Employee's decisional unit who are currently eligible and ineligible to participate in the Plan are shown on the Attachment. Employee acknowledges receipt and possession of the Attachment.

17. Effective Date. This Agreement shall become effective and enforceable upon the expiration of the revocation period established in Paragraph 11 (the "Effective Date").

AGREED TO BY:

____________________________ ______________________
Employee Date

THE COMPANY

By: ____________________________ ______________________
Stan Sherrill Date
Vice President, Employee Relations
and Labor Relation

SAMPLE WAIVER AND RELEASE OF CLAIMS
UNDER THE DUKE ENERGY RETIREMENT TRANSITION PROGRAM (OPTION 2)

This Waiver and Release of Claims (the "Release"), delivered on ____________, is entered into by and between Duke Energy Corporation and its subsidiaries and affiliates and any predecessors and successors thereto (individually and collectively referred to as the "Company"), and __________________________ ("Employee") pursuant to the Retirement Transition Program (the "Program") with the mutual exchange of promises as consideration.

WHEREAS, Employee is eligible to separate from employment on ______________ (the "Separation Date") and receive severance benefits described below provided Employee enters into and does not revoke this Release; and

WHEREAS, the Company is willing to provide the Employee the severance benefits described below, provided Employee enters into and does not revoke this Release.

THEREFORE, the Company and Employee agree as follows:

1. Program Benefits. In exchange for Employee remaining employed and in good standing with the Company and separating employment from the Company on his or her Separation Date in accordance with the Program and entering into and not revoking this Release, the Company agrees to provide the Employee the following:

   a. Separation Bonus. A lump sum cash payment equal to $_________, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Release.

   b. Outplacement Services. Outplacement services for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy.

2. Basis for Entitlement. Employee acknowledges and agrees that Employee would not be entitled to the benefits described in Paragraph 1 absent Employee's separation from employment on his or her Separation Date and execution and non-revocation of this Release in accordance with the Program. Employee further acknowledges that he or she is not entitled to a pension enhancement under the Program.

3. Adequate Consideration. Employee acknowledges and agrees that this Release provides good, valuable and sufficient consideration for Employee's obligations under this Release.

4. Release by Employee. Employee, of the Employee's own free will, voluntarily waives and releases the Company, its employee benefit, pension, welfare, and other plans or programs (including any and all fiduciaries thereof), and any of the Company's respective current or former officers, directors, agents, employees, attorneys, insurers, plan administrators, predecessors, successors or assigns from any and all rights or claims that Employee has, or may have, as of the date of the execution of this Release, based on or arising out of the employment relationship or the termination of the employment relationship, other than those rights or claims set forth below in Paragraph 5. The rights and claims so waived and released shall include, but not be limited to:

a. Those arising under any federal, state or local statute, ordinance, common law (including, but not limited to, claims of breach of promise, breach of contract, promissory estoppel, intentional or negligent infliction of emotional distress, defamation, tortious interference with a business relationship or contract and wrongful discharge), or claims in equity or public policy; and

b. Those arising under any law based on any protected status, including but not limited to, sex, age, race, color, religion, handicap or disability, national origin, pregnancy, discrimination, retaliation, or whistleblower (including, but not limited to, any rights or claims arising under Title VII of the Civil Rights Act of 1964, as amended, the Civil Rights Act of 1991, the Americans with Disabilities Act, the Rehabilitation Act, the Older Workers Benefits Protection Act of 1990, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Family and Medical Leave Act, the Genetic Information Nondiscrimination Act, the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Indiana Discrimination on Account of Age Act, the Indiana Civil Rights Statute, the Kentucky Civil Rights Statute, the Ohio Civil Rights Statute, the North Carolina Equal Employment Practices Act, the North Carolina Persons with Disabilities Protection Act, the North Carolina Retaliatory Employment Discrimination Act, the South Carolina Human Affairs Law, the Florida Civil Rights Act, the Florida Whistleblower Act, the Texas Labor Code Chapter 21, and every other local, state, or federal law, regulation, or other legal authority concerning employment rights or claims); and

c. Those arising under the Employee Retirement Income Act of 1974; and

d. Those arising under the civil rights laws of any state or municipality; and

e. Any claim for compensatory damages, punitive damages, attorneys' fees, expenses and litigation costs; and

f. Any grievance, charge or other claim arising under the applicable collective bargaining agreement, National Labor Relations Act, or other similar labor laws, regulations, and authority.

Employee acknowledges that he or she has been paid for all hours worked during his or her employment with the Company and has received all other payments owed to him or her by the Company as of his or her Separation Date. In addition, Employee acknowledges that he or she has received all leave to which he or she may have been entitled to under the Family and Medical Leave Act or applicable state law during his or her employment with the Company.

5. Claims Not Waived. Notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release any workers' compensation or unemployment compensation claims filed prior to the date of execution of this Release, or claims against the Company arising out of possible exposure to asbestos during Employee's employment with the Company at a facility or facilities owned by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release Employee's rights or claims to accrued or vested benefits under an employee benefit plan or program maintained by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Release does not waive and release claims that may arise after the date of execution of this Release, including, but not limited to, claims that may arise under an employee benefit plan or program maintained by the Company.

6. Acknowledgement of No Interference with Reporting and Compliance Rights. Employee acknowledges and agrees that it is the policy of the Company to comply with all applicable federal, state and local laws and regulations. Employee affirms that he or she has reported all compliance issues and violations of federal, state and local law or regulation or Company policy of which he or she had knowledge during the term of his or her employment, if any.

Employee represents and acknowledges that he or she has no further or additional knowledge or information regarding compliance issues or possible violations of federal, state or local law or regulations or Company policy other than what Employee may have previously reported, if any, including, but not limited to, any and all outstanding nuclear safety concerns Employee has involving any nuclear power plant owned or operated by the Company. Nothing in this Release shall be construed to prohibit, restrict or otherwise discourage Employee from participating in "protected activity" as defined in 10 CFR 50.7 and Section 211 of the Energy Reorganization Act of 1974, including, but not limited to reporting any suspected instance of illegal activity of any nature, any nuclear safety concern, any workplace safety concern, any public safety concern, or any other matter within the United States Nuclear Regulatory Commission's ("NRC") regulatory responsibilities to the NRC, the United States Department of Labor, or any other federal or state governmental agency. This Release further does not prohibit Employee from participating in any way in any state or federal administrative, judicial, or legislative proceeding or investigation. Further, nothing in this Release prevents Employee from filing a charge or complaint, with or from participating in an investigation or proceeding conducted by the Equal Opportunity Commission ("EEOC"), National Labor Relations Board ("NLRB"), Securities and Exchange Commission ("SEC"), or any other federal, state or local agency charged with the enforcement of any laws, or from exercising rights under Section 7 of the NLRA to engage in joint activity with other employees, although by signing this Release, Employee acknowledges that the Release waives Employee's right to individual relief based on claims asserted in a such a charge or complaint, regardless if such claim is brought individually or as part of a class or collective action, except where such waiver of individual relief is otherwise legally prohibited.

7. Promise Not to Sue. Employee agrees not to institute a lawsuit against the Company asserting any of the claims that are released in Paragraph 4 of this Release. **Employee acknowledges that signing this Release means that Employee has waived not only his or her right to recover in a lawsuit, claim or other action brought by him or her as described herein, but also in any claim, lawsuit or other action brought on his or her behalf (including any claim of age discrimination) against the Company based on or arising out of the employment relationship or the termination of the employment relationship up to the date this Agreement is signed. This does not mean that Employee is precluded from filing a charge of discrimination with the Equal Employment Opportunity Commission ("EEOC"), or other state commission or otherwise participating in proceedings before the EEOC or those commissions; however, if Employee does file such a charge, he or she shall be entitled to no monies, pay, compensation or relief of any type from the Company as a result of the charge.**

8. Confidentiality. Employee shall not, at any time, directly or indirectly, use any trade secrets or confidential information of the Company for Employee's benefit or the benefit of any other person or, directly or indirectly, disclose any such trade secrets or confidential information of the Company to any other person. The Company and Employee agree to keep the terms and conditions of this Agreement confidential except to the extent the terms and conditions are required to be disclosed by any judicial or administrative federal, state or local agency. Employee may also disclose the terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Employee may also disclose the terms and conditions of this Release to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Notwithstanding any provisions of this Release to the contrary the Employee may be entitled to immunity and protection from retaliation under the Defend Trade Secrets Act of 2016 for disclosing a trade secret under limited circumstances, as set forth in the Company's Innovations and Intellectual Properties Policy.

9. Cooperation with Litigation. Upon the Company's request, Employee agrees to render reasonable assistance to the Company in connection with any litigation or investigation relating to the Company's business. Such assistance shall include, but not be limited to, providing information, attending meetings, assisting with discovery, giving depositions and making court appearances. Employee agrees to promptly notify the Chief Legal Officer of the Company of any requests for information or testimony that Employee receives in connection with any litigation or investigation relating to the Company's business; provided however, that this reporting requirement will not apply in the context of "protected activity", as defined in Paragraph 6 of this Release.

10. Consultation with Attorney Advised. **Employee is advised to consult with an attorney prior to executing this Agreement.** Employee acknowledges being given that advice. Employee represents that he or she has read and fully understands all of the provisions of this Agreement. Employee represents that he or she is voluntarily signing this Agreement.

11. Due Care - Time Frame for Acceptance. **Employee acknowledges that he or she has received a copy of this Release and has been given a period of forty-five (45) days from his or her Separation Date within which to freely and voluntarily consider and sign this Release.**

    a. To enter into this Release, Employee must execute it by signing, dating and returning it to the **Employee Relations Control Center, Attn: Cathy Edwards, DEC37B, 550 South Tryon, Charlotte, North Carolina 28202**.

    b. Employee acknowledges that if Employee has signed this Release it is because Employee freely chose to do so.

    c. Employee has **seven (7) calendar days** after he or she signs this Release within which to revoke it. To be effective, a revocation must be communicated in writing to the **Employee Relations Control Center, Attn: Cathy Edwards, DEC37B, 550 South Tryon, Charlotte, North Carolina 28202**, and delivered no later than 5:00 p.m. Eastern Time on the final day of the seven (7) day period.

12. Governing Law. This Agreement shall be interpreted, enforced and governed under the laws of the State of North Carolina.

13. No Admission of Liability. This Agreement shall not in any way be construed as evidence or as an admission of any liability or wrongdoing by the Company.

14. Binding Effect of Agreement. This Agreement will be binding upon and shall operate for the benefit of the heirs, executors, administrators, assigns, and successors in interest of Employee and the Company.

15. Severability. If any portion of this Agreement should be unenforceable for any reason, the parties agree that the remaining portions will continue in effect.

16. Receipt of Required Disclosures. To the extent applicable, the job classifications and the birth dates of all individuals in Employee's decisional unit who are currently eligible and ineligible to participate in the Plan are shown on the Attachment. Employee acknowledges receipt and possession of the Attachment.

17. Effective Date. This Agreement shall become effective and enforceable upon the expiration of the revocation period established in Paragraph 11 (the "Effective Date").

AGREED TO BY:

______________________ ______________________
Employee Date

THE COMPANY

By: ______________________ ______________________
Stan Sherrill Date
Vice President, Employee Relations
and Labor Relations

EXHIBIT B: OTHER TERMS AND CONDITIONS

1. General. The contingent rights set forth in this letter agreement (the "Agreement") are not transferable otherwise than by will or the laws of descent and distribution. Nothing in this Agreement shall restrict our right to terminate your employment at any time with or without cause. The terms of this Agreement shall be binding upon and inure to the benefit of us and our successors and assigns, and to you and your beneficiaries, executors, administrators, heirs and successors. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions of this Agreement.

2. Choice of Law. Except to the extent pre-empted by federal law, this Agreement and your rights under it shall be construed and determined in accordance with the laws of the State of North Carolina.

3. Entire Agreement. This Agreement contains the entire agreement and understanding of the parties with respect to the subject matter contained in this Agreement, and supersedes all prior communications, representations and negotiations in respect thereto. This Agreement may be executed in counterparts. We shall have final authority to interpret and construe this Agreement and to make any and all determinations under it, and our decision shall be binding and conclusive upon you and your legal representative in respect of any questions arising under this Agreement. No change, modification or waiver of any provision of this Agreement shall be valid unless the same is in writing and signed by the parties.

4. Interaction with Other Rights. Any payments to you under this Agreement shall be paid from our general assets, and you shall have the status of a general unsecured creditor with respect to our obligations to make payments under this Agreement.

5. Internal Revenue Code Section 409A. The Agreement and any payments provided under it are intended to comply with, or be exempt from, Section 409A of the Internal Revenue Code of 1986, as amended ("Section 409A"). The Agreement shall in all respects be interpreted, operated, and administered in accordance with this intent. Payments provided under the Agreement may only be made upon an event and in a manner that complies with Section 409A or an applicable exemption, including to the maximum extent possible, exemptions for separation pay due to an involuntary separation from service and/or short-term deferrals. Any payments provided under the Agreement to be made upon a termination of employment that constitute deferred compensation subject to Section 409A shall only be made if such termination of employment constitutes a "separation from service" under Section 409A. If any payments or other benefits due to you under the Agreement would cause the application of an accelerated or additional tax under Section 409A, the payments or other benefits will be deferred if deferral will make such payment or other benefits compliant under Section 409A, or otherwise such payment or other benefits will be restructured, to the extent possible, in a manner that does not cause such an accelerated or additional tax and result in a material additional cost to us. Notwithstanding anything to the contrary in the Agreement, to the extent required to avoid accelerated taxation and additional taxes under Section 409A, amounts that would otherwise be payable and benefits that would otherwise be provided under this Agreement that (i) are subject to the requirements of Section 409A, (ii) are payable due to your "separation from service" with us within the meaning of Section 409A and (iii) are otherwise payable during the six (6) month period immediately following your separation from service shall instead be paid (without interest) on the first payroll date that is at least six months after your separation from service (or your death, if earlier). We make no representations or warranties that the payments provided under the Agreement comply with, or are exempt from, Section 409A, and in no event shall we be liable for any portion of any taxes, penalties, interest, or other expenses that may be incurred by you on account of non-compliance with Section 409A.

STAFF-DR-01-042

REQUEST:

Concerning employee fringe benefits:

a. Provide a detailed list of all fringe benefits available to Duke Kentucky's employees and the expected cost of each benefit in the base period and the forecasted test period. Indicate any fringe benefits which are limited to management employees.

b. Provide comparative cost information for the 12 months preceding the base period and the base period. Explain any changes in fringe benefits occurring over this 24-month period.

RESPONSE:

See STAFF-DR-01-042 Attachment.

PERSON RESPONSIBLE: Renee H. Metzler

STAFF-DR-01-042
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky
Question No. 42
Responding Witness: Renee Metzler

		12 Month Preceeding 12.1.2016 - 11.30.2017	Base Period 12.1.2017 - 11.30.2018	Variance	Test Period 4.1.2019 - 3.31.2020
1B110	Qualified Pension	333,366	360,311	26,944	348,806
1B112	Employee Savings Active	267,894	326,740	58,845	355,721
1B114	OPEB Active	(177,874)	46,076	223,950	39,676
1B210	Medical Active	544,221	616,514	72,293	641,225
1B212	Dental Active	34,305	32,771	(1,534)	35,528
1B214	Misc Other Fees	(52,599)	(2,827)	49,772	
1B216	Long Term Disability	-	7,088	7,088	19,905
1B218	FAS112 Offset	150,866	66,411	(84,456)	70,204
1B310	Service/Safety Awards	2,469	3,721	1,252	9,301
1B312	Other Work/Family Benefits	209	743	534	7,583
1B410	Tuiton Reimbursement	2,770	4,006	1,236	5,418
1B510	Basic Life	(116,194)	2,348	118,542	7,211
1B512	Accidental Death & Dismember.	(26,389)	263	26,652	635
Total		963,046	1,464,164	501,118	1,541,214

A) The schedule above represents employee benefit costs for the time period requested. None of these benefits are limited to management employees. This schedule does not represent benefits offered only to executives

B) Refer to schedule above. The main drivers of the unfavorable variance for the 24 month period in question are the favorable retiree medical expense in 2017 due to a curtailment credit recognized in 2017 tied to a plan changes, and the 2017 favorable true up adjustment of Basic Life

STAFF-DR-01-043

REQUEST:

Provide a complete description of Duke Kentucky's Other Post-Employment Benefits package(s) provided to its employees.

RESPONSE:

See the Direct Testimony of Renee H. Metzler beginning on pg. 33 where she describes Duke Energy's post-employment healthcare benefits.

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-044

REQUEST:

Provide a complete description of the financial reporting and ratemaking treatment of Duke Kentucky's pension costs.

RESPONSE:

Duke Energy Kentucky participates in qualified and non-qualified defined benefit retirement plans (Pension) and other post-retirement benefit plans (OPEB) sponsored by Duke Energy Corporation (Duke Energy). The following primary authoritative accounting guidance for Pensions and OPEB is codified as part of the Accounting Standards Codification (ASC) that relates to Compensation – Retirement Benefits (ASC Topic 715):

ASC Subtopic Name	ASC Topic-Subtopic
Retirement Benefits – Defined Benefit Plans - General	715-20
Retirement Benefits – Defined Benefit Plans – Pension	715-30
Retirement Benefits – Defined Benefit Plans – Other Postretirement	715-60

Duke Energy's Pension and OPEB costs are calculated by the company's third party actuary, Willis Towers Watson (WTW). Duke Energy determines the assumptions to be used by WTW to calculate Pension/OPEB plan obligations and costs based upon a range of assumptions presented by WTW. Upon consummation of the merger with Duke Energy in 2006, Cinergy's benefit plan obligations were re-measured. However, push-down accounting did not apply to Duke Energy Kentucky. As a result, Pension and

OPEB costs are calculated on a pre-purchase accounting basis. Duke Energy Kentucky Pension and OPEB costs and obligations are allocated to Duke Energy Kentucky by Duke Energy. A portion of Duke Energy Kentucky's Pension and OPEB costs are capitalized as a component of property, plant and equipment. Additionally, Duke Energy Kentucky is allocated its proportionate share of Pension and OPEB costs for employees of Duke Energy's shared services affiliate that provides support to Duke Energy Kentucky.

In applying the provisions of ASC 715, Duke Energy is required to recognize the funded status of a benefit plan, measured as the difference between the fair value of plan assets and the benefit obligation, in its statement of financial position. Duke Energy remeasures its Pension and OPEB plan assets and obligations annually on December 31. For a pension plan, the benefit obligation is the projected benefit obligation (PBO). For an OPEB plan, the benefit obligation is the accumulated post-retirement benefit obligation (APBO). Actuarial gains or losses (represent the effect of differences between actuarial assumptions and actual experience) and prior service costs or credits (effect of plan amendments) that arise during the period as a result of re-measurement, represent costs that are probable of future recovery, and are reflected in regulatory assets and/or regulatory liabilities in the statement of financial position. Regulatory assets and/or regulatory liabilities are recognized in the following three categories: qualified pension plans, non-qualified pension plans and OPEB plans. Duke Energy elects to amortize actuarial gains or losses in excess of the corridor of 10 percent of the greater of the market-related value of plan assets or plan projected benefit obligation into Pension and OPEB cost over the average remaining service period of active covered employees. If all

or almost all of a plan's participants are inactive, the average remaining life expectancy of the plan's participants is used instead of their average remaining service period. Prior service cost or credit is amortized over the average remaining service period of active covered employees. If all or almost all of a plan's participants are inactive, the average remaining life expectancy of the plan's participants is used instead of their average remaining service period.

PERSON RESPONSIBLE: Michael Covington
Jeffrey R. Setser

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-045

REQUEST:

For each of the following Statements of Financial Accounting Standards (SFAS), provide the information listed concerning implementation by Duke Kentucky.

a. SFAS No. 106, "Employers' Account for Postretirement Benefits Other Than Pensions."
   1) The date Duke Kentucky adopted the SFAS.
   2) The effect on the financial statement.
   3) Whether the base period or forecasted test period includes any impact of the implementation. If so, provide a detailed description of the impact.

b. SFAS No. 112, "Employers' Accounting for Postretirement Benefits."
   1) The date Duke Kentucky adopted the SFAS.
   2) The effect on the financial statements.
   3) Whether the base period or forecasted test period includes any impact of the implementation. If so, provide a detailed description of the impact.

c. SFAS No. 143, "Accounting for Asset Retirement Obligations."
   1) The date Duke Kentucky adopted the SFAS.
   2) The effect on the financial statements.
   3) Whether the base period or forecasted test period includes any impact of the implementation. If so, provide a detailed description of the impact.

d. A schedule comparing the depreciation rates utilized by Duke Kentucky prior to and after the adoption of SFAS No. 143. The schedule should identify the assets corresponding to the affected depreciation rates.

e. SFAS No. 158, "Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans."

    1) The date Duke Kentucky adopted the SFAS.

    2) The effect on the financial statements.

    3) Whether the base period or forecasted test period includes any impact of the implementation. If so, provide a detailed description of the impact.

RESPONSE:

a. 1) Duke Energy Kentucky adopted SFAS No.106 (now Accounting Standards Codification "ASC" 715-60), effective January 1, 1993.

    2) There was no material impact on the results of operations at the time of adoption.

    3) Neither the base period nor the forecast period includes any impact of the implementation.

b. 1) Duke Energy Kentucky adopted SFAS No.112, (now Accounting Standards Codification "ASC" 712) effective January 1, 1993.

    2) There was no material impact on the results of operations at the time of adoption.

    3) Neither the base period nor the forecast period includes any impact of the implementation.

c. 1) Duke Energy Kentucky implemented SFAS No. 143 (now Accounting Standards Codification "ASC" 410-20) effective January 1, 2003.

2) As included in Duke Energy Kentucky's Response to the Attorney General Second Set of Data Requests from Duke Energy Kentucky's 2006 rate case (2006-00172) item number 33 (AG-DR-02-033), we previously provided support and explanations for the accounting entries (debits and credits) used to implement SFAS No. 143 and FIN 47. This previous response and support is attached to this current data request as the content of this response is based on historical transactions and would not have changed since provided as part of the 2006 rate case. See STAFF-DR-01-045(c) Attachment.

3) There is no impact to the base or forecasted period as neither the base period nor forecasted period include the impact of implementation.

d. Depreciation of the assets associated with the recording of Asset Retirement Obligations is straight-line based on the expected remaining life of the related plant assets. Prior to implementation of SFAS 143 (now ASC 410-20) there would not have been deprecation rates established for such assets as these are specifically identified with the Asset Retirement Obligation and the plant asset(s) associated with the ARO. The following summarizes the assets resulting from the AROs recorded at the gas utility (does not include electric utility) in compliance with SFAS 143 and FIN 47 (now ASC 410-20) and includes the gross asset

balances at July 31, 2018 and the current annual depreciation rates:

- Gas Mains: $3,583,546; 2.29%

Depreciation expense for these AROs has been deferred.

e. 1) Duke Energy Kentucky adopted SFAS No. 158 (amendment to current ccounting Standards Codification "ASC" 715-30 and 715-60), effective December 31, 2006.

2) For Duke Energy Kentucky, the adoption of SFAS No. 158 recognition and disclosure provisions resulted in an increase in regulatory assets of approximately $22 million and an increase in liabilities of approximately $22 million as of December 31, 2006. The adoption of SFAS No. 158 did not have a material impact on Duke Energy Kentucky's results of operations or cash flows. Duke Energy Kentucky adopted the change in measurement date effective January 1, 2007 by re-measuring plan assets and benefit obligations as of that date, pursuant to the transition requirements of SFAS No. 158. In the first quarter of 2007, the changes in plan assets and plan obligations between the September 30, 2006 and December 31, 2006 measurement dates not related to net periodic benefit cost were required to be recognized, net of tax, as a separate adjustment of the opening balance of accumulated other comprehensive income (loss) (AOCI) and regulatory assets. This adjustment was not material. During the second quarter of 2007, Duke Energy Kentucky completed these calculations. The finalization of these actuarial calculations resulted in an immaterial adjustment to AOCI and regulatory assets.

3) The base period and forecasted test period were not impacted by the implementation. SFAS No. 158 did not change the determination of expense; it only impacted the balance sheet.

PERSON RESPONSIBLE: Jeffrey R. Setser – a., b., e.
Michael Covington – c., d.
Cynthia S. Lee

Attorney General Second Set Data Requests
Duke Energy Kentucky Case No. 2006-00172
Date Received: August 09, 2006
Response Due Date: August 23, 2006

AG-DR-02-033

REQUEST:

33. Refer to page 138 of ULH&P's December 31, 2005 Form 10K. Provide the accounting entries (debits and credits) used to implement SFAS No. 143 and FIN 47, along with all workpapers supporting those entries, including the workpapers supporting the calculation of the $29 million (2005) and $30 million (2004) regulatory liabilities for asset cost of removal. Please provide all these workpapers and calculations in electronic format (Excel) with all formulae intact.

RESPONSE:

Duke Energy Kentucky implemented SFAS No. 143 effective January 1, 2003. Duke Energy Kentucky implemented FIN 47 December 2005. See Attachments AG-DR-02-033 and AG-DR-02-033(a) for entries and workpapers for the gas asset retirement obligation recorded. No legal asset retirement obligations for electric operations were identified upon implementation of SFAS No. 143 or FIN 47.

Based on SEC guidance arising from SFAS No. 143, Duke Energy Kentucky reclassified the cost of removal component of Accumulated Depreciation to Regulatory Liabilities for SEC financial statement presentation. See Attachment AG-DR-02-033(b) for workpapers supporting the reclassification. See Attachment AG-DR-02-033(c) and reconciliation below for further support of the $30 million 2004 and $29 million 2005 balances referenced in the question.

Regulatory Liability Reconciliation:
The amounts referenced, $30 million in 2004 and $29 million in 2005, represent Duke Energy Kentucky's total Regulatory Liabilities. The regulatory liability for cost of removal (electric, common, and gas) for 2004 and 2005 was $30 million and $32 million, respectively.

(Dollars in thousands)

Regulatory Liabilities	2005	2004
Accumulated depreciation COR	$35,133	$32,515
Retirement work in progress	(3,110)	(2,982)
Subtotal COR	32,023	29,533
Regulatory asset - legal ARO	(5,197)	-
Gas cost recovery liability	(324)	446
Deferred fuel costs	650	-
Amt due from customers-income taxes	1,886	-
	$29,038	**$29,979**

WITNESS RESPONSIBLE: Carl J. Council, Jr.

ARO Transition Journal Entry Report

Company / ARO	Account	Transition thru Nov Debits	Transition thru Nov Credits	December Adjustment Cum Effect Adj Debits	December Adjustment Depreciation & Accretion calc to be included Credits
Cincinnati Gas & Electric Co.					
Beckjord 1-5 Asbestos					
Long-lived asset:	101850 - NonReg Plant in Service AR	371,656.46			
Initial liability:	230850 - Asset Retirement Obligatio		371,656.46		
Accretion Expense:	230850 - Asset Retirement Obligatio		587,193.16		2,848.84
Accumulated depreciation:			145,778.36		455.35
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	732,971.52	-	3,302.19	
Beckjord 1-5 River Structure					
Long-lived asset:	101850 - NonReg Plant in Service AR	17,789.96			
Initial liability:	230850 - Asset Retirement Obligatio		17,789.96		
Accretion Expense:	230850 - Asset Retirement Obligatio		476,766.18		2,598.42
Accumulated depreciation:			12,312.96		19.35
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	489,079.14	-	2,615.77	
Beckjord 6 Asbestos					
Long-lived asset:	101850 - NonReg Plant in Service AR	28,901.40			
Initial liability:	230850 - Asset Retirement Obligatio		28,901.40		
Accretion Expense:	230850 - Asset Retirement Obligatio		45,273.00		389.42
Accumulated depreciation:			11,274.49		62.29
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	56,547.49	-	451.71	
Beckjord 6 River Structure					
Long-lived asset:	101850 - NonReg Plant in Service AR	1,334.25			
Initial liability:	230850 - Asset Retirement Obligatio		1,334.25		
Accretion Expense:	230850 - Asset Retirement Obligatio		35,757.10		194.73
Accumulated depreciation:			922.20		1.46
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	36,879.30	-	196.19	
Conesville Asbestos					
Long-lived asset:	101850 - NonReg Plant in Service AR	12,762.62			
Initial liability:	230850 - Asset Retirement Obligatio		12,762.62		
Accretion Expense:	230850 - Asset Retirement Obligatio		19,992.12		171.96
Accumulated depreciation:			4,512.33		24.93
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	24,504.45	-	196.89	
East Bend Asbestos					
Long-lived asset:	101850 - NonReg Plant in Service AR	42,698.67			
Initial liability:	230850 - Asset Retirement Obligatio		42,698.87		
Accretion Expense:	230850 - Asset Retirement Obligatio		66,885.90		575.32
Accumulated depreciation:			12,711.63		70.23
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	79,597.53	-	645.55	
East Bend River Structure					
Long-lived asset:	101850 - NonReg Plant in Service AR	17,053.76			
Initial liability:	230850 - Asset Retirement Obligatio		17,053.76		
Accretion Expense:	230850 - Asset Retirement Obligatio		59,590.60		402.38
Accumulated depreciation:			8,888.80		23.85
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	66,459.60	-	426.23	
East Bend SCR Catalyst A 2002					
Long-lived asset:	101850 - NonReg Plant in Service AR	71,110.28			
Initial liability:	230850 - Asset Retirement Obligatio		71,110.28		
Accretion Expense:	230850 - Asset Retirement Obligatio		13,989.82		382.95
Accumulated depreciation:			27,504.85		670.85
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	41,494.67	-	1,053.80	
East Bend SCR Catalyst B 2002					
Long-lived asset:	101850 - NonReg Plant in Service AR	66,364.10			
Initial liability:	230850 - Asset Retirement Obligatio		66,364.10		
Accretion Expense:	230850 - Asset Retirement Obligatio		13,320.01		365.22
Accumulated depreciation:			20,930.09		510.49
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	34,250.10	-	875.71	
Killen Asbestos					
Long-lived asset:	101850 - NonReg Plant in Service AR	19,656.86			
Initial liability:	230850 - Asset Retirement Obligatio		19,656.86		
Accretion Expense:	230850 - Asset Retirement Obligatio		30,791.87		264.85
Accumulated depreciation:			5,737.70		31.71
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	36,529.37	-	296.56	
Killen River Structure					
Long-lived asset:	101850 - NonReg Plant in Service AR	20,022.46			

Item	Account				
Initial liability:	230850 - Asset Retirement Obligatio		20,022.46		
Accretion Expense:	230850 - Asset Retirement Obligatio		64,483.75		443.66
Accumulated depreciation:			7,728.00		28.01
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	72,211.75	-	471.67	
K CR Catalyst A 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	43,079.11			
Initial liability:	230850 - Asset Retirement Obligatio		43,079.11		
Accretion Expense:	230850 - Asset Retirement Obligatio		3,486.87		201.79
Accumulated depreciation:			17,052.12		897.48
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	20,538.99	-	1,099.27	
Killen SCR Catalyst B 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	40,558.73			
Initial liability:	230850 - Asset Retirement Obligatio		40,558.73		
Accretion Expense:	230850 - Asset Retirement Obligatio		3,348.37		193.92
Accumulated depreciation:			10,703.08		563.31
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	14,051.45	-	757.23	
Miami Fort 3-5 Asbestos					
Long-lived asset:	101850 - NonReg Plant In Service AR	216,408.49			
Initial liability:	230850 - Asset Retirement Obligatio		216,408.49		
Accretion Expense:	230850 - Asset Retirement Obligatio		338,995.60		2,915.87
Accumulated depreciation:			68,479.54		378.33
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	407,475.14	-	3,294.20	
Miami Fort 5&6 River Structure					
Long-lived asset:	101850 - NonReg Plant In Service AR	2,043.34			
Initial liability:	230850 - Asset Retirement Obligatio		2,043.34		
Accretion Expense:	230850 - Asset Retirement Obligatio		66,544.33		360.09
Accumulated depreciation:			1,290.24		1.93
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	67,834.57	-	382.02	
Miami Fort 6 Asbestos					
Long-lived asset:	101850 - NonReg Plant In Service AR	176,823.48			
Initial liability:	230850 - Asset Retirement Obligatio		176,823.48		
Accretion Expense:	230850 - Asset Retirement Obligatio		276,987.28		2,382.51
Accumulated depreciation:			55,952.53		309.13
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	332,939.79	-	2,691.64	
I Fort 7 SCR Catalyst A 2003					
Long-lived asset:	101850 - NonReg Plant In Service AR	127,465.02			
Initial liability:	230850 - Asset Retirement Obligatio		127,465.02		
Accretion Expense:	230850 - Asset Retirement Obligatio		16,405.42		623.44
Accumulated depreciation:			63,732.43		2,197.68
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	80,137.85	-	2,821.12	
Miami Fort 7 SCR Catalyst B 2003					
Long-lived asset:	101850 - NonReg Plant In Service AR	119,908.44			
Initial liability:	230850 - Asset Retirement Obligatio		119,908.44		
Accretion Expense:	230850 - Asset Retirement Obligatio		15,747.64		599.15
Accumulated depreciation:			42,406.70		1,462.30
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	58,154.34	-	2,061.45	
Miami Fort 7&8 River Structure					
Long-lived asset:	101850 - NonReg Plant In Service AR	6,899.38			
Initial liability:	230850 - Asset Retirement Obligatio		6,899.38		
Accretion Expense:	230850 - Asset Retirement Obligatio		37,197.11		230.46
Accumulated depreciation:			3,211.20		8.92
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	40,408.31	-	239.38	
Miami Fort 8 SCR Catalyst A 2002					
Long-lived asset:	101850 - NonReg Plant In Service AR	117,772.83			
Initial liability:	230850 - Asset Retirement Obligatio		117,772.83		
Accretion Expense:	230850 - Asset Retirement Obligatio		22,237.53		606.71
Accumulated depreciation:			58,886.25		1,436.26
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	81,123.78	-	2,042.97	
Miami Fort 8 SCR Catalyst B 2002					
Long-lived asset:	101850 - NonReg Plant In Service AR	109,611.81			
Initial liability:	230850 - Asset Retirement Obligatio		109,611.81		
Accretion Expense:	230850 - Asset Retirement Obligatio		21,564.35		590.29
Accumulated depreciation:			42,396.87		1,034.08
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	63,961.22	-	1,624.37	
1 SCR Catalyst A 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	110,711.89			
Initial liability:	230850 - Asset Retirement Obligatio		110,711.89		
Accretion Expense:	230850 - Asset Retirement Obligatio		9,319.05		540.14
Accumulated depreciation:			21,911.75		1,153.25
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	31,230.80	-	1,693.39	

Item	Account				
Stuart 1 SCR Catalyst B 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	102,392.60			
Initial liability:	230850 - Asset Retirement Obligatio		102,392.60		
Accretion Expense:	230850 - Asset Retirement Obligatio		8,950.81		519.60
Accumulated depreciation:			16,212.13		853.27
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	25,162.94	-	1,372.87	
Stuart 2 SCR Catalyst A 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	110,711.89			
Initial liability:	230850 - Asset Retirement Obligatio		110,711.89		
Accretion Expense:	230850 - Asset Retirement Obligatio		9,319.05		540.14
Accumulated depreciation:			21,911.75		1,153.25
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	31,230.80	-	1,693.39	
Stuart 2 SCR Catalyst B 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	102,392.60			
Initial liability:	230850 - Asset Retirement Obligatio		102,392.60		
Accretion Expense:	230850 - Asset Retirement Obligatio		8,950.81		519.60
Accumulated depreciation:			16,212.13		853.27
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	25,182.94	-	1,372.87	
Stuart 3 SCR Catalyst A 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	106,577.02			
Initial liability:	230850 - Asset Retirement Obligatio		106,577.02		
Accretion Expense:	230850 - Asset Retirement Obligatio		9,143.70		530.39
Accumulated depreciation:			18,749.58		986.83
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	27,893.28	-	1,517.22	
Stuart 3 SCR Catalyst B 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	98,177.10			
Initial liability:	230850 - Asset Retirement Obligatio		98,177.10		
Accretion Expense:	230850 - Asset Retirement Obligatio		8,741.79		507.86
Accumulated depreciation:			14,131.63		743.77
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	22,873.42	-	1,251.83	
Stuart 4 SCR Catalyst A 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	122,031.52			
Initial liability:	230850 - Asset Retirement Obligatio		122,031.52		
Accretion Expense:	230850 - Asset Retirement Obligatio		9,877.29		571.60
Accumulated depreciation:			38,643.34		2,033.86
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	48,520.63	-	2,605.46	
Stuart 4 SCR Catalyst B 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	106,577.02			
Initial liability:	230850 - Asset Retirement Obligatio		106,577.02		
Accretion Expense:	230850 - Asset Retirement Obligatio		9,143.70		530.39
Accumulated depreciation:			18,749.56		986.83
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	27,893.28	-	1,517.22	
Stuart 4 SCR Catalyst C 2005					
Long-lived asset:	101850 - NonReg Plant In Service AR	102,941.47			
Initial liability:	230850 - Asset Retirement Obligatio		102,941.47		
Accretion Expense:	230850 - Asset Retirement Obligatio		3,977.42		507.86
Accumulated depreciation:			7,594.02		843.78
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	11,571.44	-	1,351.64	
Stuart Asbestos					
Long-lived asset:	101850 - NonReg Plant In Service AR	426,891.86			
Initial liability:	230850 - Asset Retirement Obligatio		426,891.86		
Accretion Expense:	230850 - Asset Retirement Obligatio		668,709.27		5,751.90
Accumulated depreciation:			147,457.08		814.68
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	816,166.35	-	6,566.58	
Stuart River Structure					
Long-lived asset:	101850 - NonReg Plant In Service AR	18,679.43			
Initial liability:	230850 - Asset Retirement Obligatio		18,679.43		
Accretion Expense:	230850 - Asset Retirement Obligatio		159,760.13		936.81
Accumulated depreciation:			10,411.20		24.11
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	170,171.33	-	960.92	
Zimmer Asbestos					
Long-lived asset:	101850 - NonReg Plant In Service AR	298,501.14			
Initial liability:	230850 - Asset Retirement Obligatio		298,501.14		
Accretion Expense:	230850 - Asset Retirement Obligatio		417,176.75		3,757.31
Accumulated depreciation:			70,136.64		417.48
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	487,313.39	-	4,174.79	
Zimmer River Structure					
Long-lived asset:	101850 - NonReg Plant In Service AR	22,058.81			
Initial liability:	230850 - Asset Retirement Obligatio		22,058.61		
Accretion Expense:	230850 - Asset Retirement Obligatio		30,828.48		277.66
Accumulated depreciation:			5,182.80		30.65

Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	36,011.28	-	308.51	
Zimmer SCR Catalyst A 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	148,956.94			
Initial liability:	230850 - Asset Retirement Obligatio		148,956.94		
Accretion Expense:	230850 - Asset Retirement Obligatio		12,297.27		712.21
Accumulated depreciation:			39,308.15		2,068.84
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	51,605.42	-	2,781.05	
Zimmer SCR Catalyst B 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	139,685.43			
Initial liability:	230850 - Asset Retirement Obligatio		139,685.43		
Accretion Expense:	230850 - Asset Retirement Obligatio		11,757.86		881.49
Accumulated depreciation:			27,646.14		1,455.06
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	39,404.00	-	2,136.55	
Zimmer SCR Catalyst C 2004					
Long-lived asset:	101850 - NonReg Plant In Service AR	129,189.58			
Initial liability:	230850 - Asset Retirement Obligatio		129,189.58		
Accretion Expense:	230850 - Asset Retirement Obligatio		11,293.28		655.59
Accumulated depreciation:			20,455.02		1,078.58
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	31,748.28	-	1,732.17	
Gas Mains					
Long-lived asset:	101200 - Gas plant	6,305,213.00			
Initial liability:	230850 - Asset Retirement Obligatio		25,600,275.00		
Accumulated depreciation:			2,460,667.00		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	21,755,729.00	-		
CGE TOTAL					
Long-lived asset:	101850 - NonReg Plant In Service AR	3,776,197.33			
Long-lived asset:	101200 - Gas plant	6,305,213.00			
Initial liability:	230850 - Asset Retirement Obligatio		29,376,472.33		
Accretion Expense:	230850 - Asset Retirement Obligatio		3,805,804.83		34,878.53
Accumulated depreciation:			3,575,772.31		25,883.65
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	21,755,729.00			
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	4,720,909.94		60,562.18	
ULHP					
Gas Mains					
Long-lived asset:	101200 - Gas plant	1,745,998.00			
Initial liability:	230850 - Asset Retirement Obligatio		8,305,777.00		
Accumulated depreciation:			636,898.00		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	5,196,675.00	-		
KO Transmission					
Gas Mains					
Long-lived asset:	101200 - Gas plant	32,890.00			
Initial liability:	230850 - Asset Retirement Obligatio		73,695.00		
Accumulated depreciation:			27,580.00		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	435300 - ARO Extraordinary Deduct	88,585.00	-		
PSI Energy, Inc.					
Cayuga Asbestos					
Long-lived asset:	101800 - Reg Plant In Service ARO	155,162.02			
Initial liability:	230800 - ARO Liability		155,162.02		
Accretion Expense:	230800 - ARO Liability		243,055.35		
Accumulated depreciation:			56,167.92		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	299,223.27	-		
Cayuga River Structure					
Long-lived asset:	101800 - Reg Plant In Service ARO	10,684.41			
Initial liability:	230800 - ARO Liability		10,684.41		
Accretion Expense:	230800 - ARO Liability		85,165.35		
Accumulated depreciation:			6,073.20		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	91,238.55	-		
E[illegible]dsport Asbestos					
Long-lived asset:	101800 - Reg Plant In Service ARO	650,548.04			
Initial liability:	230800 - ARO Liability		650,548.04		
Accretion Expense:	230800 - ARO Liability		899,001.36		
Accumulated depreciation:			626,325.16		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	1,525,326.52	-		
Gallagher Asbestos					

Long-lived asset:	101800 - Reg Plant In Service ARO	1,228,287.37	
Initial liability:	230800 - ARO Liability		1,228,287.37
Accretion Expense:	230800 - ARO Liability		1,947,671.14
Accumulated depreciation:			604,130.94
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	2,551,802.08	-
Ga[illegible]er River Structure			
Long-lived asset:	101800 - Reg Plant In Service ARO	5,644.15	
Initial liability:	230800 - ARO Liability		5,644.15
Accretion Expense:	230800 - ARO Liability		104,520.81
Accumulated depreciation:			4,241.28
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	108,762.09	-
Gibson 1 SCR Catalyst A 2005			
Long-lived asset:	101800 - Reg Plant In Service ARO	248,745.65	
Initial liability:	230800 - ARO Liability		248,745.65
Accretion Expense:	230800 - ARO Liability		6,792.14
Accumulated depreciation:			24,183.60
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	30,975.74	-
Gibson 1 SCR Catalyst B 2005			
Long-lived asset:	101800 - Reg Plant In Service ARO	232,799.86	
Initial liability:	230800 - ARO Liability		232,799.88
Accretion Expense:	230800 - ARO Liability		6,475.80
Accumulated depreciation:			16,975.00
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	23,450.80	-
Gibson 1-4 Asbestos			
Long-lived asset:	101800 - Reg Plant In Service ARO	669,481.94	
Initial liability:	230800 - ARO Liability		669,481.94
Accretion Expense:	230800 - ARO Liability		1,048,717.52
Accumulated depreciation:			195,445.61
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	1,244,163.13	-
Gibson 1-4 River Structure			
Long-lived asset:	101800 - Reg Plant In Service ARO	2,441.43	
Initial liability:	230800 - ARO Liability		2,441.43
Accretion Expense:	230800 - ARO Liability		13,555.71
Accumulated depreciation:			1,101.60
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	14,657.31	-
Gi[illegible]n 2 SCR Catalyst A 2002			
Long-lived asset:	101800 - Reg Plant In Service ARO	229,427.63	
Initial liability:	230800 - ARO Liability		229,427.63
Accretion Expense:	230800 - ARO Liability		43,319.89
Accumulated depreciation:			114,713.90
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	158,033.79	-
Gibson 2 SCR Catalyst B 2002			
Long-lived asset:	101800 - Reg Plant In Service ARO	213,529.31	
Initial liability:	230800 - ARO Liability		213,529.31
Accretion Expense:	230800 - ARO Liability		42,008.46
Accumulated depreciation:			82,591.63
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	124,600.09	-
Gibson 2 SCR Catalyst C 2004			
Long-lived asset:	101800 - Reg Plant In Service ARO	221,379.13	
Initial liability:	230800 - ARO Liability		221,379.13
Accretion Expense:	230800 - ARO Liability		17,896.31
Accumulated depreciation:			37,241.28
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	55,137.59	-
Gibson 3 SCR Catalyst A 2002			
Long-lived asset:	101800 - Reg Plant In Service ARO	235,752.34	
Initial liability:	230800 - ARO Liability		235,752.34
Accretion Expense:	230800 - ARO Liability		44,514.09
Accumulated depreciation:			138,083.49
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	182,597.58	-
Gibson 3 SCR Catalyst B 2002			
Long-lived asset:	101800 - Reg Plant In Service ARO	221,556.02	
Initial liability:	230800 - ARO Liability		221,556.02
Accretion Expense:	230800 - ARO Liability		42,709.16
Accumulated depreciation:			96,636.18
Depreciation Adjustments:		-	-
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	139,345.34	-
G[illegible]n 3 SCR Catalyst C 2004			
Long-lived asset:	101800 - Reg Plant In Service ARO	229,948.28	
Initial liability:	230800 - ARO Liability		229,948.28
Accretion Expense:	230800 - ARO Liability		16,238.81
Accumulated depreciation:			43,569.18
Depreciation Adjustments:		-	-

Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	61,807.99	-		
Gibson 4 SCR Catalyst A 2003					
Long-lived asset:	101800 - Reg Plant In Service ARO	255,153.30			
Initial liability:	230800 - ARO Liability		255,153.30		
Accretion Expense:	230800 - ARO Liability		32,839.57		
Accumulated depreciation:			160,857.49		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	193,697.06	-		
Gibson 4 SCR Catalyst B 2003					
Long-lived asset:	101800 - Reg Plant In Service ARO	241,646.35			
Initial liability:	230800 - ARO Liability		241,646.35		
Accretion Expense:	230800 - ARO Liability		31,101.16		
Accumulated depreciation:			100,110.61		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	131,211.77	-		
Gibson 4 SCR Catalyst C 2004					
Long-lived asset:	101800 - Reg Plant In Service ARO	110,669.26			
Initial liability:	230800 - ARO Liability		110,669.26		
Accretion Expense:	230800 - ARO Liability		8,948.15		
Accumulated depreciation:			18,620.64		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	27,568.79	-		
Gibson 5 Asbestos					
Long-lived asset:	101800 - Reg Plant In Service ARO	82,661.73			
Initial liability:	230800 - ARO Liability		82,661.73		
Accretion Expense:	230800 - ARO Liability		129,486.39		
Accumulated depreciation:			24,132.73		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	153,619.12	-		
Gibson 5 River Structure					
Long-lived asset:	101800 - Reg Plant In Service ARO	305.48			
Initial liability:	230800 - ARO Liability		305.48		
Accretion Expense:	230800 - ARO Liability		1,696.59		
Accumulated depreciation:			136.80		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	1,833.39	-		
Gibson 5 SCR Catalyst A 2005					
Long-lived asset:	101800 - Reg Plant In Service ARO	128,812.96			
Initial liability:	230800 - ARO Liability		128,812.96		
Accretion Expense:	230800 - ARO Liability		3,451.46		
Accumulated depreciation:			15,026.16		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	18,479.62	-		
Gibson 5 SCR Catalyst B 2005					
Long-lived asset:	101800 - Reg Plant In Service ARO	120,916.06			
Initial liability:	230800 - ARO Liability		120,916.06		
Accretion Expense:	230800 - ARO Liability		3,301.68		
Accumulated depreciation:			10,076.36		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	13,378.04	-		
Noblesville Asbestos					
Long-lived asset:	101800 - Reg Plant In Service ARO	57,426.65			
Initial liability:	230800 - ARO Liability		57,426.65		
Accretion Expense:	230800 - ARO Liability		89,958.70		
Accumulated depreciation:			18,172.40		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	108,129.10	-		
Wabash River Asbestos					
Long-lived asset:	101800 - Reg Plant In Service ARO	410,210.13			
Initial liability:	230800 - ARO Liability		410,210.13		
Accretion Expense:	230800 - ARO Liability		650,462.22		
Accumulated depreciation:			164,264.74		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	814,726.96	-		
Wabash River River Structure					
Long-lived asset:	101800 - Reg Plant In Service ARO	6,533.60			
Initial liability:	230800 - ARO Liability		6,533.60		
Accretion Expense:	230800 - ARO Liability		168,498.22		
Accumulated depreciation:			4,555.20		
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	173,053.42	-		
PSI TOTAL					
Long-lived asset:	101800 - Reg Plant In Service ARO	5,969,742.90			
Initial liability:	230800 - ARO Liability		5,969,742.90		
Accretion Expense:	230800 - ARO Liability		5,683,384.04		58,308.90
Accumulated depreciation:			2,563,435.10		43,886.45
Depreciation Adjustments:		-	-		
Cumulative-effect adjustment:	182303 - ARO Other Regulatory Asset	8,246,819.14		102,197.35	

Fin 47 Gas Mains
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Total CG&E (and Cinergy) Consolidated

CG&E Consolicated Mains 12/31/05 Adoption entry:		
dr. ARC	8,083,902	
dr. COR	26,952,404	
dr. Cum effect	68,585	
cr. ARC Accum dep		3,125,144
cr. ARO		31,979,747

CG&E Standalone

CG&E Bare Steel and Cast Iron 12/31/05 Adoption entry:		
dr. ARC	1,173,599	
dr. COR	7,632,664	
cr. ARC Accum dep		1,044,399
cr. ARO		7,761,864

CG&E Coated Steel 12/31/05 Adoption entry:		
dr. ARC	2,007,400	
dr. COR	11,272,921	
cr. ARC Accum dep		971,366
cr. ARO		12,308,955

CG&E Plastic 12/31/05 Adoption entry:		
dr. ARC	3,124,214	
dr. COR	2,850,144	
cr. ARC Accum dep		444,902
cr. ARO		5,529,456

Total CG&E Standalone

CG&E Mains 12/31/05 Adoption Entry:		
dr. ARC	6,305,213	
dr. COR	21,755,729	
cr. ARC Accum dep		2,460,667
cr. ARO		25,600,275

ULH&P

ULH&P Bare Steel and Cast Iron 12/31/05 Adoption entry:		
dr. ARC	180,463	
dr. COR	1,128,299	
cr. ARC Accum dep		169,113
cr. ARO		1,139,649

ULH&P Coated Steel 12/31/05 Adoption entry:		
dr. ARC	657,230	
dr. COR	3,297,557	
cr. ARC Accum dep		345,251
cr. ARO		3,609,536

ULH&P Plastic 12/31/05 Adoption entry:		
dr. ARC	908,305	
dr. COR	770,819	
cr. ARC Accum dep		122,533
cr. ARO		1,556,591

Total ULH&P

CG&E Mains 12/31/05 Adoption Entry:		
dr. ARC	1,745,998	
dr. COR	5,196,675	
cr. ARC Accum dep		636,896
cr. ARO		6,305,777

KO Transmission

KO 12/31/05 River Project Adoption entry:		
dr. ARC	32,691	
dr. Cum effect	68,585	
cr. ARC Accum dep		27,580
cr. ARO		73,695

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Main type:	In-service for river portion:	Cinergy's Purchase date	DOT regulations effective date:	ARO vintage	Age at 12/31/2005:	Expected Settlement Date:	Inflation rate:	Discount rate:	Obligation 2005 $s	Inflation factor	Inflated to Settlement
KO											
Coated steel	1948	6/1/1990	8/19/1970	6/1/1990	57	6/30/2007	2.50%	5.33%	$ 20,000	1.0377	$ 20,755
Coated steel	1948	6/1/1990	8/19/1970	6/1/1990	57	6/30/2008	2.50%	5.33%	20,000	1.0637	$ 21,274
Coated steel	1948	6/1/1990	8/19/1970	6/1/1990	57	6/30/2009	2.50%	5.33%	20,000	1.0903	$ 21,805
Coated steel	1948	6/1/1990	8/19/1970	6/1/1990	57	6/30/2010	2.50%	5.43%	20,000	1.1175	$ 22,351
									$ 80,000		

Main type:	$ Discounted to 12/31/2005	$ Discounted to 6/1/1990	Accretion Cum Catch	Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
KO										
Coated steel	19,205	8,551	10,654	7,802	18,955	18,709	18,468	18,234	17,309	16,434
Coated steel	18,687	8,320	10,367	7,171	18,444	18,204	17,970	17,742	16,842	15,991
Coated steel	18,185	8,097	10,089	6,613	17,949	17,716	17,488	17,266	16,391	15,562
Coated steel	17,618	7,723	9,895	5,994	17,385	17,155	16,930	16,711	15,848	15,032
	73,695	32,691	41,005	27,580	72,733	71,784	70,857	69,952	66,390	63,018

KO 12/31/05 River Project Adoption entry:

dr. ARC	32,691	
dr. Cum effect	68,585	
cr. ARC Accum dep		27,580
cr. ARO		73,695

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Main type:	Miles:	% of total	Average in-service:	DOT regulations effective date:	ARO vintage	Life per Spanos' study:	Expected Settlement Date:	Obligation 2005 $s
CG&E								
Bare steel (1)	142	3%	1924	8/19/1970	8/19/1970	N/A	2006-2015	1,749,021
Cast Iron (1)	587	11%	1927	8/19/1970	8/19/1970	N/A	2006-2015	7,222,702
Coated steel	2,697	49%	N/A	8/19/1970	dependent on in-service date	60	dependent on in-service date	33,175,475
Plastic	2,077	38%	N/A	8/19/1970	dependent on in-service date	50	dependent on in-service date	25,546,017
	5,502							67,693,215
ULH&P								
Bare steel (2)	19	1%	1927	8/19/1970	8/19/1970	N/A	2006-2010	233,387
Cast Iron (2)	80	6%	1930	8/19/1970	8/19/1970	N/A	2006-2010	986,410
Coated steel	660	49%	N/A	8/19/1970	dependent on in-service date	53	dependent on in-service date	8,121,574
Plastic	598	44%	N/A	8/19/1970	dependent on in-service date	50	dependent on in-service date	7,352,007
	1,357							16,693,378
Total	6,859							84,386,593

(1) Will be removed over next 10 years with AMRP program.
(2) Will be removed over next 5 years with AMRP program.

Fin 47 Gas Mains
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Attorney General Second Set Data Request
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Main type:	Vintage (DOT regulations effective date):	Expected Settlement Date:	Inflation rate:	Discount rate:	Footage:	Obligation 2005 $s	Inflation factor	Inflated to Settlement	$ Discounted to 12/31/2005	$ Discounted to 8/19/1970	Accretion Cum Catch	ARC Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
CG&E																		
Bare mains and cast iro	8/19/1970	6/30/2006	2.50%	5.33%	385,053	$ 897,172	1.0124	$ 908,318	885,244	141,100	744,145	139,150	873,742	862,389	851,305	840,482	797,870	757,527
Bare mains and cast iro	8/19/1970	6/30/2007	2.50%	5.33%	385,053	$ 897,172	1.0377	$ 931,026	861,494	137,314	724,180	131,746	850,301	839,252	828,465	817,933	776,465	737,203
Bare mains and cast iro	8/19/1970	6/30/2008	2.50%	5.33%	385,053	$ 897,172	1.0637	$ 954,301	838,263	133,611	704,651	124,800	827,371	816,620	806,124	795,876	755,526	717,323
Bare mains and cast iro	8/19/1970	6/30/2009	2.50%	5.33%	385,053	$ 897,172	1.0903	$ 978,159	815,773	130,027	685,747	118,329	805,174	794,712	784,497	774,524	735,256	698,078
Bare mains and cast iro	8/19/1970	6/30/2010	2.50%	5.43%	385,053	$ 897,172	1.1175	$ 1,002,613	790,339	121,611	668,728	107,896	779,874	769,548	759,468	749,629	710,914	674,295
Bare mains and cast iro	8/19/1970	6/30/2011	2.50%	5.54%	385,053	$ 897,172	1.1455	$ 1,027,678	764,175	113,514	650,661	98,250	753,868	743,699	733,776	724,092	686,010	650,027
Bare mains and cast iro	8/19/1970	6/30/2012	2.50%	5.54%	385,053	$ 897,172	1.1741	$ 1,053,370	742,085	110,233	631,852	93,126	732,075	722,200	712,564	703,160	666,179	631,236
Bare mains and cast iro	8/19/1970	6/30/2013	2.50%	5.64%	385,053	$ 897,172	1.2035	$ 1,079,704	715,377	102,587	612,790	84,646	705,551	695,859	686,404	677,179	640,924	606,701
Bare mains and cast iro	8/19/1970	6/30/2014	2.50%	5.75%	385,053	$ 897,172	1.2335	$ 1,106,697	688,259	95,282	592,978	76,827	678,635	669,145	659,889	650,861	615,401	581,961
Bare mains and cast iro	8/19/1970	6/30/2015	2.50%	5.85%	385,053	$ 897,172	1.2644	$ 1,134,364	660,853	88,321	572,532	69,628	651,449	642,178	633,138	624,322	589,719	557,120
						$ 8,971,723			$ 7,761,864	$ 1,173,599	$ 6,588,265	$ 1,044,399	$ 7,658,039	$ 7,555,604	$ 7,455,631	$ 7,358,060	$ 6,974,263	$ 6,611,471

CG&E Bare Main and Cast Iron 12/31/05 Adoption entry:

dr. ARC	1,173,599	
dr. COR	7,632,664	
cr. ARC Accum dep		1,044,399
cr. ARO		7,761,864

Main type:	Vintage (DOT regulations effective date):	Expected Settlement Date:	Inflation rate:	Discount rate:	Footage:	Obligation 2005 $s	Inflation factor	Inflated to Settlement	$ Discounted to 12/31/2005	$ Discounted to 8/19/1970	Accretion Cum Catch	ARC Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
ULH&P																		
Bare mains and cast iro	8/19/1970	6/30/2006	2.50%	5.33%	104,704	$ 243,959	1.0124	$ 246,990	240,716	38,368	202,348	37,838	237,588	234,501	231,487	228,544	216,957	205,987
Bare mains and cast iro	8/19/1970	6/30/2007	2.50%	5.33%	104,704	$ 243,959	1.0377	$ 253,165	234,258	37,339	196,919	35,824	231,214	228,210	225,277	222,413	211,137	200,461
Bare mains and cast iro	8/19/1970	6/30/2008	2.50%	5.33%	104,704	$ 243,959	1.0637	$ 259,494	227,941	36,332	191,609	33,936	224,979	222,056	219,202	216,415	205,443	195,055
Bare mains and cast iro	8/19/1970	6/30/2009	2.50%	5.33%	104,704	$ 243,959	1.0903	$ 265,981	221,825	35,357	186,468	32,176	218,943	216,098	213,321	210,609	199,931	189,822
Bare mains and cast iro	8/19/1970	6/30/2010	2.50%	5.43%	104,704	$ 243,959	1.1175	$ 272,631	214,909	33,069	181,841	29,339	212,064	209,256	206,515	203,839	193,312	183,354
						$ 1,219,797			$1,139,649	$ 180,463	$ 959,186	$ 169,113	$1,124,788	$1,110,121	$ 1,095,801	$1,081,820	$1,026,779	$ 974,678

ULH&P Bare Steel and Cast Iron 12/31/05 Adoption entry:

dr. ARC	180,463	
dr. COR	1,128,299	
cr. ARC Accum dep		169,113
cr. ARO		1,139,649

Attorney General Second Set Data Request
Duke Energy Kentucky Case No. 2006-00172
Attachment AG-DR-02-033 (a)

Fin 47 Gas Mains
December [illegible]

DOT Regs Dt: 8/19/1970

Avg. Age	Footage	Avg.	Years Old	Age	Expected retirement (settlement)	Vintage	Obligation 2005 $s	Inflation factor	Inflated to Settlement	Discount rate:	to 12/31/2005	to Vintage	Accretion Cum Catch	ARC Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
1946 Total	11,398	1946	59.5	6/30/1946	6/30/2006	8/19/1970	$ 26,557	1.0124	$ 26,887	5.33%	26,204	4,177	22,028	4,119	25,864	25,528	25,200	24,879	23,618	22,424
1947 Total	1,667	1947	58.5	6/30/1947	6/30/2007	8/19/1970	$ 3,884	1.0377	$ 4,031	5.33%	3,730	594	3,135	570	3,681	3,633	3,587	3,541	3,362	3,192
1948 Total	38,668	1948	57.5	6/30/1948	6/30/2008	8/19/1970	$ 90,096	1.0637	$ 95,833	5.33%	84,181	13,418	70,763	12,533	83,087	82,007	80,953	79,924	75,872	72,035
1949 Total	31,847	1949	56.5	6/30/1949	6/30/2009	8/19/1970	$ 74,204	1.0903	$ 80,902	5.33%	67,471	10,754	56,717	9,787	66,594	65,729	64,884	64,059	60,812	57,737
1950 Total	32,251	1950	55.5	6/30/1950	6/30/2010	8/19/1970	$ 75,145	1.1175	$ 83,976	5.43%	66,197	10,186	56,011	9,037	65,320	64,455	63,611	62,787	59,544	56,477
1951 Total	87,097	1951	54.5	6/30/1951	6/30/2011	8/19/1970	$ 202,936	1.1455	$ 232,456	5.54%	172,853	25,676	147,176	22,224	170,521	168,221	165,977	163,786	155,172	147,033
1952 Total	32,648	1952	53.5	6/30/1952	6/30/2012	8/19/1970	$ 76,070	1.1741	$ 89,314	5.54%	62,920	9,346	53,574	7,896	62,072	61,234	60,417	59,620	56,484	53,521
1953 Total	17,416	1953	52.5	6/30/1953	6/30/2013	8/19/1970	$ 40,579	1.2035	$ 48,835	5.64%	32,357	4,640	27,717	3,829	31,912	31,474	31,046	30,629	28,989	27,441
1954 Total	46,665	1954	51.5	6/30/1954	6/30/2014	8/19/1970	$ 108,729	1.2335	$ 134,122	5.75%	83,411	11,547	71,864	9,311	82,245	81,095	79,973	78,879	74,581	70,529
1955 Total	72,678	1955	50.5	6/30/1955	6/30/2015	8/19/1970	$ 169,340	1.2644	$ 214,109	5.85%	124,735	16,670	108,065	13,142	122,960	121,210	119,504	117,840	111,308	105,155
1956 Total	118,071	1956	49.5	6/30/1956	6/30/2016	8/19/1970	$ 275,105	1.2960	$ 356,533	5.96%	194,155	25,050	169,105	19,317	191,344	188,574	185,873	183,240	172,911	163,190
1957 Total	252,687	1957	48.5	6/30/1957	6/30/2017	8/19/1970	$ 588,761	1.3284	$ 782,102	6.17%	392,862	47,240	345,622	35,652	386,980	381,186	375,540	370,039	348,484	328,239
1958 Total	208,404	1958	47.5	6/30/1958	6/30/2018	8/19/1970	$ 485,581	1.3616	$ 661,166	6.27%	308,952	35,865	273,087	26,502	304,250	299,619	295,109	290,714	273,507	257,362
1959 Total	365,793	1959	46.5	6/30/1959	6/30/2019	8/19/1970	$ 852,298	1.3956	$ 1,189,497	6.38%	516,041	57,832	458,209	41,860	508,060	500,202	492,549	485,096	455,929	428,588
1960 Total	598,467	1960	45.5	6/30/1960	6/30/2020	8/19/1970	$ 1,394,428	1.4305	$ 1,994,767	6.49%	801,706	86,738	714,968	61,521	789,108	776,709	764,636	752,881	706,907	663,855
1961 Total	657,910	1961	44.5	6/30/1961	6/30/2021	8/19/1970	$ 1,532,930	1.4663	$ 2,247,721	6.59%	835,367	87,253	748,113	60,671	822,034	808,915	796,144	783,711	735,122	689,665
1962 Total	395,316	1962	43.5	6/30/1962	6/30/2022	8/19/1970	$ 921,086	1.5029	$ 1,384,344	6.59%	482,678	50,415	432,263	34,380	474,975	467,394	460,015	452,832	424,756	398,491
1963 Total	389,230	1963	42.5	6/30/1963	6/30/2023	8/19/1970	$ 906,906	1.5405	$ 1,397,108	6.59%	457,007	47,734	409,273	31,936	449,713	442,536	435,549	428,748	402,165	377,297
1964 Total	437,587	1964	41.5	6/30/1964	6/30/2024	8/19/1970	$ 1,019,578	1.5790	$ 1,609,948	6.59%	493,978	51,596	442,383	33,878	486,094	478,336	470,784	463,433	434,700	407,820
1965 Total	730,012	1965	40.5	6/30/1965	6/30/2025	8/19/1970	$ 1,700,928	1.6185	$ 2,752,969	6.59%	792,458	82,772	709,686	53,358	779,810	767,365	755,250	743,456	697,362	654,240
1966 Total	606,811	1966	39.5	6/30/1966	6/30/2026	8/19/1970	$ 1,413,870	1.6590	$ 2,345,571	6.59%	633,436	66,162	567,274	41,888	623,326	613,378	603,694	594,267	557,423	522,954
1967 Total	458,888	1967	38.5	6/30/1967	6/30/2027	8/19/1970	$ 1,069,209	1.7004	$ 1,818,133	6.59%	460,637	48,113	412,524	29,926	453,285	446,051	439,009	432,153	405,360	380,294
1968 Total	847,441	1968	37.5	6/30/1968	6/30/2028	8/19/1970	$ 1,974,538	1.7430	$ 3,441,536	6.59%	817,878	85,427	732,451	52,214	804,824	791,979	779,476	767,304	719,731	675,226
1969 Total	677,002	1969	36.5	6/30/1969	6/30/2029	8/19/1970	$ 1,577,415	1.7865	$ 2,818,102	6.49%	643,175	69,586	573,589	41,810	633,069	623,121	613,436	604,005	567,122	532,583
1970 Total	449,176	1970	35.5	6/30/1970	6/30/2030	8/19/1970	$ 1,046,580	1.8312	$ 1,916,493	6.49%	410,762	44,441	366,321	26,256	404,308	397,955	391,769	385,746	362,191	340,133
1971 Total	347,100	1971	34.5	6/30/1971	6/30/2031	6/30/1971	$ 808,743	1.8770	$ 1,517,991	6.49%	305,537	34,899	270,638	20,070	300,736	296,010	291,409	286,929	269,408	253,001
1972 Total	221,128	1972	33.5	6/30/1972	6/30/2032	6/30/1972	$ 515,228	1.9239	$ 991,247	6.49%	187,332	22,789	164,544	12,725	184,389	181,491	178,670	175,924	165,181	155,121
1973 Total	189,102	1973	32.5	6/30/1973	6/30/2033	6/30/1973	$ 440,608	1.9720	$ 868,877	6.49%	154,206	19,976	134,230	10,821	151,783	149,398	147,075	144,814	135,971	127,690
1974 Total	50,214	1974	31.5	6/30/1974	6/30/2034	6/30/1974	$ 116,999	2.0213	$ 236,489	6.49%	39,415	5,437	33,978	2,855	38,796	38,186	37,593	37,015	34,754	32,638
1975 Total	65,509	1975	30.5	6/30/1975	6/30/2035	6/30/1975	$ 152,636	2.0718	$ 316,236	6.49%	49,497	7,270	42,226	3,696	48,719	47,953	47,208	46,482	43,644	40,986
1976 Total	29,750	1976	29.5	6/30/1976	6/30/2036	6/30/1976	$ 69,318	2.1236	$ 147,204	6.49%	21,633	3,384	18,249	1,664	21,293	20,959	20,633	20,316	19,075	17,913
1977 Total	25,743	1977	28.5	6/30/1977	6/30/2037	6/30/1977	$ 59,981	2.1767	$ 130,562	6.49%	18,019	3,002	15,017	1,426	17,736	17,457	17,186	16,922	15,888	14,921
1978 Total	58,605	1978	27.5	6/30/1978	6/30/2038	6/30/1978	$ 136,550	2.2311	$ 304,661	6.49%	39,486	7,004	32,481	3,211	38,865	38,254	37,660	37,081	34,817	32,696
1979 Total	51,883	1979	26.5	6/30/1979	6/30/2039	6/30/1979	$ 120,887	2.2869	$ 276,459	6.49%	33,648	6,356	27,293	2,808	33,120	32,599	32,092	31,599	29,670	27,863
1980 Total	203,156	1980	25.5	6/30/1980	6/30/2040	6/30/1980	$ 473,353	2.3441	$ 1,109,581	6.49%	126,803	25,509	101,293	10,843	124,810	122,849	120,939	119,080	111,809	104,999
1981 Total	186,715	1981	24.5	6/30/1981	6/30/2041	6/30/1981	$ 435,046	2.4027	$ 1,045,279	6.49%	112,179	24,031	88,148	9,814	110,417	108,682	106,992	105,347	98,915	92,890
1982 Total	121,238	1982	23.5	6/30/1982	6/30/2042	6/30/1982	$ 282,485	2.4628	$ 695,690	6.49%	70,114	15,994	54,120	6,265	69,013	67,928	66,872	65,844	61,824	58,058
1983 Total	102,378	1983	22.5	6/30/1983	6/30/2043	6/30/1983	$ 238,541	2.5243	$ 602,154	6.49%	56,991	13,844	43,148	5,193	56,096	55,215	54,356	53,521	50,252	47,192
1984 Total	157,433	1984	21.5	6/30/1984	6/30/2044	6/30/1984	$ 366,819	2.5874	$ 949,119	6.49%	84,345	21,820	62,525	7,820	83,020	81,715	80,445	79,208	74,371	69,842
1985 Total	165,289	1985	20.5	6/30/1985	6/30/2045	6/30/1985	$ 385,123	2.6521	$ 1,021,392	6.49%	85,240	23,482	61,758	8,024	83,900	82,582	81,298	80,049	75,160	70,583
1986 Total	408,669	1986	19.5	6/30/1986	6/30/2046	6/30/1986	$ 952,199	2.7184	$ 2,588,476	6.49%	202,864	59,509	143,355	19,345	199,676	196,539	193,484	190,509	178,876	167,982
1987 Total	525,605	1987	18.5	6/30/1987	6/30/2047	6/30/1987	$ 1,224,660	2.7864	$ 3,412,368	6.49%	251,147	78,450	172,696	24,196	247,200	243,316	239,534	235,851	221,450	207,963
1988 Total	768,187	1988	17.5	6/30/1988	6/30/2048	6/30/1988	$ 1,789,876	2.8560	$ 5,111,957	6.49%	353,261	117,524	235,737	34,284	347,710	342,246	336,926	331,746	311,489	292,519
1989 Total	630,384	1989	16.5	6/30/1989	6/30/2049	6/30/1989	$ 1,468,795	2.9274	$ 4,299,810	6.49%	279,041	98,853	180,188	27,191	274,657	270,341	266,139	262,047	246,046	231,061
1990 Total	566,865	1990	15.5	6/30/1990	6/30/2050	6/30/1990	$ 1,320,795	3.0006	$ 3,963,214	6.49%	241,534	91,114	150,419	23,545	237,738	234,003	230,366	226,824	212,973	200,003
1991 Total	636,656	1991	14.5	6/30/1991	6/30/2051	6/30/1991	$ 1,483,408	3.0756	$ 4,562,434	6.49%	261,119	104,891	156,228	25,358	257,016	252,977	249,045	245,216	230,242	216,220
1992 Total	244,995	1992	13.5	6/30/1992	6/30/2052	6/30/1992	$ 570,838	3.1525	$ 1,799,587	6.49%	96,705	41,373	55,333	9,311	95,186	93,690	92,234	90,816	85,270	80,077
1993 Total	107,015	1993	12.5	6/30/1993	6/30/2053	6/30/1993	$ 249,345	3.2313	$ 805,720	6.49%	40,660	18,524	22,137	3,860	40,022	39,393	38,780	38,184	35,853	33,669
1994 Total	64,770	1994	11.5	6/30/1994	6/30/2054	6/30/1994	$ 150,914	3.3121	$ 499,847	6.49%	23,688	11,492	12,197	2,203	23,316	22,950	22,593	22,246	20,887	19,615
1995 Total	49,351	1995	10.5	6/30/1995	6/30/2055	6/30/1995	$ 114,988	3.3949	$ 390,376	6.49%	17,374	8,975	8,399	1,571	17,101	16,832	16,570	16,316	15,319	14,386
1996 Total	22,296	1996	9.5	6/30/1996	6/30/2056	6/30/1996	$ 51,950	3.4798	$ 180,775	6.49%	7,554	4,156	3,398	658	7,435	7,319	7,205	7,094	6,661	6,255
1997 Total	52,203	1997	8.5	6/30/1997	6/30/2057	6/30/1997	$ 121,633	3.5668	$ 433,841	6.49%	17,025	9,974	7,051	1,414	16,758	16,494	16,238	15,988	15,012	14,098
1998 Total	28,724	1998	7.5	6/30/1998	6/30/2058	6/30/1998	$ 66,927	3.6560	$ 244,683	6.49%	9,017	5,625	3,392	704	8,876	8,736	8,600	8,468	7,951	7,467
1999 Total	46,266	1999	6.5	6/30/1999	6/30/2059	6/30/1999	$ 107,800	3.7474	$ 403,966	6.49%	13,981	9,287	4,693	1,007	13,761	13,545	13,334	13,129	12,327	11,577
2000 Total	33,140	2000	5.5	6/30/2000	6/30/2060	6/30/2000	$ 77,216	3.8411	$ 296,592	6.49%	9,638	6,819	2,819	625	9,486	9,337	9,192	9,051	8,498	7,981
2001 Total	89,197	2001	4.5	6/30/2001	6/30/2061	6/30/2001	$ 207,829	3.9371	$ 818,242	6.49%	24,969	18,811	6,158	1,412	24,577	24,191	23,815	23,449	22,017	20,676
2002 Total	122,447	2002	3.5	6/30/2002	6/30/2062	6/30/2002	$ 285,301	4.0355	$ 1,151,333	6.49%	32,994	26,469	6,525	1,546	32,476	31,966	31,469	30,985	29,093	27,321
2003 Total	183,814	2003	2.5	6/30/2003	6/30/2063	6/30/2003	$ 428,285	4.1364	$ 1,771,559	6.49%	47,677	40,728	6,948	1,700	46,927	46,190	45,472	44,773	42,039	39,479
2004 Total	95,627	2004	1.5	6/30/2004	6/30/2064	6/30/2004	$ 222,812	4.2398	$ 944,679	6.49%	23,871	21,718	2,153	544	23,496	23,127	22,767	22,417	21,048	19,766
2005 Total	21,818	2005	0.5	6/30/2005	6/30/2065	6/30/2005	$ 50,835	4.3458	$ 220,918	6.49%	5,242	5,079	163	43	5,160	5,079	5,000	4,923	4,622	4,341
Grand Total	14,238,401						$33,175,475				$ 12,308,955	$2,007,400	##########	$ 971,366	$ 12,116,702	$ 11,927,455	$11,743,177	$ 11,563,729	$ 10,861,827	$ 10,204,334

miles: 2,697

CG&E Coated Steel 12/31/05 Adoption entry:

dr. ARC	$ 2,007,400	
dr. COR	$11,272,921	
cr. ARC Accum dep		$ 971,366
cr. ARO		$12,308,955

AG-DR-02-033 (a) Attachment.xls workbook, CG&E Coated Steel (ARO calc) tab

Fin 47 Gas Mains
December 31, 2005 Adoption Entries

Attorney General Second Set Data Request
Duke Energy Kentucky Case No. 2006-00172
Attachment AG-DR-02-033 (a)

DOT Regs Dt: 8/19/1970

Avg. Age	Footage	Avg.	Years Old	Age	Expected retirement (settlement)	Vintage	Obligation 2005 $s	Inflation factor	Inflated to Settlement	Discount rate:	$ Discounted to 12/31/2005	$ Discounted to Vintage	Accretion Cum Catch	ARC Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
1966 Total	4,511	1966	39.5	6/30/1966	6/30/2016	8/19/1970	$ 10,511	1.2960	$ 13,622	5.96%	7,418	957	6,461	738	7,310	7,205	7,101	7,001	6,606	6,235
1969 Total	72,726	1969	36.5	6/30/1969	6/30/2019	8/19/1970	$ 169,452	1.3956	$ 236,493	6.38%	102,598	11,498	91,100	8,323	101,011	99,449	97,927	96,445	90,647	85,211
1970 Total	72,674	1970	35.5	6/30/1970	6/30/2020	8/19/1970	$ 169,330	1.4305	$ 242,232	6.49%	97,354	10,533	86,821	7,471	95,824	94,319	92,853	91,425	85,842	80,614
1971 Total	182,194	1971	34.5	6/30/1971	6/30/2021	6/30/1971	$ 424,512	1.4663	$ 622,458	6.59%	231,337	25,531	205,805	17,619	227,645	224,011	220,475	217,032	203,576	190,988
1972 Total	179,039	1972	33.5	6/30/1972	6/30/2022	6/30/1972	$ 417,161	1.5029	$ 626,971	6.59%	218,606	25,721	192,885	17,235	215,117	211,683	208,341	205,088	192,373	180,477
1973 Total	147,265	1973	32.5	6/30/1973	6/30/2023	6/30/1973	$ 343,127	1.5405	$ 528,595	6.59%	172,908	21,685	151,223	14,097	170,149	167,433	164,790	162,216	152,159	142,750
1974 Total	13,688	1974	31.5	6/30/1974	6/30/2024	6/30/1974	$ 31,893	1.5790	$ 50,360	6.59%	15,452	2,066	13,386	1,301	15,205	14,963	14,726	14,496	13,598	12,757
1975 Total	10,746	1975	30.5	6/30/1975	6/30/2025	6/30/1975	$ 25,043	1.6185	$ 40,532	6.59%	11,667	1,663	10,005	1,014	11,481	11,298	11,120	10,946	10,267	9,632
1976 Total	6,819	1976	29.5	6/30/1976	6/30/2026	6/30/1976	$ 15,888	1.6590	$ 26,358	6.59%	7,118	1,081	6,037	638	7,005	6,893	6,784	6,678	6,264	5,877
1977 Total	11,138	1977	28.5	6/30/1977	6/30/2027	6/30/1977	$ 25,952	1.7004	$ 44,129	6.59%	11,180	1,810	9,370	1,032	11,002	10,826	10,655	10,489	9,839	9,230
1978 Total	4,387	1978	27.5	6/30/1978	6/30/2028	6/30/1978	$ 10,222	1.7430	$ 17,816	6.59%	4,234	731	3,503	402	4,166	4,100	4,035	3,972	3,726	3,495
1979 Total	17,195	1979	26.5	6/30/1979	6/30/2029	6/30/1979	$ 40,064	1.7865	$ 71,576	6.49%	16,336	3,086	13,250	1,636	16,079	15,826	15,580	15,341	14,404	13,527
1980 Total	81,025	1980	25.5	6/30/1980	6/30/2030	6/30/1980	$ 188,788	1.8312	$ 345,708	6.49%	74,096	14,906	59,190	7,603	72,931	71,785	70,670	69,583	65,334	61,355
1981 Total	20,522	1981	24.5	6/30/1981	6/30/2031	6/30/1981	$ 47,816	1.8770	$ 89,750	6.49%	18,065	3,870	14,195	1,897	17,781	17,501	17,229	16,964	15,929	14,958
1982 Total	128	1982	23.5	6/30/1982	6/30/2032	6/30/1982	$ 298	1.9239	$ 574	6.49%	108	25	84	12	107	105	103	102	96	90
1983 Total	3,017	1983	22.5	6/30/1983	6/30/2033	6/30/1983	$ 7,030	1.9720	$ 13,862	6.49%	2,460	598	1,863	269	2,422	2,384	2,346	2,310	2,169	2,037
1984 Total	4,884	1984	21.5	6/30/1984	6/30/2034	6/30/1984	$ 11,380	2.0213	$ 23,002	6.49%	3,834	992	2,842	427	3,773	3,714	3,656	3,600	3,380	3,174
1985 Total	4,425	1985	20.5	6/30/1985	6/30/2035	6/30/1985	$ 10,310	2.0718	$ 21,361	6.49%	3,343	921	2,422	378	3,291	3,239	3,189	3,140	2,948	2,769
1986 Total	855	1986	19.5	6/30/1986	6/30/2036	6/30/1986	$ 1,992	2.1236	$ 4,231	6.49%	622	182	439	71	612	602	593	584	548	515
1987 Total	6,298	1987	18.5	6/30/1987	6/30/2037	6/30/1987	$ 14,674	2.1767	$ 31,942	6.49%	4,408	1,377	3,031	510	4,339	4,271	4,204	4,140	3,887	3,650
1988 Total	9,553	1988	17.5	6/30/1988	6/30/2038	6/30/1988	$ 22,258	2.2311	$ 49,662	6.49%	6,436	2,141	4,295	750	6,335	6,236	6,139	6,044	5,675	5,330
1989 Total	7,964	1989	16.5	6/30/1989	6/30/2039	6/30/1989	$ 18,556	2.2869	$ 42,436	6.49%	5,165	1,830	3,335	604	5,084	5,004	4,926	4,850	4,554	4,277
1990 Total	27,030	1990	15.5	6/30/1990	6/30/2040	6/30/1990	$ 62,980	2.3441	$ 147,630	6.49%	16,871	6,364	10,507	1,973	16,606	16,345	16,091	15,844	14,876	13,970
1991 Total	58,042	1991	14.5	6/30/1991	6/30/2041	6/30/1991	$ 135,238	2.4027	$ 324,934	6.49%	34,872	14,008	20,864	4,064	34,324	33,785	33,260	32,748	30,748	28,876
1992 Total	345,417	1992	13.5	6/30/1992	6/30/2042	6/30/1992	$ 804,822	2.4628	$1,982,078	6.49%	199,762	85,462	114,299	23,081	196,623	193,533	190,525	187,596	176,141	165,413
1993 Total	674,308	1993	12.5	6/30/1993	6/30/2043	6/30/1993	$ 1,571,138	2.5243	$3,966,059	6.49%	375,372	171,007	204,365	42,766	369,474	363,668	358,015	352,511	330,985	310,828
1994 Total	731,137	1994	11.5	6/30/1994	6/30/2044	6/30/1994	$ 1,703,549	2.5874	$4,407,816	6.49%	391,708	190,021	201,686	43,721	385,553	379,495	373,596	367,852	345,390	324,355
1995 Total	641,460	1995	10.5	6/30/1995	6/30/2045	6/30/1995	$ 1,494,602	2.6521	$3,963,859	6.49%	330,802	170,882	159,920	35,902	325,604	320,488	315,506	310,655	291,686	273,922
1996 Total	628,514	1996	9.5	6/30/1996	6/30/2046	6/30/1996	$ 1,464,438	2.7184	$3,980,956	6.49%	311,995	171,649	140,346	32,625	307,093	302,268	297,569	292,994	275,103	258,349
1997 Total	940,048	1997	8.5	6/30/1997	6/30/2047	6/30/1997	$ 2,190,312	2.7864	$6,103,042	6.49%	449,178	263,148	186,030	44,756	442,120	435,173	428,408	421,822	396,064	371,943
1998 Total	720,552	1998	7.5	6/30/1998	6/30/2048	6/30/1998	$ 1,678,886	2.8560	$4,794,966	6.49%	331,355	206,711	124,644	31,024	326,148	321,024	316,034	311,175	292,174	274,380
1999 Total	178,043	1999	6.5	6/30/1999	6/30/2049	6/30/1999	$ 414,840	2.9274	$1,214,420	6.49%	78,811	52,354	26,457	6,811	77,573	76,354	75,167	74,011	69,492	65,260
2000 Total	675,371	2000	5.5	6/30/2000	6/30/2050	6/30/2000	$ 1,573,614	3.0006	$4,721,830	6.49%	287,767	203,594	84,173	22,408	283,245	278,794	274,461	270,241	253,739	238,286
2001 Total	853,466	2001	4.5	6/30/2001	6/30/2051	6/30/2001	$ 1,988,575	3.0756	$6,116,146	6.49%	350,041	263,713	86,328	23,755	344,541	339,127	333,856	328,723	308,650	289,853
2002 Total	942,091	2002	3.5	6/30/2002	6/30/2052	6/30/2002	$ 2,195,073	3.1525	$6,920,041	6.49%	371,866	298,324	73,542	20,909	366,022	360,271	354,671	349,218	327,894	307,925
2003 Total	867,098	2003	2.5	6/30/2003	6/30/2053	6/30/2003	$ 2,020,337	3.2313	$6,528,411	6.49%	329,455	281,440	48,014	14,101	324,278	319,183	314,221	309,390	290,498	272,806
2004 Total	1,024,395	2004	1.5	6/30/2004	6/30/2054	6/30/2004	$ 2,386,839	3.3121	$7,905,524	6.49%	374,654	340,867	33,787	10,247	368,767	362,972	357,330	351,837	330,352	310,233
2005 Total	795,930	2005	0.5	6/30/2005	6/30/2055	6/30/2005	$ 1,854,516	3.3949	$6,295,960	6.49%	280,203	271,466	8,737	2,735	275,800	271,466	267,247	263,138	247,070	232,023
	10,983,956						$25,546,017				$ 5,529,456	$3,124,214	$ 2,405,242	$ 444,902	$ 5,442,439	$ 5,356,792	$ 5,273,402	$5,192,205	$ 4,874,684	$ 4,577,370

miles: 2,077

CG&E Plastic 12/31/05 Adoption entry:

dr. ARC	$3,124,214	
dr. COR	$2,850,144	
cr. ARC Accum dep		$ 444,902
cr. ARO		$5,529,456

AG-DR-02-033 (a) Attachment.xls workbook, CG&E Plastic (ARO calc) tab

Fin 47 Gas Mains
December 31, 2005 Adoption Entries

DOT Regs Dt: 8/19/1970

Avg. Age	Footage	Avg.	Years Old	Age	Expected retirement (settlement)	Vintage	Obligation 2005 $s	Inflation factor	Inflated to Settlement	Discount rate:	$ Discounted to 12/31/2005	$ Discounted to Vintage	Accretion Cum Catch	ARC Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
1924 Total	183	1924	81.5	6/30/1924	6/30/2006	8/19/1970	$ 380	1.0124	$ 385	5.33%	375	60	315	59	370	365	360	356	338	321
1941 Total	82	1941	64.5	6/30/1941	6/30/2006	8/19/1970	$ 191	1.0124	$ 193	5.33%	189	30	158	30	186	184	181	179	170	161
1946 Total	2,608	1946	59.5	6/30/1946	6/30/2006	8/19/1970	$ 6,077	1.0124	$ 6,152	5.33%	5,996	956	5,040	942	5,918	5,841	5,766	5,693	5,404	5,131
1947 Total	1,067	1947	58.5	6/30/1947	6/30/2006	8/19/1970	$ 2,486	1.0124	$ 2,517	5.33%	2,453	391	2,062	386	2,421	2,390	2,359	2,329	2,211	2,099
1948 Total	2,778	1948	57.5	6/30/1948	6/30/2006	8/19/1970	$ 6,468	1.0124	$ 6,548	5.33%	6,382	1,017	5,365	1,003	6,299	6,217	6,137	6,059	5,752	5,461
1949 Total	16	1949	56.5	6/30/1949	6/30/2006	8/19/1970	$ 37	1.0124	$ 38	5.33%	37	6	31	6	36	36	35	35	33	31
1950 Total	634	1950	55.5	6/30/1950	6/30/2006	8/19/1970	$ 1,477	1.0124	$ 1,496	5.33%	1,458	232	1,225	229	1,439	1,420	1,402	1,384	1,314	1,247
1951 Total	113	1951	54.5	6/30/1951	6/30/2006	8/19/1970	$ 263	1.0124	$ 267	5.33%	260	41	218	41	256	253	250	247	234	222
1952 Total	383	1952	53.5	6/30/1952	6/30/2006	8/19/1970	$ 892	1.0124	$ 903	5.33%	881	140	740	138	869	858	847	836	794	753
1953 Total	14,993	1953	52.5	6/30/1953	6/30/2006	8/19/1970	$ 34,934	1.0124	$ 35,368	5.33%	34,469	5,494	28,975	5,418	34,021	33,579	33,148	32,726	31,067	29,496
1954 Total	4,079	1954	51.5	6/30/1954	6/30/2007	8/19/1970	$ 9,504	1.0377	$ 9,863	5.33%	9,126	1,455	7,672	1,396	9,008	8,891	8,776	8,665	8,225	7,809
1955 Total	69,259	1955	50.5	6/30/1955	6/29/2008	8/19/1970	$ 161,373	1.0377	$ 167,463	5.33%	147,121	23,450	123,671	21,905	145,209	143,322	141,480	139,682	132,600	125,895
1956 Total	9,827	1956	49.5	6/30/1956	6/30/2009	8/19/1970	$ 22,897	1.0903	$ 24,964	5.33%	20,820	3,318	17,501	3,020	20,549	20,282	20,021	19,767	18,765	17,816
1957 Total	14,526	1957	48.5	6/30/1957	6/30/2010	8/19/1970	$ 33,846	1.1175	$ 37,823	5.43%	29,815	4,588	25,228	4,070	29,421	29,031	28,651	28,280	26,819	25,438
1958 Total	51,120	1958	47.5	6/30/1958	6/30/2011	8/19/1970	$ 119,110	1.1455	$ 136,436	5.54%	101,453	15,070	86,383	13,044	100,084	98,734	97,417	96,131	91,075	86,298
1959 Total	35,569	1959	46.5	6/30/1959	6/29/2012	8/19/1970	$ 82,876	1.1455	$ 94,931	5.54%	66,888	9,936	56,952	8,394	65,985	65,095	64,227	63,379	60,046	56,896
1960 Total	62,539	1960	45.5	6/30/1960	6/30/2013	8/19/1970	$ 145,716	1.2035	$ 175,362	5.64%	116,189	16,662	99,527	13,748	114,593	113,019	111,484	109,985	104,097	98,538
1961 Total	36,145	1961	44.5	6/30/1961	6/30/2014	8/19/1970	$ 84,218	1.2335	$ 103,886	5.75%	64,607	8,944	55,663	7,212	63,704	62,813	61,944	61,097	57,768	54,629
1962 Total	24,547	1962	43.5	6/30/1962	6/30/2015	8/19/1970	$ 57,195	1.2644	$ 72,315	5.85%	42,129	5,630	36,499	4,439	41,530	40,939	40,362	39,800	37,594	35,516
1963 Total	65,830	1963	42.5	6/30/1963	6/29/2016	8/19/1970	$ 153,384	1.2644	$ 193,935	5.85%	106,736	14,265	92,471	11,001	105,218	103,720	102,260	100,836	95,247	89,982
1964 Total	73,822	1964	41.5	6/30/1964	6/30/2017	8/19/1970	$ 172,005	1.3284	$ 228,489	6.17%	114,774	13,801	100,973	10,416	113,055	111,363	109,713	108,106	101,809	95,894
1965 Total	375,928	1965	40.5	6/30/1965	6/30/2018	8/19/1970	$ 875,912	1.3616	$ 1,192,639	6.27%	557,301	64,694	492,606	47,805	548,819	540,466	532,329	524,402	493,364	464,240
1966 Total	89,055	1966	39.5	6/30/1966	6/30/2019	8/19/1970	$ 207,498	1.3956	$ 289,592	6.38%	125,634	14,080	111,554	10,191	123,691	121,778	119,915	118,100	110,999	104,343
1967 Total	105,389	1967	38.5	6/30/1967	6/29/2020	8/19/1970	$ 245,556	1.3956	$ 342,707	6.38%	139,761	15,663	124,099	11,110	137,600	135,472	133,399	131,380	123,481	116,076
1968 Total	222,180	1968	37.5	6/30/1968	6/30/2021	8/19/1970	$ 517,679	1.4663	$ 759,068	6.59%	282,108	29,466	252,642	20,489	277,606	273,175	268,862	264,664	248,255	232,904
1969 Total	158,444	1969	36.5	6/30/1969	6/30/2022	8/19/1970	$ 369,175	1.5029	$ 554,850	6.59%	193,459	20,207	173,253	13,780	190,372	187,333	184,376	181,497	170,244	159,717
1970 Total	150,890	1970	35.5	6/30/1970	6/30/2023	8/19/1970	$ 351,574	1.5405	$ 541,607	6.59%	177,165	18,505	158,660	12,381	174,337	171,555	168,846	166,210	155,905	146,264
1971 Total	78,807	1971	34.5	6/30/1971	6/29/2024	6/30/1971	$ 183,620	1.5405	$ 282,871	6.59%	86,808	9,581	77,228	6,237	85,423	84,059	82,732	81,440	76,391	71,667
1972 Total	73,450	1972	33.5	6/30/1972	6/30/2025	6/30/1972	$ 171,139	1.6185	$ 276,989	6.59%	79,733	9,381	70,352	5,930	78,460	77,208	75,989	74,803	70,165	65,826
1973 Total	23,894	1973	32.5	6/30/1973	6/30/2026	6/30/1973	$ 55,673	1.6590	$ 92,360	6.59%	24,942	3,128	21,814	1,918	24,544	24,153	23,771	23,400	21,949	20,592
1974 Total	35,078	1974	31.5	6/30/1974	6/30/2027	6/30/1974	$ 81,732	1.7004	$ 138,980	6.59%	35,212	4,707	30,505	2,798	34,650	34,097	33,558	33,034	30,986	29,070
1975 Total	78,922	1975	30.5	6/30/1975	6/29/2028	6/30/1975	$ 183,888	1.7004	$ 312,692	6.59%	74,324	10,591	63,733	6,096	73,138	71,971	70,834	69,728	65,405	61,361
1976 Total	10,987	1976	29.5	6/30/1976	6/30/2029	6/30/1976	$ 25,600	1.7865	$ 45,735	6.49%	10,438	1,633	8,805	909	10,274	10,113	9,955	9,802	9,204	8,643
1977 Total	9,898	1977	28.5	6/30/1977	6/30/2030	6/30/1977	$ 23,062	1.8312	$ 42,232	6.49%	9,052	1,508	7,544	811	8,909	8,769	8,633	8,500	7,981	7,495
1978 Total	16,803	1978	27.5	6/30/1978	6/30/2031	6/30/1978	$ 39,151	1.8770	$ 73,485	6.49%	14,791	2,624	12,167	1,362	14,559	14,330	14,107	13,890	13,042	12,248
1979 Total	35,388	1979	26.5	6/30/1979	6/29/2032	6/30/1979	$ 82,454	1.8770	$ 154,764	6.49%	29,253	5,526	23,728	2,763	28,794	28,341	27,901	27,472	25,794	24,223
1980 Total	65,188	1980	25.5	6/30/1980	6/30/2033	6/30/1980	$ 151,888	1.9720	$ 299,523	6.49%	53,158	10,694	42,464	5,146	52,323	51,501	50,700	49,921	46,873	44,018
1981 Total	39,691	1981	24.5	6/30/1981	6/30/2034	6/30/1981	$ 92,480	2.0213	$ 186,930	6.49%	31,155	6,674	24,481	3,086	30,666	30,184	29,715	29,258	27,471	25,798
1982 Total	43,777	1982	23.5	6/30/1982	6/30/2035	6/30/1982	$ 102,000	2.0718	$ 211,327	6.49%	33,077	7,545	25,531	3,346	32,557	32,045	31,547	31,062	29,165	27,389
1983 Total	49,823	1983	22.5	6/30/1983	6/29/2036	6/30/1983	$ 116,088	2.0718	$ 240,514	6.49%	35,352	8,587	26,765	3,646	34,797	34,250	33,717	33,199	31,172	29,273
1984 Total	25,122	1984	21.5	6/30/1984	6/30/2037	6/30/1984	$ 58,534	2.1767	$ 127,412	6.49%	17,584	4,549	13,035	1,846	17,308	17,036	16,771	16,513	15,505	14,561
1985 Total	48,824	1985	20.5	6/30/1985	6/30/2038	6/30/1985	$ 113,760	2.2311	$ 253,814	6.49%	32,896	9,062	23,833	3,506	32,379	31,870	31,375	30,892	29,006	27,239
1986 Total	67,235	1986	19.5	6/30/1986	6/30/2039	6/30/1986	$ 156,658	2.2869	$ 358,262	6.49%	43,605	12,791	30,814	4,707	42,920	42,245	41,589	40,949	38,449	36,107
1987 Total	140,344	1987	18.5	6/30/1987	6/29/2040	6/30/1987	$ 327,002	2.2869	$ 747,824	6.49%	85,476	26,700	58,776	9,323	84,133	82,811	81,524	80,270	75,369	70,779
1988 Total	176,099	1988	17.5	6/30/1988	6/30/2041	6/30/1988	$ 410,311	2.4027	$ 985,848	6.49%	105,801	35,198	70,603	11,624	104,139	102,502	100,909	99,358	93,291	87,609
1989 Total	190,511	1989	16.5	6/30/1989	6/30/2042	6/30/1989	$ 443,891	2.4628	$ 1,093,194	6.49%	110,176	39,031	71,145	12,154	108,445	106,741	105,082	103,466	97,148	91,232
1990 Total	276,251	1990	15.5	6/30/1990	6/30/2043	6/30/1990	$ 643,665	2.5243	$ 1,624,818	6.49%	153,783	58,012	95,771	16,971	151,366	148,988	146,672	144,417	135,598	127,340
1991 Total	171,336	1991	14.5	6/30/1991	6/29/2044	6/30/1991	$ 399,213	2.5243	$ 1,007,742	6.49%	89,570	35,980	53,590	9,847	88,163	86,777	85,429	84,115	78,979	74,169
1992 Total	63,920	1992	13.5	6/30/1992	6/30/2045	6/30/1992	$ 148,934	2.6521	$ 394,989	6.49%	32,964	14,103	18,861	3,593	32,446	31,936	31,439	30,956	29,066	27,296
1993 Total	22,262	1993	12.5	6/30/1993	6/30/2046	6/30/1993	$ 51,870	2.7184	$ 141,006	6.49%	11,051	5,034	6,016	1,188	10,877	10,706	10,540	10,378	9,744	9,151
1994 Total	2,392	1994	11.5	6/30/1994	6/30/2047	6/30/1994	$ 5,573	2.7864	$ 15,530	6.49%	1,143	554	588	120	1,125	1,107	1,090	1,073	1,008	946
1995 Total	231	1995	10.5	6/30/1995	6/29/2048	6/30/1995	$ 538	2.7864	$ 1,500	6.49%	104	54	50	11	102	100	99	97	91	86
1996 Total	3,970	1996	9.5	6/30/1996	6/30/2049	6/30/1996	$ 9,250	2.9274	$ 27,079	6.49%	1,757	967	791	173	1,730	1,703	1,676	1,650	1,550	1,455
1997 Total	3,446	1997	8.5	6/30/1997	6/30/2050	6/30/1997	$ 8,029	3.0006	$ 24,093	6.49%	1,468	860	608	138	1,445	1,423	1,400	1,379	1,295	1,216
1998 Total	6,275	1998	7.5	6/30/1998	6/30/2051	6/30/1998	$ 14,621	3.0756	$ 44,968	6.49%	2,574	1,606	968	227	2,533	2,493	2,455	2,417	2,269	2,131
1999 Total	42,640	1999	6.5	6/30/1999	6/29/2052	6/30/1999	$ 99,351	3.0756	$ 305,569	6.49%	16,423	10,910	5,513	1,339	16,165	15,911	15,664	15,423	14,481	13,599
2000 Total	15,337	2000	5.5	6/30/2000	6/30/2053	6/30/2000	$ 35,735	3.2313	$ 115,473	6.49%	5,827	4,123	1,705	428	5,736	5,646	5,558	5,472	5,138	4,825
2001 Total	22,748	2001	4.5	6/30/2001	6/30/2054	6/30/2001	$ 53,002	3.3121	$ 175,551	6.49%	8,320	6,268	2,052	533	8,189	8,060	7,935	7,813	7,336	6,889
2002 Total	16,124	2002	3.5	6/30/2002	6/30/2055	6/30/2002	$ 37,569	3.3949	$ 127,543	6.49%	5,676	4,554	1,123	301	5,587	5,499	5,414	5,331	5,005	4,700
2003 Total	29,863	2003	2.5	6/30/2003	6/29/2056	6/30/2003	$ 69,581	3.3949	$ 236,222	6.49%	9,873	8,434	1,439	399	9,718	9,565	9,416	9,272	8,705	8,175
2004 Total	8,143	2004	1.5	6/30/2004	6/30/2057	6/30/2004	$ 18,974	3.5668	$ 67,677	6.49%	2,656	2,416	240	69	2,614	2,573	2,533	2,494	2,342	2,199
2005 Total	18,891	2005	0.5	6/30/2005	6/30/2058	6/30/2005	$ 44,016	3.6560	$ 160,921	6.49%	5,930	5,745	185	55	5,837	5,745	5,656	5,569	5,229	4,911
	3,485,654						$8,121,574				$ 3,609,536	$ 657,230	$ 2,952,306	$345,251	$3,554,644	$3,500,590	$3,447,934	$3,396,640	$3,195,812	$3,007,401

miles: 660

ULH&P Coated Steel 12/31/05 Adoption entry:

dr. ARC	$ 657,230	
dr. COR	$3,297,657	
cr. ARC Accum dep		$ 345,251
cr. ARO		$3,609,536

Fin 47 Gas Mains
December 31, 2005 Adoption Entries

DOT Regs Dt: 8/19/1970

Avg. Age	Footage	Avg.	Years Old	Age	Expected retirement (settlement)	Vintage	Obligation 2005 $s	Inflation factor	Inflated to Settlement	Discount rate:	$ Discounted to 12/31/2005	$ Discounted to Vintage	Accretion Cum Catch	ARC Depreciation Cum Catch	$ Discounted to 9/30/2005	$ Discounted to 6/30/2005	$ Discounted to 3/31/2005	$ Discounted to 12/31/2004	$ Discounted to 12/31/2003	$ Discounted to 12/31/2002
1965 Total	592	1965	40.5	6/30/1965	6/30/2015	8/19/1970	$ 1,379	1.2644	$ 1,744	5.85%	1,016	136	880	107	1,002	987	973	960	907	857
1968 Total	3,762	1968	37.5	6/30/1968	6/30/2018	8/19/1970	$ 8,765	1.3616	$ 11,935	6.27%	5,577	647	4,930	478	5,492	5,409	5,327	5,248	4,937	4,646
1970 Total	33,238	1970	35.5	6/30/1970	6/30/2020	8/19/1970	$ 77,440	1.4305	$ 110,780	6.49%	44,523	4,817	39,706	3,417	43,823	43,135	42,464	41,811	39,258	36,867
1971 Total	50,664	1971	34.5	6/30/1971	6/30/2021	6/30/1971	$ 118,047	1.4663	$ 173,091	6.59%	64,329	7,100	57,230	4,899	63,303	62,292	61,309	60,352	56,610	53,109
1972 Total	44,242	1972	33.5	6/30/1972	6/30/2022	6/30/1972	$ 103,084	1.5029	$ 154,930	6.59%	54,019	6,356	47,663	4,259	53,157	52,309	51,483	50,679	47,537	44,597
1973 Total	28,637	1973	32.5	6/30/1973	6/30/2023	6/30/1973	$ 66,724	1.5405	$ 102,790	6.59%	33,624	4,217	29,407	2,741	33,087	32,559	32,045	31,544	29,589	27,759
1974 Total	10,679	1974	31.5	6/30/1974	6/30/2024	6/30/1974	$ 24,882	1.5790	$ 39,290	6.59%	12,055	1,612	10,444	1,015	11,863	11,673	11,489	11,310	10,609	9,953
1975 Total	7,031	1975	30.5	6/30/1975	6/30/2025	6/30/1975	$ 16,382	1.6185	$ 26,515	6.59%	7,632	1,088	6,545	664	7,511	7,391	7,274	7,160	6,717	6,301
1976 Total	3,214	1976	29.5	6/30/1976	6/30/2026	6/30/1976	$ 7,489	1.6590	$ 12,423	6.59%	3,355	510	2,845	301	3,301	3,249	3,197	3,148	2,952	2,770
1977 Total	746	1977	28.5	6/30/1977	6/30/2027	6/30/1977	$ 1,738	1.7004	$ 2,956	6.59%	749	121	628	69	737	725	714	703	659	618
1978 Total	7,535	1978	27.5	6/30/1978	6/30/2028	6/30/1978	$ 17,557	1.7430	$ 30,600	6.59%	7,272	1,255	6,017	690	7,156	7,042	6,931	6,822	6,399	6,004
1979 Total	8,783	1979	26.5	6/30/1979	6/30/2029	6/30/1979	$ 20,464	1.7865	$ 36,560	6.49%	8,344	1,576	6,768	835	8,213	8,084	7,958	7,836	7,357	6,909
1980 Total	12,817	1980	25.5	6/30/1980	6/30/2030	6/30/1980	$ 29,864	1.8312	$ 54,686	6.49%	11,721	2,358	9,363	1,203	11,537	11,355	11,179	11,007	10,335	9,706
1981 Total	3,149	1981	24.5	6/30/1981	6/30/2031	6/30/1981	$ 7,337	1.8770	$ 13,772	6.49%	2,772	594	2,178	291	2,728	2,685	2,644	2,603	2,444	2,295
1983 Total	1,295	1983	22.5	6/30/1983	6/30/2033	6/30/1983	$ 3,017	1.9720	$ 5,950	6.49%	1,056	257	800	115	1,039	1,023	1,007	992	931	874
1984 Total	4,344	1984	21.5	6/30/1984	6/30/2034	6/30/1984	$ 10,122	2.0213	$ 20,459	6.49%	3,410	882	2,528	379	3,356	3,303	3,252	3,202	3,007	2,823
1986 Total	1,664	1986	19.5	6/30/1986	6/30/2036	6/30/1986	$ 3,877	2.1236	$ 8,234	6.49%	1,210	355	855	138	1,191	1,172	1,154	1,136	1,067	1,002
1987 Total	3,019	1987	18.5	6/30/1987	6/30/2037	6/30/1987	$ 7,034	2.1767	$ 15,312	6.49%	2,113	660	1,453	244	2,080	2,047	2,015	1,984	1,863	1,750
1988 Total	585	1988	17.5	6/30/1988	6/30/2038	6/30/1988	$ 1,363	2.2311	$ 3,041	6.49%	394	131	263	46	388	382	376	370	348	326
1989 Total	2,787	1989	16.5	6/30/1989	6/30/2039	6/30/1989	$ 6,494	2.2869	$ 14,851	6.49%	1,807	640	1,167	211	1,779	1,751	1,724	1,697	1,594	1,497
1990 Total	2,583	1990	15.5	6/30/1990	6/30/2040	6/30/1990	$ 6,018	2.3441	$ 14,108	6.49%	1,612	608	1,004	189	1,587	1,562	1,538	1,514	1,422	1,335
1991 Total	10,044	1991	14.5	6/30/1991	6/30/2041	6/30/1991	$ 23,403	2.4027	$ 56,229	6.49%	6,034	2,424	3,610	703	5,940	5,846	5,755	5,667	5,321	4,997
1992 Total	79,826	1992	13.5	6/30/1992	6/30/2042	6/30/1992	$ 185,999	2.4628	$ 458,070	6.49%	46,166	19,751	26,415	5,334	45,441	44,727	44,032	43,355	40,707	38,228
1993 Total	138,683	1993	12.5	6/30/1993	6/30/2043	6/30/1993	$ 323,131	2.5243	$ 815,688	6.49%	77,202	35,170	42,031	8,796	75,989	74,795	73,632	72,500	68,073	63,927
1994 Total	186,769	1994	11.5	6/30/1994	6/30/2044	6/30/1994	$ 435,172	2.5874	$ 1,125,977	6.49%	100,062	48,541	51,521	11,168	98,490	96,942	95,435	93,968	88,230	82,856
1995 Total	160,937	1995	10.5	6/30/1995	6/30/2045	6/30/1995	$ 374,983	2.6521	$ 994,499	6.49%	82,995	42,873	40,122	9,007	81,691	80,408	79,158	77,941	73,182	68,725
1996 Total	194,077	1996	9.5	6/30/1996	6/30/2046	6/30/1996	$ 452,199	2.7184	$ 1,229,268	6.49%	96,340	53,003	43,337	10,074	94,826	93,336	91,886	90,473	84,948	79,775
1997 Total	236,363	1997	8.5	6/30/1997	6/30/2047	6/30/1997	$ 550,726	2.7864	$ 1,534,532	6.49%	112,940	66,165	46,775	11,253	111,165	109,419	107,718	106,062	99,585	93,520
1998 Total	173,172	1998	7.5	6/30/1998	6/30/2048	6/30/1998	$ 403,491	2.8560	$ 1,152,386	6.49%	79,635	49,679	29,956	7,456	78,384	77,152	75,953	74,785	70,219	65,942
1999 Total	186,042	1999	6.5	6/30/1999	6/30/2049	6/30/1999	$ 433,478	2.9274	$ 1,268,981	6.49%	82,352	54,706	27,646	7,117	81,058	79,784	78,544	77,337	72,614	68,192
2000 Total	194,065	2000	5.5	6/30/2000	6/30/2050	6/30/2000	$ 452,171	3.0006	$ 1,356,798	6.49%	82,689	58,502	24,187	6,439	81,389	80,110	78,865	77,653	72,911	68,471
2001 Total	278,069	2001	4.5	6/30/2001	6/30/2051	6/30/2001	$ 647,900	3.0756	$ 1,992,710	6.49%	114,047	85,921	28,127	7,740	112,255	110,491	108,774	107,102	100,562	94,437
2002 Total	290,520	2002	3.5	6/30/2002	6/30/2052	6/30/2002	$ 676,912	3.1525	$ 2,133,987	6.49%	114,675	91,996	22,679	6,448	112,873	111,100	109,373	107,691	101,115	94,957
2003 Total	332,353	2003	2.5	6/30/2003	6/30/2053	6/30/2003	$ 774,382	3.2313	$ 2,502,296	6.49%	126,278	107,874	18,404	5,405	124,294	122,341	120,439	118,587	111,346	104,565
2004 Total	259,982	2004	1.5	6/30/2004	6/30/2054	6/30/2004	$ 605,758	3.3121	$ 2,006,351	6.49%	95,084	86,509	8,575	2,601	93,590	92,119	90,687	89,293	83,840	78,734
2005 Total	203,100	2005	0.5	6/30/2005	6/30/2055	6/30/2005	$ 473,223	3.3949	$ 1,606,562	6.49%	71,500	69,271	2,229	698	70,377	69,271	68,194	67,146	63,046	59,206
	3,155,368						$7,352,007		$21,088,358		$ 1,556,591	$ 908,305	$ 648,287	$ 122,533	$1,532,092	$1,507,977	$1,484,499	$1,461,638	$1,372,239	$1,288,532
miles:	598																			

ULH&P Coated Steel 12/31/05 Adoption entry:

dr. ARC	$ 908,305	
dr. COR	$ 770,819	
cr. ARC Accum dep		$ 122,533
cr. ARO		$1,556,591

Fin 47 Gas Mains
December 31, 2005 Adoption Entries

Assumed rate of inflation: 2.50% a

	Inflation Factors			Discount Rates		
				CGE, PSI, and ULHP		
				b	c	
	# Periods Into Future	Factor		Risk-free Rate	Credit Spread	Discount Rate
2006	0.5	1.0124	2006	4.47%	0.68%	5.20%
2007	1.5	1.0377	2007	4.46%	0.86%	5 20%
2008	2.5	1.0637	2008	4.44%	0.68%	5.20%
2009	3.5	1.0903	2009	4.45%	0.73%	5.20%
2010	4.5	1.1175	2010	4.42%	0.80%	5.30%
2011	5.5	1.1455	2011	4.43%	0.88%	5.40%
2012	6.5	1.1741	2012	4.44%	0.93%	5.40%
2013	7.5	1.2035	2013	4.46%	0.98%	5.50%
2014	8.5	1.2335	2014	4.49%	1.02%	5.60%
2015	9.5	1.2644	2015	4.58%	1.06%	5.70%
2016	10.5	1.2960	2016	4.63%	1.10%	5.80%
2017	11.5	1.3284	2017	4.69%	1.23%	6.00%
2018	12.5	1.3616	2018	4.73%	1.35%	6.10%
2019	13.5	1.3956	2019	4.76%	1.40%	6.20%
2020	14.5	1.4305	2020	4.80%	1.45%	6.30%
2021	15.5	1.4663	2021	4.83%	1.50%	6.40%
2022	16.5	1.5029	2022	4.83%	1.50%	6.40%
2023	17.5	1.5405	2023	4.83%	1.51%	6.40%
2024	18.5	1.5790	2024	4.63%	1.51%	6.40%
2025	19.5	1.6185	2025	4.63%	1.51%	6.40%
2026	20.5	1.6590	2026	4.81%	1.52%	6.40%
2027	21.5	1.7004	2027	4.80%	1 52%	6.40%
2028	22.5	1.7430	2028	4.76%	1.52%	6 40%
2029	23.5	1.7865	2029	4.76%	1.53%	6.30%
2030	24.5	1.8312	2030	4.74%	1.53%	6.30%
2031	25.5	1.8770	2031	4.74%	1.53%	6.30%
2032	26.5	1.9239	2032	4.74%	1.54%	6.30%
2033	27.5	1.9720	2033	4.74%	1.54%	6.30%
2034	28 5	2.0213	2034	4.74%	1.54%	6 30%
2035	29.5	2.0716	2035	4.74%	1.55%	6.30%
2036	30.5	2.1236	2036	4.74%	1.55%	6.30%
2037	31.5	2.1767	2037	4.74%	1.55%	6.30%
2038	32.5	2.2311	2038	4.74%	1.55%	6.30%
2039	33.5	2.2869	2039	4.74%	1.55%	6.30%
2040	34.5	2.3441	2040	4.74%	1.55%	6.30%
2041	35.5	2.4027	2041	4.74%	1.55%	6.30%
2042	36.5	2.4628	2042	4.74%	1.55%	6 30%
2043	37.5	2.5243	2043	4.74%	1.55%	6.30%
2044	38.5	2.5874	2044	4.74%	1.55%	6 30%
2045	39.5	2.6521	2045	4.74%	1.55%	6 30%
2046	40.5	2.7184	2046	4.74%	1.55%	6.30%
2047	41.5	2.7864	2047	4.74%	1.55%	6.30%
2048	42.5	2.8560	2048	4.74%	1.55%	6.30%
2049	43.5	2.9274	2049	4.74%	1.55%	6.30%
2050	44.5	3.0006	2050	4.74%	1.55%	6.30%
2051	45.5	3.0756	2051	4.74%	1.55%	6.30%
2052	46.5	3.1525	2052	4.74%	1.55%	6.30%
2053	47.5	3.2313	2053	4.74%	1.55%	6.30%
2054	46.5	3.3121	2054	4.74%	1.55%	6.30%
2055	49.5	3.3949	2055	4.74%	1.55%	6.30%
2056	50.5	3.4798	2056	4.74%	1.55%	6.30%
2057	51.5	3.5668	2057	4.74%	1.55%	8.30%
2058	52.5	3.6560	2058	4.74%	1.55%	6.30%
2059	53.5	3.7474	2059	4.74%	1.55%	6.30%
2060	54.5	3.8411	2060	4.74%	1.55%	6.30%
2061	55.5	3 9371	2061	4.74%	1.55%	6.30%
2062	56.5	4.0355	2062	4.74%	1.55%	6.30%
2063	57.5	4.1364	2063	4.74%	1.55%	6 30%
2064	58.5	4.2398	2064	4.74%	1.56%	6.30%
2065	59.5	4.3458	2065	4.74%	1 55%	6.30%
2066	60.5	4 4544	2066	4.74%	1.55%	6 30%
2067	61.5	4.5658	2067	4.74%	1.55%	6 30%
2068	62.5	4.6800	2068	4.74%	1.55%	6.30%
2069	63.5	4.7970	2069	4.74%	1.55%	6 30%
2070	64.5	4.9169	2070	4 74%	1 55%	6.30%
2071	65.5	5.0398	2071	4.74%	1.56%	6 30%
2072	66.5	5.1658	2072	4.74%	1.55%	6.30%
2073	87.5	5.2949	2073	4.74%	1.55%	6 30%
2074	88.5	5.4273	2074	4.74%	1.55%	6 30%
2075	69.5	5.5630	2076	4.74%	1.55%	6.30%
2076	70.5	5.7021	2076	4.74%	1.55%	6.30%
2077	71.5	5.8446	2077	4.74%	1.55%	6.30%
2076	72.5	5.9907	2076	4.74%	1.55%	6.30%
2079	73.5	6.1405	2079	4.74%	1.55%	6 30%
2080	74 5	6.2940	2080	4.74%	1.55%	6.30%
2081	75.5	6.4514	2061	4.74%	1.55%	6.30%

a Rate of inflation obtained from Jon Gomez, Manager - Power Operations Financial Analysis. Rate based on historical CPI.

b Rate obtained from Bloomberg report run by Ed Bowen, Treasury. Average of bid and ask price used, where different, from an approximate midpoint of each year. Interpolated where necessary.

c Credit spread obtained from Barclays Capital report provided by Larry Riffe, Treasury. Interpolated where necessary. Midpoint used when reoffer spread was a range.

Fin 47 Gas Mains
December 31, 2005 Adoption Entries

Attorney General Second Set Data Request
Duke Energy Kentucky Case No. 2006-00172
Attachment AG-DR-02-033 (a)

	Pro-Forma Gas Main ARO Liability					
	9/30/2005	6/30/2005	3/31/2005	12/31/2004	12/31/2003	12/31/2002
KOT						
River project	72,733	71,784	70,857	69,952	66,390	63,018
ULH&P						
AMRP items	1,124,788	1,110,121	1,095,801	1,081,820	1,026,779	974,678
Coated Steel	3,554,644	3,500,590	3,447,934	3,396,640	3,195,812	3,007,401
Plastic	1,532,092	1,507,977	1,484,499	1,461,638	1,372,239	1,288,532
Total ULH&P	6,211,523	6,118,688	6,028,234	5,940,097	5,594,831	5,270,610
CG&E Standalone						
AMRP items	7,658,039	7,555,604	7,455,631	7,358,060	6,974,263	6,611,471
Coated Steel	12,116,702	11,927,455	11,743,177	11,563,729	10,861,827	10,204,334
Plastic	5,442,439	5,356,792	5,273,402	5,192,205	4,874,684	4,577,370
Total CG&E Standalone	25,217,179	24,839,850	24,472,210	24,113,994	22,710,773	21,393,174
Total CG&E Consolidated	31,501,436	31,030,322	30,571,302	30,124,044	28,371,994	26,726,803

AG-DR-02-033 (a) Attachment.xls workbook, Pro-forma Data tab

OUCC Q.15-379-J

GANNETT FLEMING, INC.
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April 30, 2003

VIA FEDERAL-EXPRESS

Ms. Peggy Laub
Manager, Fixed Asset Accounting
Cinergy Corporation
139 East Fourth Street
Cincinnati, OH 45202

Dear Peggy:

The Valuation and Rate Division of Gannett Fleming, Inc. was retained by Cinergy Corp. to perform a study that would result in a determination of the portion of Account 108, Accumulated Provision for Depreciation, that relates to cost of removal as of December 31, 2002. The results of the study are presented in the attached tabulations. In our opinion, the amounts set forth on the attachments provide a reasonable estimate of the net amount of the historical accumulated accruals and charges related to cost of removal. The remainder of this letter provides background on this issue and the methods that we used to estimate the portion of accumulated depreciation related to cost of removal.

Cinergy Corp. has for many years provided for and charged the cost of removing plant in service to Account 108, Accumulated Provision for Depreciation. Such entries were in accordance with both the Uniform System of Accounts as promulgated by the Federal Energy Regulatory Commission and Generally Accepted Accounting Principles (GAAP) as defined by the Financial Accounting Standards Board (FASB). With the issuance of FAS 143, Accounting for Asset Retirement Obligations (ARO), the FASB has changed GAAP for "legal obligations associated with the retirement of long-lived assets..." FAS 143 requires that the liability for the ARO be recognized at fair value when it is incurred and that asset retirement costs be capitalized as part of the asset. The amount to be reported as the cumulative effect of implementing this financial standard is the difference between the amounts previously recognized, i.e., the cost of removal entries recorded to Account 108, and the net amount to be recognized pursuant to the statement.

There are two alternatives for the determination of the portion of the Accumulated Provision for Depreciation that relates to costs of removal and the accruals for such costs. The first alternative is the identification of the portion of historical accruals that represented accruals for cost of removal and the historical costs of removal charged to accumulated depreciation. This approach is neither practical nor feasible. The time required to research such entries over a period of at least 60 years would exceed the time limits of implementation. Further, it is questionable if the records required for such a determination could be located, if they exist at this point.

Ms. Peggy Laub
Cincinnati, OH 45202 - 2 - April 30, 2003

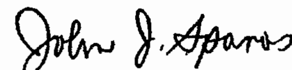
The second alternative is to estimate the net amount of these entries using two calculations of the theoretical accumulated depreciation, one that includes and one that excludes a factor for cost of removal. The theoretical accumulated depreciation is also referred to as the theoretical reserve or the calculated accrued depreciation. The theoretical calculation is used regularly to measure the adequacy of the book accumulated depreciation. Although it represents the portion of service value (original cost less net salvage) that will not be recovered through future depreciation expense if the current estimates of service life and net salvage are used for the remaining life of the plant in service (the prospective view), it also can be considered as a measure of the accumulation of historical entries of accruals, retirements, cost of removal and gross salvage (the retrospective view). This is particularly true when the overall history is the primary basis for the estimates of service life and net salvage. By calculating the theoretical reserve with and without an adjustment for cost of removal, the ratio of the difference between these two calculations to the calculation with cost of removal can be applied to the actual book amount as an estimate of the portion of the accumulated depreciation that relates to cost of removal entries.

However, when there has been a trend in the historical data such as the ever increasing levels of cost of removal as a percent of the original cost retired, the results of applying the ratio developed from the theoretical accumulated depreciation calculations described above require adjustment. That is, the use of the forecasted cost of removal percent that is used in depreciation studies overstates the level of historical entries that occurred when cost of removal was not as great. The adjustment in this case is the deduction of identifiable cost of removal charges to the accumulated depreciation account.

We believe that the result of the calculation described above including the adjustment for actual cost of removal entries provides a reasonable estimate of the portion of Account 108, Accumulated Provision for Depreciation, that relates to cost of removal.

Very truly yours,

GANNETT FLEMING, INC.



JOHN J. SPANOS
Vice President
Valuation and Rate Division

JJS:krm

Attachments

PSI ENERGY, INC.
PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
	STEAM PRODUCTION PLANT							
3100	RIGHTS OF WAY	NONDEPRECIABLE	9,191,766.04					
3110	STRUCTURES AND IMPROVEMENTS							
	GIBSON UNIT 5	100-R2.5 *	114,413,940.35	49,443,097	(35)	8,359,909	0	0
	ALL OTHER UNITS	100-R2.5 *	289,164,926.01	199,321,466	(35)	34,333,863	0	0
	TOTAL ACCOUNT 311		403,578,866.36	248,764,563		42,693,772		0
3120	BOILER PLANT							
	GIBSON UNIT 5	50-S0.5 *	187,648,736.49	109,104,708	(32)	9,079,654	2	(854,263)
	ALL OTHER UNITS	50-S0.5 *	1,276,961,034.51	572,046,034	(32)	69,408,152	2	(4,220,793)
	TOTAL ACCOUNT 312		1,464,609,771.00	681,150,742		78,487,806		(5,075,056)
3121	BOILER PLANT - COAL CARS	30-R3	9,295,282	3,739,454	(30)	508,496	5	(104,705)
3140	TURBOGENERATOR UNITS							
	GIBSON UNIT 5	65-S1 *	29,704,639.85	16,645,221	(34)	2,258,169	4	(227,647)
	ALL OTHER UNITS	65-S1 *	289,495,801.63	193,483,503	(34)	31,313,223	4	(3,832,429)
	TOTAL ACCOUNT 314		319,200,441.48	209,128,724		33,571,392		(4,060,076)
3150	ACCESSORY ELECTRIC EQUIPMENT							
	GIBSON UNIT 5	55-R2 *	21,367,167.41	16,690,622	(12)	1,171,579	2	(212,426)
	ALL OTHER UNITS	55-R2 *	95,373,942.85	61,915,350	(12)	3,824,533	2	(587,517)
	TOTAL ACCOUNT 315		116,741,110.26	78,605,972		4,996,112		(799,943)
3160	ACCESSORY ELECTRIC EQUIPMENT							
	GIBSON UNIT 5	40-S0 *	20,371,407.38	8,514,424	(8)	405,334	3	(170,288)
	ALL OTHER UNITS	40-S0 *	77,504,068.47	26,441,177	(8)	761,666	3	(369,605)
	TOTAL ACCOUNT 316		97,875,475.85	34,955,601		1,167,000		(539,893)
	TOTAL STEAM PRODUCTION PLANT		2,420,492,712.98	1,256,345,056		161,424,578		(10,579,673)
	HYDRO PLANT							
3310	STRUCTURES AND IMPROVEMENTS	SQUARE *	3,638,309.65	1,815,279	(20)	289,304	0	0
3320	RESERVOIRS, DAMS AND WATERWAYS	SQUARE *	12,230,828.27	8,508,049	(20)	1,351,978	0	0
3330	WATER WHEELS, TURBINES AND GENERATORS	70-R2.5 *	7,628,476.77	4,324,402	(10)	357,376	0	0
3340	ACCESSORY ELECTRIC EQUIPMENT	55-R3 *	665,259.45	482,287	0	0	0	0
3360	MISCELLANEOUS POWER PLANT EQUIPMENT	50-R2.5 *	961,293.21	175,314	0	0	0	0
	TOTAL HYDRO PLANT		25,122,166.35	15,305,331		1,998,658		0

PSI ENERGY, INC.
PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
	OTHER PRODUCTION PLANT							
3404	LAND AND LAND RIGHTS	NONDEPRECIABLE	382,541.34					
3410	STRUCTURES AND IMPROVEMENTS	SQUARE *	11,606,661.92	2,967,933	(5)	139,729	0	0
3420	FUEL HOLDERS, PRODUCERS AND ACCESSORIES	SQUARE *	3,115,616.13	759,777	(5)	33,119	0	0
3430	PRIME MOVERS	52-R2.5 *	130,007,062.25	43,320,470	(15)	5,679,464	5	(1,886,179)
3431	PRIME MOVERS - DYNERGY	52-R2.5 *	13,134,350.34	685,016	(15)	62,411	5	(31,137)
3440	GENERATORS	44-R4 *	47,442,410.77	17,739,239	0	0	0	0
3442	GENERATORS - DYNERGY	44-R4 *	13,134,351.98	685,017	0	0	0	0
3450	ACCESSORY ELECTRIC EQUIPMENT	45-S1.5 *	18,566,037.60	4,871,778	0	0	0	0
3460	MISCELLANEOUS POWER PLANT EQUIPMENT	40-R1.5 *	1,918,628.72	291,031	0	0	0	0
	TOTAL OTHER PRODUCTION PLANT		239,308,060.05	71,320,261		5,914,723		(1,917,316)
	TRANSMISSION PLANT							
3500	LAND AND LAND RIGHTS	NONDEPRECIABLE	2,652,361.98					
3501	RIGHTS OF WAY	75-R4	30,215,370.24	13,414,886	0	0	0	0
3520	STRUCTURES AND IMPROVEMENTS	75-R3	14,619,665.72	5,065,008	0	0	0	0
3530	STATION EQUIPMENT	60-R2	324,103,455.54	111,401,508	(17)	15,440,488	7	(6,398,289)
3540	TOWERS AND FIXTURES	70-R2.5	70,088,209.24	45,841,778	(14)	5,514,237	4	(1,600,504)
3550	POLES AND FIXTURES	56-S0	116,027,681.49	53,742,086	(71)	19,849,052	11	(3,010,300)
3560	OVERHEAD CONDUCTORS AND DEVICES	65-R2	148,649,187.79	63,448,968	(56)	22,995,698	16	(6,614,656)
3570	UNDERGROUND CONDUIT	65-R3	1,314,297.03	16,381	(35)	2,129	10	(1,010)
3580	UNDERGROUND CONDUCTORS AND DEVICES	30-SQ	53,110.46	26,632	0	0	0	0
	TOTAL TRANSMISSION PLANT		709,623,469.49	292,957,263		63,801,604		(17,624,759)
	DISTRIBUTION PLANT							
3600	LAND AND LAND RIGHTS	NONDEPRECIABLE	6,653,655.88					
3601	RIGHTS OF WAY	70-R3	1,060,237.34	742,289	0	0	0	0
3610	STRUCTURES AND IMPROVEMENTS	60-R1.5	10,433,564.25	3,852,529	0	0	0	0
3620	STATION EQUIPMENT	60-R0.5	276,966,911.23	83,624,597	(23)	13,349,087	8	(4,796,209)
3640	POLES, TOWERS AND FIXTURES	43-R0.5	280,288,784.37	118,241,993	(67)	29,748,670	7	(3,675,134)
3650	OVERHEAD CONDUCTORS AND DEVICES	50-R0.5	160,463,697.16	51,351,269	(64)	12,093,097	9	(1,637,114)
3660	UNDERGROUND CONDUIT	65-R3	7,269,063.15	1,922,306	(27)	389,761	2	(29,713)
3670	UNDERGROUND CONDUCTORS AND DEVICES	55-R2	255,547,029.47	51,850,805	(26)	8,105,821	1	(385,373)
3680	LINE TRANSFORMERS	35-R1	319,683,392.62	142,376,849	(16)	14,151,287	6	(6,023,717)
3691	SERVICES - UNDERGROUND	40-R1.5	139,908,937.46	57,834,651	(31)	9,077,165	1	(118,645)
3692	SERVICES - OVERHEAD	35-R1	36,138,475.69	27,399,570	(67)	8,552,615	7	(798,614)
3700	METERS	32-R2	124,447,115.34	52,961,493	(10)	3,673,280	10	(3,771,157)
3710	INSTALLATIONS ON CUSTOMER PREMISES	14-L0	22,472,390.69	9,233,405	(13)	96,479	8	(121,614)
3730	STREET LIGHTING & SIGNAL SYSTEM	24-R1	27,291,361.39	13,196,764	(23)	1,086,742	3	(253,513)
	TOTAL DISTRIBUTION PLANT		1,668,611,605.94	614,786,820		100,324,204		(21,810,803)

PSI ENERGY, INC.
PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
	GENERAL PLANT							
3890	LAND AND LAND RIGHTS	NONDEPRECIABLE	2,500,385.91					
3900	STRUCTURES AND IMPROVEMENTS - MAJOR	60-R1	75,586,119.59	27,770,895	(5)	387,274	5	(599,284)
3900	STRUCTURES AND IMPROVEMENTS - MINOR	40-R3	14,544,330.87	4,649,551	(10)	202,534	5	(92,173)
	TOTAL ACCOUNT 3900		90,130,450.46	32,420,446		589,808		(691,457)
3901	STRUCTURES AND IMPROVEMENTS - AMORTIZED	SQUARE	964,374.35	873,787	0	0	0	0
3910	OFFICE FURNITURE AND EQUIPMENT	20-SQ	12,208,307.08	7,195,951	0	0	0	0
3911	OFFICE FURNITURE AND EQUIPMENT - INFO. SYSTEM	5-SQ	3,045,985.72	254,690	0	0	0	0
3920	TRAILERS	26-L1.5	3,459,092.95	514,024	0	0	10	(51,182)
3930	STORES EQUIPMENT	20-SQ	830,081.67	436,978	0	0	0	0
3940	TOOLS, SHOP AND GARAGE EQUIPMENT	25-SQ	6,070,989.42	1,865,444	0	0	0	0
3950	LABORATORY EQUIPMENT	20-SQ	6,658,732.38	1,229,370	0	0	0	0
3960	POWER OPERATED EQUIPMENT	20-S0.5	1,035,166.24	252,356	0	0	0	0
3970	COMMUNICATION EQUIPMENT	19-L2	44,695,441.14	20,425,319	0	0	0	0
3980	MISCELLANEOUS EQUIPMENT	15-SQ	4,154,166.40	2,016,860	0	0	0	0
	TOTAL GENERAL PLANT		175,953,143.90	67,584,223		589,808		(742,639)
	TOTAL ELECTRIC PLANT		5,239,111,148.71	2,318,300,954		334,053,575		(52,675,190)

Σ(1) 79,581,510
+ 275,288 step transformers
79,862,658 cost of removal at 12/31/2002 for CG&E generation.

CINCINNATI GAS & ELECTRIC COMPANY - COMMON AND ELECTRIC
PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
	COMMON PLANT							
1710	STRUCTURES AND IMPROVEMENTS - MAJOR	100-R1 *	87,291,464.09	19,273,638	0	0	0	0
1710	STRUCTURES AND IMPROVEMENTS - MINOR	40-R3	3,916,435.25	3,703,724	(5)	176,368	0	0
	TOTAL ACCOUNT 1710		91,207,899.34	22,977,362		176,368		0
1720	OFFICE FURNITURE AND EQUIPMENT	20-SQ	17,292,098.65	7,401,963	0	0	0	0
1721	OFFICE FURNITURE AND EQUIPMENT - EDP EQUIP.	5-SQ	242,220.24	232,943	0	0	0	0
1733	TRAILERS	21-L2	270,880.29	77,257	0	0	20	(19,314)
1740	STORES EQUIPMENT	20-SQ	1,082,063.29	585,863	0	0	0	0
1760	LABORATORY AND TEST EQUIPMENT	15-SQ	16,561.34	10,561	0	0	0	0
1770	TOOLS, SHOP AND GARAGE EQUIPMENT	25-SQ	1,016,185.65	487,338	0	0	0	0
1780	COMMUNICATION EQUIPMENT	23-S1.5	7,739,237.76	2,897,822	0	0	0	0
1790	MISCELLANEOUS EQUIPMENT	15-SQ	68,260.29	56,380	0	0	0	0
	TOTAL COMMON PLANT		118,934,397.07	34,727,469		176,368		(19,314)
	STEAM PRODUCTION PLANT							
3010	STRUCTURES AND IMPROVEMENTS - ZIMMER	100-R2.5 *	304,065,682.89	97,295,616	(3)	2,889,969	2	(1,926,646)
3020	BOILER PLANT - ZIMMER	55-S0.5 *	563,555,469.17	182,723,232	(1)	1,809,141	0	0
3040	TURBOGENERATOR UNITS - ZIMMER	65-R2.5 *	175,131,680.28	59,847,586	(4)	2,370,201	3	(1,777,651)
3050	ACCESSORY ELECTRIC EQUIPMENT - ZIMMER	55-R2.5 *	159,488,550.19	55,090,915	(1)	545,455	0	0
3060	MISCELLANEOUS POWER PLANT - ZIMMER	75-R1 *	28,425,201.48	7,378,267	(2)	146,104	1	(73,052)
3110	STRUCTURES AND IMPROVEMENTS	100-R2.5 *	185,672,009.10	136,944,376	(5)	6,583,864	1	(1,316,773)
3120	BOILER PLANT	55-S0.5 *	916,083,375.75	556,567,396	(8)	41,227,215	0	0
3122	BOILER PLANT - SCRUBBER	35-S2 *	78,045,066.59	927,692	(5)	44,176	0	0
3129	BOILER PLANT - RETROFIT PRECIPITATORS	55-S0.5 *	43,384,973.50	44,719,098	(10)	4,085,373	0	0
3130	BOILER PLANT - KENTUCKY	55-S0.5 *	1,883,974.54	989,703	(8)	71,830	0	0
3140	TURBOGENERATOR UNITS	65-R1.5 *	313,841,146.24	187,314,122	(7)	12,487,608	2	(3,567,688)
3150	ACCESSORY ELECTRIC EQUIPMENT	65-R2.5 *	97,725,739.29	66,670,569	(5)	3,174,790	0	0
3160	MISCELLANEOUS POWER PLANT	75-R1 *	40,552,630.44	13,865,692	(5)	666,620	1	(133,324)
	TOTAL STEAM PRODUCTION PLANT		2,905,875,389.29	1,410,314,284		(1) 76,082,346		(8,795,334)
	OTHER PRODUCTION PLANT							
3310	STRUCTURES AND IMPROVEMENTS	SQUARE *	2,042,796.44	1,753,976	(5)	83,523	0	0
3310	STRUCTURES AND IMPROVEMENTS - WOODSDALE	SQUARE *	33,725,782.31	16,225,771	(15)	2,116,405	0	0
	TOTAL ACCOUNT 3310		35,768,578.75	17,979,747		2,199,928		0
3320	FUEL HOLDERS, PRODUCERS AND ACCESSORIES	SQUARE *	2,757,220.53	2,890,225	(5)	137,630	0	0
3320	FULE HOLDERS, PRODUCERS AND ACCESSORIES - WOODSDAI	SQUARE *	15,484,613.29	8,950,576	(15)	1,167,466	0	0
	TOTAL ACCOUNT 3320		18,241,833.82	11,840,801		1,305,096		0
3330	PRIME MOVERS	SQUARE *	28,799,889.51	3,790,683	0	0	0	0
3340	GENERATORS	70-R2.5 *	45,065,171.31	39,973,806	0	0	0	0
3340	GENERATORS - WOODSDALE	70-R2.5 *	165,773,624.81	73,740,551	0	0	0	0
	TOTAL ACCOUNT 3340		210,838,796.12	113,714,357		0		0

00603-020609

CINCINNATI GAS & ELECTRIC COMPANY - COMMON AND ELECTRIC
PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
ACCESSORY ELECTRIC EQUIPMENT	55-S0.5 *	2,519,834.36	2,220,402	0	0	0	0
ACCESSORY ELECTRIC EQUIPMENT - WOODSDALE	55-S0.5 *	16,911,503.05	8,463,281	0	0	0	0
TOTAL ACCOUNT 3350		19,431,337.41	10,683,683		0		0
MISCELLANEOUS POWER PLANT EQUIPMENT	30-S3 *	6,869,329.75	1,429,746	0	0	0	0
MISCELLANEOUS POWER PLANT EQUIPMENT - WOODSDALE	30-S3 *	3,712,919.59	1,747,373	0	0	0	0
TOTAL ACCOUNT 3360		10,582,249.34	3,177,119		0		0
TOTAL OTHER PRODUCTION PLANT		323,662,684.95	161,186,390		(1) 3,505,024		0
TRANSMISSION PLANT							
RIGHTS OF WAY	75-R4	23,619,368.85	3,306,183	0	0	0	0
STRUCTURES AND IMPROVEMENTS	75-R3	9,283,138.39	3,376,452	(12)	368,340	2	(61,390)
STATION EQUIPMENT	55-R1	250,860,619.76	69,423,980	(3)	2,082,719	3	(2,082,719)
TOWERS AND FIXTURES	70-R3	37,416,268.50	26,894,723	(25)	5,603,067	5	(1,120,613)
POLES AND FIXTURES	45-R1.5	50,711,038.56	20,219,069	(30)	6,739,896	40	(8,986,262)
OVERHEAD CONDUCTORS AND DEVICES	55-R2	77,893,285.35	41,588,586	(15)	7,338,606	30	(14,677,612)
UNDERGROUND CONDUIT	70-R3	4,739,396.00	2,527,944	0	0	0	0
UNDERGROUND CONDUCTORS AND DEVICES	45-R3	4,389,012.54	1,611,111	(1)	17,901	11	(196,914)
OTHER EQUIPMENT - GSU EQUIPMENT	40-R3	0.00	0	0	0	0	0
TOTAL TRANSMISSION PLANT		458,692,107.95	168,946,048		22,150,529		(27,125,510)
DISTRIBUTION PLANT							
RIGHTS OF WAY	75-R4	24,898,442.69	(19,401)	0	0	0	0
STRUCTURES AND IMPROVEMENTS	55-R1.5	4,933,613.00	3,278,629	(10)	298,048	0	0
STATION EQUIPMENT	55-S0.5	185,109,183.83	69,988,617	(8)	5,330,935	3	(1,999,[illegible]0)
POLES, TOWERS AND FIXTURES	46-R0.5	192,558,703.82	79,515,741	(31)	22,408,982	21	(15,180,[illegible]78)
OVERHEAD CONDUCTORS AND DEVICES	50-R0.5	240,368,780.62	71,925,482	(13)	8,905,060	8	(5,480,[illegible]7)
UNDERGROUND CONDUIT	65-R3	81,624,049.00	20,441,663	(40)	5,840,444	0	0
UNDERGROUND CONDUCTORS AND DEVICES	55-R1	174,987,821.50	41,613,551	(10)	3,963,195	5	(1,981,598)
LINE TRANSFORMERS	35-R1	268,179,746.04	95,182,689	(12)	(8,460,663)	2	(23,266,830)
LINE TRANSFORMERS - CUSTOMER	40-O1	4,722,718.81	1,603,717	(2)	35,638	12	(213,829)
SERVICES - UNDERGROUND	60-R1.5	2,194,510.82	1,302,253	(30)	339,718	15	(169,859)
SERVICES - OVERHEAD	45-S0	45,040,555.99	27,748,139	(85)	11,271,869	5	(867,067)
METERS	28-R1.5	71,110,722.08	18,887,685	(0)	0	20	(4,721,916)
LEASED PROPERTY ON CUSTOMER PREMISES	22-L2	102,502.52	(108,637)	(0)	0	0	0
STREET LIGHT - OVERHEAD	27-L0.5	8,963,986.62	8,578,869	(14)	1,143,849	9	(735,232)
STREET LIGHT - BOULEVARD	37-R0.5	12,000,112.10	3,049,825	(5)	152,481	5	(152,481)
STREET LIGHT - CUSTOMER POLES	28-O1	7,667,279.05	3,370,073	(16)	490,192	6	(183,822)
TOTAL DISTRIBUTION PLANT		1,324,382,510.49	446,336,465		51,719,728		(54,952,109)
GENERAL PLANT							
STRUCTURES AND IMPROVEMENTS	100-R1 *	14,465,375.20	7,905,009	(1)	78,267	0	0
OFFICE FURNITURE AND EQUIPMENT	20-SQ	722,365.74	371,116	0	0	0	0
OFFICE FURNITURE AND EQUIPMENT - EDP EQUIP.	5-SQ	518,735.39	53,925	0	0	0	0
TRAILERS	21-L2	2,352,318.27	556,786	0	0	25	(185,595)

CINCINNATI GAS & ELECTRIC COMPANY - COMMON AND ELECTRIC
PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
3740	STORES EQUIPMENT	20-SQ	42,830.08	34,600	0	0	0	0
3780	LABORATORY AND TEST EQUIPMENT	15-SQ	3,702,649.75	1,069,355	0	0	0	0
3770	TOOLS, SHOP AND GARAGE EQUIPMENT	25-SQ	7,750,255.85	2,215,895	0	0	0	0
3780	COMMUNICATION EQUIPMENT	23-S1.5	1,573,026.72	549,781	0	0	0	0
3790	MISCELLANEOUS EQUIPMENT	15-SQ	48,711.57	22,884	0	0	0	0
	TOTAL GENERAL PLANT		31,178,288.55	12,779,351		78,267		(185,595)
	TOTAL ELECTRIC PLANT		5,162,723,358.30	2,234,290,007		153,712,262		(91,077,952)

* Curve shown is interim survivor curve. Each facility in the account is assigned an individual probable retirement year.

LAWRENCEBURG GAS COMPANY

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	Account (1)	Survivor Curve (2)	Original Cost (3)	Book Reserve (4)	Cost of Removal Percent (5)	Cost of Removal (6)	Gross Salvage Percent (7)	Gross Salvage (8)
	DISTRIBUTION PLANT							
2741	Rights of Way - General		117,365.60	17,325	0	0	0	0
2750	Structures and Improvements - General		107,376.20	27,490	(10)	2,499	0	0
	MAINS							
2761	Cast Iron, Copper and All Valves		36,371.76	18,906	(30)	4,537	5	(756)
2762	Steel		8,748,244.39	2,999,909	(30)	503,985	5	(89,998)
2763	Plastic		3,701,843.76	455,503	(30)	76,525	5	(15,058)
	Total Mains		12,486,459.91	3,474,318		585,047		(105,812)
2780	M & R - Gen-System - Excl. Elect. Equip.		680,369.30	261,387	(10)	25,581	0	0
2781	M & R - Gen-System - Elect. Equip.		166,531.54	99,902	(10)	9,082	0	0
2782	Measuring and Regulating - Gen-Dist		54,236.03	29,028	(79)	13,104	4	(663)
2790	Measuring and Regulating - City Gate		54,680.47	13,508	(10)	1,228	0	0
	SERVICES							
2801	Cast Iron, Copper and All Valves		6,522.97	6,788	(31)	1,619	1	(52)
2802	Steel		947,358.78	472,771	(31)	78,917	1	(2,506)
2803	Plastic		3,105,198.49	988,063	(31)	169,643	1	(5,132)
	Total Services		4,059,080.24	1,467,622		250,179		(7,690)
2810	Meters		798,199.01	174,578	0	0	10	(19,398)
2820	Meter Installations		313,918.33	181,775	(20)	30,296	0	0
2830	House Regulators		394,194.73	78,285	0	0	25	(26,088)
2840	House Regulator Installations		254,923.61	34,949	0	0	10	(3,883)
2850	Industrial Meas & Reg - Sta. Equip.		93,756.71	63,931	(12)	6,974	2	(1,162)
2851	Industrial Meas & Reg - Sta. Eq. - Comm.		13,732.05	7,214	(10)	656	0	0
	Total Distribution Plant		19,594,823.63	5,951,292		924,646		(164,696)
	GENERAL PLANT							
2910	Office Furniture and Equipment		7,996.19	2,256	0	0	0	0
2921	Trailers		3,165.75	2,398	0	0	0	0
2940	Tools, Shop and Garage Equipment		129,046.67	72,415	0	0	0	0
2960	Power Operated Equipment		24,202.90	18,320	0	0	0	0
2970	Communication Equipment		45,173.89	25,590	0	0	0	0
	Total General Plant		209,585.40	120,979		0		0
	TOTAL GAS PLANT		19,804,409.03	6,072,272		924,646		(164,696)

CINCINNATI GAS & ELECTRIC COMPANY - GAS

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	Account (1)	Survivor Curve (2)	Original Cost (3)	Book Reserve (4)	Cost of Removal Percent (5)	Cost of Removal (6)	Gross Salvage Percent (7)	Gross Salvage (8)
	RODUCTION PLANT							
2041	ghts of Way	50-SQ	4,147.12	3,349	0	0	0	0
2050	ructures and Improvements	50-R2.5	3,799,963.03	3,287,952	(10)	293,259	0	0
2110	uid Petroleum Gas Equipment	45-R1	4,514,562.32	4,273,118	(7)	245,985	2	(69,960)
2200	her Equipment	14-L0.5	30,094.62	30,095	0	0	0	0
	Total Production Plant		8,348,767.09	7,594,514		539,244		(69,960)
	STRIBUTION PLANT							
2741	ghts of Way - General	75-R3	2,178,941.03	213,325	0	0	0	0
2750	ructures and Improvements - General	47-S0.5	813,742.92	422,192	(2)	5,595	2	(5,588)
	AINS							
2761	Cast Iron, Copper and All Valves	46-R2.5	20,659,551.10	19,704,936	(56)	6,175,119	6	(525,656)
2762	Steel	60-R3	220,897,507.60	77,669,144	(56)	25,452,309	6	(2,319,144)
2763	Plastic	50-R3	142,379,020.33	17,598,173	(56)	5,388,595	6	(441,386)
2765	Steel - Feeder Lines	60-R3	55,030,300.66	22,578,287	(56)	7,247,837	6	(640,590)
	Total Mains		438,966,379.79	137,550,540		44,263,860		(3,926,776)
2780	& R - Gen-System - Excl. Elect. Equip.	33-R0.5	10,605,386.30	1,208,853	(8)	92,103	3	(34,539)
2781	& R - Gen-System - Elect. Equip.	12-S2	2,080,735.66	1,375,103	(5)	65,481	0	0
2782	easuring and Regulating - Gen-Dist	48-S0.5	3,158,644.68	1,442,896	(87)	422,978	2	(15,599)
2790	easuring and Regulating - City Gate	10-L0.5	263,231.94	137,255	0	0	0	0
	ERVICES							
2801	Cast Iron, Copper and All Valves	35-R2	13,069,273.88	13,791,182	(27)	2,575,673	2	(116,157)
2802	Steel	40-R1	17,963,694.20	8,211,317	(27)	1,538,980	2	(40,106)
2803	Plastic	42-R2	167,327,910.92	46,244,590	(27)	4,659,919	2	(300,716)
	Total Services		198,360,879.00	68,247,089		8,774,572		(456,979)
2810	eters	43-R2	31,815,066.89	7,467,008	(3)	36,884	8	(173,180)
2820	eter Installations	43-R3	19,763,909.28	6,599,369	(2)	105,630	2	(50,479)
2830	ouse Regulators	48-R2	11,095,869.77	1,978,839	(4)	54,385	14	(198,644)
2840	ouse Regulator Installations	48-R2	8,552,830.62	1,984,520	0	0	0	0
2850	dustrial Meas & Reg - Sta. Equip.	30-R1	2,582,682.56	645,032	(12)	52,570	2	(4,914)
2851	dustrial Meas & Reg - Sta. Eq. - Comm.	30-R1	419,375.31	214,363	(10)	19,488	0	0

CINCINNATI GAS & ELECTRIC COMPANY - GAS

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	Account (1)	Survivor Curve (2)	Original Cost (3)	Book Reserve (4)	Cost of Removal Percent (5)	Cost of Removal (6)	Gross Salvage Percent (7)	Gross Salvage (8)
2870	Other Equipment	25-R3	156,572.68	42,287	0	0	0	0
2871	Other Equipment - Street Lighting	38-R1	765,822.29	339,473	(23)	65,066	3	(8,437)
	Total Distribution Plant		731,480,270.70	229,668,144		53,958,612		(4,875,185)
	GENERAL PLANT							
2900	Structures and Improvements	25-S1	274,744.76	179,634	0	0	0	0
2910	Office Furniture and Equipment	20-SQ	1,234,192.44	315,119	0	0	0	0
2911	Office Furniture and Equipment - Edp Eq.	5-SQ	141,147.15	52,772	0	0	0	0
2920	Transportation Equipment - Autos	10-R3	1,482,725.56	1,481,978	0	0	10	(164,664)
2921	Trailers	12-R2.5	517,955.04	178,498	0	0	25	(45,800)
2940	Tools, Shop and Garage Equipment	25-SQ	5,864,912.19	2,141,481	0	0	0	0
2950	Laboratory and Test Equipment	15-SQ	332,763.49	106,177	0	0	0	0
2960	Power Operated Equipment	11-R2.5	564,061.07	382,206	0	0	35	(142,723)
2970	Communication Equipment	13-S2.5	118,431.31	17,981	0	0	0	0
	Total General Plant		10,530,933.01	4,855,844		0		(353,187)
	TOTAL GAS PLANT		750,359,970.80	242,318,502		54,497,856		(5,298,332)

UNION LIGHT, HEAT AND POWER COMPANY - GAS

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE AS OF DECEMBER 31, 2002

Account	Survivor Curve	Original Cost	Book Reserve	Cost of Removal Percent	Cost of Removal	Gross Salvage Percent	Gross Salvage
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
PRODUCTION PLANT							
Rights of Way	50-SQ	24,438.55	24,439	0	0	0	0
Structures and Improvements	45-R3	1,413,005.63	1,368,602	(10)	124,418	0	0
Liquid Petroleum Gas Equipment	35-S1.5	2,821,288.88	1,796,327	(6)	96,822	1	(17,108)
Total Production Plant		4,258,733.06	3,189,368		221,240		(17,108)
DISTRIBUTION PLANT							
Rights of Way - General	65-R4	1,020,156.20	418,183	0	0	0	0
Rights of Way - Feeder Lines	65-R4	8,228.92	0	0	0	0	0
Structures and Improvements - General	45-R3	126,984.32	117,419	(10)	10,674	0	0
M & R - Gen-System - Elect. Equip.	15-S2.5	371,004.91	321,924	(6)	18,396	1	(3,066)
M & R - Gen-System - Excl. Elect. Equip.	35-R1	2,589,856.88	1,427,292	(7)	29,881	2	(7,193)
Measuring and Regulating - Gen-Dist	50-S0.5	590,592.75	465,730	(78)	156,340	3	(3,860)
Industrial Meas & Reg - Sta. Equip.	25-R2	413,128.38	181,705	(13)	9,961	3	(2,609)
Industrial Meas & Reg - Sta. Eq. - Comm.	25-R2	41,727.01	22,001	(12)	2,400	2	(400)
MAINS							
Cast Iron, Copper and All Valves	41-R2.5	2,810,050.71	2,454,656	(27)	488,308	7	(124,191)
Steel	50-R2	63,888,978.82	21,994,316	(27)	3,233,758	7	(627,185)
Plastic	50-R2.5	47,448,543.04	4,948,413	(27)	984,186	7	(196,596)
Steel - Feeder Lines	50-R2	17,684,480.55	9,225,067	(27)	1,818,178	7	(378,879)
Total Mains		131,832,053.12	38,622,452		6,524,430		(1,326,851)
SERVICES							
Cast Iron, Copper and Valves	33-R0.5	2,854,189.83	3,427,482	(36)	821,380	6	(134,079)
Steel	36-R1	3,257,332.36	2,334,299	(36)	532,881	6	(88,686)
Plastic	45-R1	46,136,701.15	17,171,280	(36)	3,206,681	6	(756,443)
Total Services		52,248,223.36	22,933,061		4,560,942		(979,208)

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UNION LIGHT, HEAT AND POWER COMPANY - GAS

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	Account	Survivor Curve	Original Cost	Book Reserve	Cost of Removal Percent	Cost of Removal	Gross Salvage Percent	Gross Salvage
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
[illegible]01	Meters	34-R3	9,217,400.73	2,005,031	(2)	29,085	17	(183,387)
[illegible]02	Meter Installations	34-R3	5,926,170.34	1,126,407	0	0	0	0
[illegible]03	House Regulators	39-R1.5	2,490,931.88	412,238	(3)	10,320	33	(132,237)
[illegible]05	House Regulator Installations	39-R1.5	1,752,691.24	364,355	(1)	2,943	1	(1,718)
[illegible]30	Other Equipment - Street Lighting	30-S2.5	30,411.24	5,756	0	0	0	0
[illegible]40	Other Equipment	20-R2	86,636.93	22,975	0	0	0	0
	Total Distribution Plant		208,746,198.21	68,446,529		11,355,372		(2,640,549)
	GENERAL PLANT							
[illegible]720	Office Furniture and Equipment	20-SQ	21,861.24	11,069	0	0	0	0
[illegible]731	Autos and Trucks	10-R2.5	111,957.85	112,173	0	0	0	0
[illegible]732	Power Operated Equipment	12-R3	74,870.59	74,871	0	0	0	0
[illegible]733	Trailers	15-SQ	96,157.81	49,414	0	0	0	0
[illegible]770	Tools, Shop and Garage Equipment	25-SQ	1,801,315.97	739,307	0	0	0	0
[illegible]790	Miscellaneous Equipment	20-SQ	18,430.11	18,430	0	0	0	0
	Total General Plant		2,124,593.57	1,005,264		0		0
	Total Gas Plant		215,129,524.84	72,641,161		11,576,612		(2,657,657)

UNION LIGHT, HEAT AND POWER COMPANY - COMMON AND ELECTRIC

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT	SURVIVOR CURVE	ORIGINAL COST	BOOK RESERVE	COST OF REMOVAL PERCENT	COST OF REMOVAL	GROSS SALVAGE PERCENT	GROSS SALVAGE
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	CO[illegible]N PLANT							
1710	STR[illegible]TURES AND IMPROVEMENTS - MAJOR	100-R1	8,399,783.58	3,170,965	(2)	62,176	0	0
1720	OFF[illegible] FURNITURE AND EQUIPMENT	20-SQ	678,814.57	387,780	0	0	0	0
1721	OFF[illegible] FURNITURE AND EQUIPMENT - EDP EQUIP.	5-SQ	12,981.20	12,850	0	0	0	0
1740	STO[illegible] EQUIPMENT	20-SQ	5,582.77	(24,080)	0	0	0	0
1770	TOO[illegible] SHOP AND GARAGE EQUIPMENT	25-SQ	160,057.28	77,396	0	0	0	0
1790	MIS[illegible]LANEOUS EQUIPMENT	15-SQ	19,736.23	14,904	0	0	0	0
	TOT[illegible] COMMON PLANT		9,276,934.63	3,639,805		62,176		0
	TRA[illegible]SSION PLANT							
3401	LAN[illegible]	NONDEPRECIABLE	519,072.60					
3403	RIG[illegible] OF WAY	75-R4	905,970.01	418,453	0	0	0	0
3420	STR[illegible]TURES AND IMPROVEMENTS	75-R3	483,876.51	397,274	(10)	36,116	0	0
3430	STA[illegible]N EQUIPMENT	55-R1	7,827,122.49	3,116,090	(3)	93,483	3	(93,483)
3450	POL[illegible]AND FIXTURES	45-R1.5	4,352,217.28	2,598,535	(30)	606,325	40	(192,942)
3460	OVE[illegible]EAD CONDUCTORS AND DEVICES	65-R2	3,804,019.39	1,992,891	(15)	281,350	30	(407,192)
	TOTA[illegible] TRANSMISSION PLANT		17,892,278.28	8,523,243		1,017,274		(693,617)
	DIS[illegible]UTION PLANT							
3501	LAN[illegible]	NONDEPRECIABLE	658,392.97					
3503	RIG[illegible] OF WAY	75-R4	4,459,567.36	1,957,677	0	0	0	0
3510	STR[illegible]URES AND IMPROVEMENTS	65-R1.5	202,429.84	194,920	(10)	17,720	0	0
3620	STA[illegible] EQUIPMENT	55-S0.5	26,180,770.85	6,813,261	(5)	340,683	5	(340,683)
3640	POL[illegible] TOWERS AND FIXTURES	46-R0.5	38,838,263.51	14,496,400	(30)	2,571,536	15	(1,607,210)
3550	OVE[illegible]AND CONDUCTORS AND DEVICES	50-R0.5	51,016,242.82	25,935,832	(44)	4,740,236	14	(2,262,385)
3560	UND[illegible]ROUND CONDUIT	65-R3	12,436,062.37	2,025,985	(45)	455,846	5	(72,357)
3570	UND[illegible]ROUND CONDUCTORS AND DEVICES	55-R1	29,617,190.34	5,626,480	(33)	1,091,439	18	(696,726)
3581	LIN[illegible]ANSFORMERS	35-R1	43,671,438.21	18,620,805	(13)	2,571,999	33	(5,299,947)
3583	LIN[illegible]ANSFORMERS - CUSTOMER	40-O1	273,660.52	273,681	(2)	5,761	7	(20,164)
3691	SER[illegible]ES - UNDERGROUND	60-R1.5	178,766.29	131,334	(35)	36,774	10	(10,507)
3692	SER[illegible]ES - OVERHEAD	45-S0	9,191,391.55	7,119,632	(63)	1,416,096	8	(323,944)
3600	MET[illegible]	28-R1.5	13,643,327.68	2,794,449	(1)	32,876	16	(436,592)
3620	LEA[illegible] PROPERTY ON CUSTOMER PREMISES	22-L2	9,647.36	9,648	0	0	0	0
3631	STR[illegible]T LIGHT - OVERHEAD	27-L0.5	2,407,929.93	2,342,397	(15)	279,723	12	(242,882)
3633	STR[illegible]T LIGHT - BOULEVARD	37-R0.5	2,352,113.06	945,476	(4)	42,021	14	(132,073)
3637	STR[illegible]T LIGHT - CUSTOMER POLES	26-O1	1,464,548.78	1,374,029	(30)	239,830	20	(187,367)
	TOTA[illegible] DISTRIBUTION PLANT		236,598,733.20	90,661,766		13,842,519		(11,631,817)

UNION LIGHT, HEAT AND POWER COMPANY - COMMON AND ELECTRIC

PERCENTAGE OF BOOK RESERVE ASSOCIATED WITH COST OF REMOVAL AND GROSS SALVAGE
AS OF DECEMBER 31, 2002

	ACCOUNT (1)	SURVIVOR CURVE (2)	ORIGINAL COST (3)	BOOK RESERVE (4)	COST OF REMOVAL PERCENT (5)	COST OF REMOVAL (6)	GROSS SALVAGE PERCENT (7)	GROSS SALVAGE (8)
	GENERAL PLANT							
3710	STRUCTURES AND IMPROVEMENTS - MINOR	40-R3	39,189.75	16,408	(5)	781	0	0
3720	OFFICE FURNITURE AND EQUIPMENT	20-SQ	46,575.69	23,836	0	0	0	0
3733	TRAILERS	21-L2	103,992.88	33,252	0	0	20	(6,682
3770	TOOLS, SHOP AND GARAGE EQUIPMENT	25-SQ	478,643.19	176,937	0	0	0	0
3780	COMMUNICATION EQUIPMENT	23-S1.5	84,462.76	52,932	0	0	0	0
	TOTAL GENERAL PLANT		752,864.27	303,165		781		(6,682
	TOTAL ELECTRIC AND COMMON PLANT		264,520,810.38	103,127,999		14,922,750		(12,332,11

* Curve shown is interim survivor curve. Each facility in the account is assigned an individual probable retirement year.

09603-020609

R:\Plant\Asset Retirement Obligation\[Regulated Property - COR.xls]2002

Cost of Removal in Regulated Assets
December 31,2002

	CGE (1)	Law Gas	ULHP	CGE Consolidated	PSI
COR - 12/31/2002	128,347,460	924,646	26,499,362	155,771,468	334,053,575
RWIP 12/31/2002	-8,632,794	107,397	-1,288,995	-9,814,392	-18,093,730
COR in Reserve	119,714,666	1,032,043	25,210,367	145,957,076	315,959,845

Cost of Removal in Regulated Assets
December 31,2003

	CGE (1)	Law Gas	ULHP	CGE Consolidated	PSI
COR - 12/31/2003	138,157,494	1,045,448	28,943,569	168,146,511	360,838,738
RWIP 12/31/2003	-11,264,103	-83,703	-1,500,880	-12,848,686	-23,508,127
COR in Reserve	126,893,391	961,745	27,442,689	155,297,825	337,330,611

Net Change in Cost of Removal in Regulated Assets
December 31,2003

	CGE (1)	Law Gas	ULHP	CGE Consolidated	PSI
COR - 12/31/2003	-9,810,034	-120,802	-2,444,207	-12,375,043	-26,785,163
RWIP 12/31/2003	2,631,309	191,100	211,885	3,034,294	5,414,397
COR in Reserve	-7,178,725	70,298	-2,232,322	-9,340,749	-21,370,766

(1) Excludes production and step-up transformers which are non-regulated property

Attorney General Second Set Data Request
Duke Energy Kentucky Case No. 2006-00172
Attachment AG-DR-02-033 (c)

Duke Energy-Kentucky
Analysis of Regulatory Liability for Cost of Removal
For Rate Case No. 2006-00172

	Regulatory Liabilities - COR	
Dec-02	**Retirement work in progress (RWIP) beginning balance**	**1,288,995.25**
	(Accum Depreciation COR not separted in GL until 4/03)	
Jan-03	RWIP activity	70,298.50
	Balance	**1,359,293.75**
Feb-03	RWIP activity	79,181.86
	Balance	**1,438,475.61**
Mar-03	RWIP activity	66,759.72
	Balance	**1,505,235.33**
Apr-03	Transfer 12/03 Accumulated depreciation COR balance	(26,499,362.00)
	Accumulated depreciation COR - January - April	(1,182,537.24)
	RWIP activity	(29,205.42)
	Balance	**(26,205,869.33)**
May-03	Accumulated depreciation COR	(263,193.57)
	RWIP activity	(39,146.63)
	Balance	**(26,508,209.53)**
Jun-03	Accumulated depreciation COR	(287,895.31)
	RWIP activity	100,633.19
	Balance	**(26,695,471.65)**
Jul-03	Accumulated depreciation COR	(289,137.04)
	RWIP activity	(163,379.70)
	Balance	**(27,147,988.39)**
Aug-03	Accumulated depreciation COR	(291,589.33)
	RWIP activity	95,138.15
	Balance	**(27,344,439.57)**
Sep-03	Accumulated depreciation COR	(292,732.48)
	RWIP activity	168,795.33
	Balance	**(27,468,376.72)**
Oct-03	Accumulated depreciation COR	(295,921.27)
	Correction to allign GL between COR and life	744,933.87
	RWIP activity	110,443.35
	Balance	**(26,908,920.77)**
Nov-03	Accumulated depreciation COR	(297,338.08)
	RWIP activity	80,307.60
	Balance	**(27,125,951.25)**
Dec-03	Accumulated depreciation COR	(295,747.60)
	RWIP activity	(20,990.43)
	Balance	**(27,442,689.28)**
Jan-04	Accumulated depreciation COR	(304,263.33)
	RWIP activity	92,349.89
	Balance	**(27,654,602.72)**
Feb-04	Accumulated depreciation COR	(305,150.49)
	RWIP activity	138,960.04
	Balance	**(27,820,793.17)**
Mar-04	Accumulated depreciation COR	(306,212.52)
	RWIP activity	158,859.11
	Balance	**(27,968,146.58)**

Apr-04	Accumulated depreciation COR	(307,433.76)
	RWIP activity	141,474.68
	Balance	**(28,134,105.66)**
May-04	Accumulated depreciation COR	(308,696.30)
	RWIP activity	218,874.97
	Balance	**(28,223,926.99)**
Jun-04	Accumulated depreciation COR	(310,284.49)
	Correction to allign GL between COR and life	(480.00)
	RWIP activity	34,562.01
	Balance	**(28,500,129.47)**
Jul-04	Accumulated depreciation COR	(311,386.41)
	RWIP activity	166,299.76
	Balance	**(28,645,216.12)**
Aug-04	Accumulated depreciation COR	(312,560.96)
	RWIP activity	150,899.00
	Balance	**(28,806,878.08)**
Sep-04	Accumulated depreciation COR	(314,644.36)
	RWIP activity	92,976.87
	Balance	**(29,028,545.57)**
Oct-04	Accumulated depreciation COR	(315,961.77)
	RWIP activity	(747,950.46)
	Balance	**(30,092,457.80)**
Nov-04	Accumulated depreciation COR	(318,502.53)
	RWIP activity	1,010,972.04
	Balance	**(29,399,988.29)**
Dec-04	Accumulated depreciation COR	(310,286.92)
	RWIP activity	177,229.44
	Balance	**(29,533,045.77)**
Jan-05	Accumulated depreciation COR	(316,244.89)
	RWIP activity	93,005.52
	Balance	**(29,756,285.14)**
Feb-05	Accumulated depreciation COR	(317,612.22)
	RWIP activity	40,281.74
	Balance	**(30,033,615.62)**
Mar-05	Accumulated depreciation COR	(318,318.86)
	RWIP activity	65,532.92
	Balance	**(30,286,401.56)**
Apr-05	Accumulated depreciation COR	(322,310.15)
	RWIP activity	87,476.16
	Balance	**(30,521,235.55)**
May-05	Accumulated depreciation COR	(319,997.84)
	RWIP activity	94,890.74
	Balance	**(30,746,342.65)**
Jun-05	Accumulated depreciation COR	(323,995.41)
	RWIP activity	107,912.68
	Balance	**(30,962,425.38)**
Jul-05	Accumulated depreciation COR	(325,688.69)
	RWIP activity	105,717.58
	Balance	**(31,182,396.49)**
Aug-05	Accumulated depreciation COR	(327,092.57)
	RWIP activity	98,324.78
	Balance	**(31,411,164.28)**
Sep-05	Accumulated depreciation COR	(332,502.51)

	RWIP activity	116,175.70
	Balance	**(31,627,491.09)**
Oct-05	Intercompany sale	10,509.76
	Accumulated depreciation COR	(334,365.81)
	RWIP activity	69,833.69
	Balance	**(31,881,513.45)**
Nov-05	Intercompany sale	(11,876.50)
	Accumulated depreciation COR	(335,394.17)
	RWIP activity	106,654.33
	Balance	**(32,122,129.79)**
Dec-05	Intercompany sale	14,633.13
	Accumulated depreciation COR	(30,106.93)
	Correct to GL for sale/retirement of vehicle	17,765.00
	RWIP activity	97,182.17
	Balance	**(32,022,656.42)**
Jan-06	Accumulated depreciation COR	(202,841.29)
	Transfer of Caleb assets	(102,239.13)
	RWIP activity	91,712.49
	Balance	**(32,236,024.35)**
Feb-06	Accumulated depreciation COR	(203,122.45)
	RWIP activity	236,895.78
	Balance	**(32,202,251.02)**
Mar-06	Accumulated depreciation COR	(194,630.95)
	RWIP activity	202,588.71
	Balance	**(32,194,293.26)**
Apr-06	Accumulated depreciation COR	(192,558.30)
	RWIP activity	112,884.00
	Balance	**(32,273,967.56)**
May-06	Accumulated depreciation COR	(192,998.26)
	RWIP activity	272,925.01
	Balance	**(32,194,040.81)**
Jun-06	Accumulated depreciation COR	(196,634.75)
	RWIP activity	170,430.54
	Balance	**(32,220,245.02)**
Jul-06	Transfer of assets	(25,536.06)
	Accumulated depreciation COR	(197,580.22)
	RWIP activity	64,265.26
	Balance	**(32,379,096.04)**
	Financial Statement July 31, 2006	
	Accumulated Depreciation COR	(35,588,629.50)
	Retirement work in progress	3,209,533.46
		(32,379,096.04)

Regulatory Liabilities - Regulatory Asset - Legal ARO

Dec-05	Implimentation of FIN 47 - Gas ARO	**5,196,675.00**
Jan-06	Deferred depreciation/accretion	45,643.69
	Balance	**5,242,318.69**
Feb-06	Deferred depreciation/accretion	42,715.08
	Balance	**5,285,033.77**
Mar-06	Deferred depreciation/accretion	46,027.09
	Balance	**5,331,060.86**
Apr-06	Deferred depreciation/accretion	45,175.28
	Balance	**5,376,236.14**

May-06	Deferred depreciation/accretion	46,425.03
	Balance	**5,422,661.17**
Jun-06	Deferred depreciation/accretion	45,564.64
	Balance	**5,468,225.81**
Jul-06	Deferred depreciation/accretion	46,826.99
	Balance	**5,515,052.80**
	Financial Statement July 31, 2006	
	Regulatory Asset - legal ARO	5,515,052.80

Other Noncurrent Liabilities - Legal ARO

Dec-05	Implimentation of FIN 47 - Gas ARO	**(6,305,777.00)**
Jan-06	Transfer of Caleb assets	(1,736,392.95)
	Deferred accretion	(39,756.31)
	Miscellanous correction	146.49
	Balance	**(8,081,779.77)**
Feb-06	Deferred accretion	(39,384.21)
	Balance	**(8,121,163.98)**
Mar-06	Deferred accretion	(39,993.22)
	Miscellanous correction	2,703.00
	Balance	**(8,158,454.20)**
Apr-06	Deferred accretion	(39,141.41)
	Balance	**(8,197,595.61)**
May-06	Deferred accretion	(40,391.16)
	Balance	**(8,237,986.77)**
Jun-06	Deferred accretion	(39,530.77)
	Balance	**(8,277,517.54)**
Jul-06	Deferred accretion	(40,793.12)
	Balance	**(8,318,310.66)**
	Financial Statement July 31, 2006	
	Other Noncurrent Liability - Legal ARO	**(8,318,310.66)**

Summary

Financial Statement at December 31, 2003	
Regulatory Liabilities - COR	(27,442,689.28)
Regulatory Liabilities - Reg Asset - Legal ARO	-
Subtotal Regulatory Liabilities	(27,442,689.28)
Other Noncurrent Liabilities - Legal ARO	-
Total	(27,442,689.28)
Financial Statement at December 31, 2004	
Regulatory Liabilities - COR	(29,533,045.77)
Regulatory Liabilities - Reg Asset - Legal ARO	-
Subtotal Regulatory Liabilities	(29,533,045.77)
Other Noncurrent Liabilities - Legal ARO	-
Total	(29,533,045.77)
Financial Statement at December 31, 2005	
Regulatory Liabilities - COR	(32,022,656.42)
Regulatory Liabilities - Reg Asset - Legal ARO	5,196,675.00
Subtotal Regulatory Liabilities	(26,825,981.42)
Other Noncurrent Liabilities - Legal ARO	(6,305,777.00)
Total	(33,131,758.42)
Financial Statement at July 31, 2006	
Regulatory Liabilities - COR	(32,379,096.04)

Regulatory Liabilities - Reg Asset - Legal ARO	5,515,052.80
Subtotal Regulatory Liabilities	(26,864,043.24)
Other Noncurrent Liabilities - Legal ARO	(8,318,310.66)
Total	(35,182,353.90)

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-046

REQUEST:

As the historical data becomes available, provide detailed monthly income statements for each forecasted month of the base period including the month in which the Commission hears this case.

RESPONSE:

See STAFF-DR-01-046 Attachment which includes detailed revenue and expense for the actual months of December 2017 through July 2018 and the forecasted months of August through November 2018. The forecasted months will be updated as the actual information becomes available.

PERSON RESPONSIBLE: Sarah E. Lawler

STAFF-DR-01-046
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: "X" ORIGINAL UPDATED REVISED

WITNESS RESPONSIBLE:
S. E. LAWLER

			ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	BUDGET	BUDGET	BUDGET	BUDGET
Account	Description	Total	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
403002	Depreciation Expense	12,685,689	986,181	986,218	997,759	1,027,026	1,031,788	1,004,652	1,043,178	1,030,404	1,128,511	1,129,212	1,160,524	1,160,236
403150	Depreciation Expense - ARO	0	0	6,282	6,282	(12,564)	0	0	0	0	0	0	0	0
404200	Amort Exp - Limited Term	1,657,404	147,346	147,251	154,931	148,629	148,613	138,341	139,327	187,266	111,439	111,439	111,439	111,383
407355	DSM Amortization	(908,965)	561,463	(233,576)	(329,245)	(355,219)	(402,968)	(42,090)	(10,616)	(96,714)	0	0	0	0
408121	Taxes Property-Operating	2,914,632	227,667	242,250	242,250	242,250	249,945	242,250	242,250	242,250	245,880	245,880	245,880	245,880
408150	State Unemployment Tax	2,431	33	3,915	771	(2,341)	15	57	(31)	12	0	0	0	0
408151	Federal Unemployment Tax	2,522	334	1,728	(50)	(278)	327	369	349	(257)	0	0	0	0
408152	Employer FICA Tax	272,289	27,658	33,103	32,164	45,161	32,183	33,300	37,847	30,873	0	0	0	0
408205	Highway Use Tax	241	0	258	0	0	6	(24)	0	1	0	0	0	0
408470	Franchise Tax	2,636	0	0	0	1,318	0	879	439	0	0	0	0	0
408700	Fed Social Security Tax-Elec	5,000	7,000	0	0	(7,000)	0	0	5,000	0	0	0	0	0
408800	Federal Highway Use Tax - Gas	163	0	0	1	0	0	0	0	162	0	0	0	0
408851	Sales and Use Expense	(1,791)	0	(2)	(243)	0	5	1	(1,558)	6	0	0	0	0
408960	Allocated Payroll Taxes	393,502	69,852	47,279	24,094	(7,821)	9,795	3,532	8,813	17,437	56,751	59,126	52,300	52,344
409060	Federal Income Taxes Utility Op Income	3,738,244	311,520	311,520	311,520	311,520	311,520	311,520	311,520	311,520	311,520	311,520	311,520	311,524
409104	State/Local Inc Tx Exp Utility Op Inc PY	258,385	258,385	0	0	0	0	0	0	0	0	0	0	0
409160	State/Local Inc Tax Exp Utility Op Inc	100,491	8,374	8,374	8,374	8,374	8,374	8,374	8,374	8,374	8,374	8,374	8,374	8,377
410060	Deferred FIT Utility Operating Inc	(989,111)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,426)	(82,425)
410160	Deferred SIT Utility Operating Inc	399,273	33,273	33,273	33,273	33,273	33,273	33,273	33,273	33,273	33,273	33,273	33,273	33,270
411065	Amortization of Investment Tax Credit	(67,241)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,603)	(5,608)
426891	IC Sale of AR Fees VIE	138,589	10,568	13,129	14,836	13,448	15,205	15,508	16,502	17,012	3,566	3,692	5,707	9,416
480000	Residential Sales-Gas	66,975,343	8,340,117	13,132,271	10,339,872	7,453,246	7,158,228	3,715,099	2,438,671	2,311,636	2,125,455	2,192,689	2,829,703	4,938,356
480990	Gas Residential Sales-Unbilled	735,909	2,499,849	(1,045,741)	(1,258,027)	159,993	(1,183,928)	(1,489,893)	(11,734)	15,140	26,282	554,106	575,165	1,894,697
481000	Industrial Sales-Gas	1,649,164	240,524	386,075	292,172	203,083	185,536	75,665	35,022	35,620	36,678	42,228	43,092	73,469
481090	Gas Industrial Sales Unbilled	(24,075)	(4,020)	(18,173)	(25,437)	12,904	(25,972)	(4,562)	1,213	746	1,476	14,979	596	22,175
481200	Gas Commercial Sales	25,014,426	3,005,622	4,843,645	3,728,266	2,809,229	2,721,970	1,309,181	794,201	754,152	1,009,259	847,241	1,268,913	1,922,747
481290	Gas Commercial Sales Unbilled	12,853	664,424	(481,813)	(306,544)	(24,421)	(473,678)	(269,300)	(106,366)	2,814	(86,278)	303,418	82,884	707,713
482000	Other Sales to Public Auth-Gas	2,417,294	304,155	529,945	401,649	292,314	280,594	113,606	64,621	54,153	41,598	57,256	109,247	168,156
482090	Gas OPA Unbilled	23,247	69,551	(116,309)	(64,160)	79,980	(104,376)	(35,969)	(880)	1,181	10,251	46,999	24,277	112,702
482200	Gas Public St Hwy Ltng	822	80	85	78	81	79	78	82	80	41	50	45	43
484000	Interdepartmental Sales	33,747	4,259	6,726	8,445	6,070	5,204	2,882	143	18	0	0	0	0
488000	Misc Service Revenue-Gas	33,548	2,422	2,236	1,976	2,303	2,041	1,806	1,962	1,470	4,333	4,333	4,333	4,333
488100	IC Misc Svc Reg Gas Reg	472,274	2,850	42,580	42,580	85,160	0	42,580	42,580	42,580	42,841	42,841	42,841	42,841
489000	Transp Gas of Others	1,529,373	139,934	147,775	123,614	138,802	134,169	116,181	123,263	122,956	115,576	110,434	127,165	129,504
489010	IC Gas Transp Rev Reg	348,048	43,506	43,506	43,506	43,506	43,506	43,506	43,506	43,506	0	0	0	0
489020	Comm Gas Transp Only	1,268,503	151,543	172,211	120,195	152,563	104,805	60,321	55,117	53,796	85,233	67,251	108,862	136,606
489025	Comm Gas Transp Unbilled	13,917	38,494	(26,085)	(18,288)	(2,731)	(24,163)	(15,445)	(6,046)	247	(6,790)	8,122	13,185	53,417
489030	Indust Gas Transp Only	2,896,158	301,071	343,666	281,574	306,852	253,535	198,410	170,050	188,413	201,073	207,869	223,823	219,822
489035	Indust Gas Transp Unbilled	(12,183)	(9,303)	(41,236)	(58,273)	21,872	(48,519)	(14,297)	(2,302)	782	10,708	2,774	38,001	87,610
489040	OPA Gas Transp Only	364,575	59,371	67,643	45,514	51,699	37,094	12,770	10,331	10,091	7,158	7,842	19,416	35,646
489045	OPA Gas Transp Unbilled	6,915	12,663	(18,991)	(10,592)	12,494	(16,223)	(5,997)	(530)	221	1,004	1,009	5,978	25,879
489200	Transportation Fees	0	0	(2)	2	0	0	0	0	0	0	0	0	0
493010	Rent from Gas Properties - I/C	4,832	0	0	0	0	0	0	0	0	1,208	1,208	1,208	1,208
495031	Gas Losses Damaged Lines	18,997	218	117	13,685	883	44	72	1,724	2,254	0	0	0	0
496020	Provision for Rate Refund	(3,263,200)	0	(588,711)	(469,319)	(433,381)	(501,976)	(254,099)	(196,486)	(192,079)	(93,858)	(116,771)	(142,812)	(273,708)
711000	Gas Boiler Labor	8,574	407	828	6,066	498	447	288	40	0	0	0	0	0
712000	Gas Production-Other Power Ex	13,423	10,621	825	0	1,042	555	362	9	9	0	0	0	0
717000	Liq Petro Gas Exp-Vapor Proc	128,974	9,373	5,164	5,467	8,402	1,920	10,025	17,383	15,460	13,741	14,918	17,194	9,927
728000	Liquid Petroleum Gas	1,677,312	382,448	1,281,656	0	0	633	0	0	0	0	0	0	12,575
735000	Gas Misc Production Exp	102,045	3,128	22,325	10,713	14,193	564	193	48	171	12,490	13,563	15,632	9,025
742000	Maint Gas Production Equipmen	143,025	18,522	21,371	5,900	3,226	16,962	4,177	39,688	3,775	8,266	5,909	6,379	8,850
801000	Purchases Gas & NGL	38,019,180	7,380,817	8,676,252	5,531,090	3,653,116	3,024,295	1,325,330	1,119,832	528,050	879,967	874,332	1,608,957	3,417,142
801001	Purchases Gas & NGL-Aff	1,360,936	174,141	179,009	174,298	169,936	165,820	165,945	165,849	165,938	0	0	0	0
805002	Unrecovered Purchase Gas Adj	1,812,748	(2,127,234)	(505,587)	1,626,044	1,296,841	1,533,437	455,644	(473,375)	6,978	0	0	0	0
805003	Purchase Gas Cost Unbilled Rev	830,292	1,746,593	(959,758)	(960,929)	125,397	(994,550)	(988,490)	(66,389)	10,685	(40,680)	865,876	364,192	1,728,345
807000	Gas Purchased Expenses	492,954	30,966	70,455	80,390	73,845	35,524	34,806	40,390	37,317	22,322	22,223	22,315	22,401
807100	I/C Gas Purchased Expenses	13,758	1,034	5,053	3,146	1,433	690	1,009	927	466	0	0	0	0
813001	Other Gas Supply Expenses	176,689	42,857	23,687	96,461	(18,736)	15,140	4,484	(24,448)	37,244	0	0	0	0
850001	Operation Supv & Eng-Tran	246	0	0	0	0	0	0	88	158	0	0	0	0
871000	Distribution Load Dispatching	162,771	11,641	12,759	11,808	12,416	10,951	12,096	12,772	7,335	17,488	18,986	21,885	12,634
874000	Mains And Services	2,197,699	165,233	140,492	160,380	126,225	199,889	108,645	153,538	182,564	225,494	273,534	242,758	218,947
875000	Measuring And Reg Stations-Ge	6,441	11	10	4,525	425	49	1,362	12	47	0	0	0	0
876000	Measuring & Reg Station-Indus	7,397	1,856	129	0	1,091	0	1,464	782	2,075	0	0	0	0
878000	Meter And House Regulator Exp	1,474,796	244,899	64,033	35,615	33,373	47,594	18,199	35,048	182,500	226,099	208,639	206,305	172,492
879000	Customer Installation Expense	1,152,497	85,180	127,001	140,935	108,167	59,001	73,796	77,301	85,704	100,044	112,453	90,423	92,492

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: "X" ORIGINAL UPDATED REVISED

Account	Description	Total	ACTUAL Dec-17	ACTUAL Jan-18	ACTUAL Feb-18	ACTUAL Mar-18	ACTUAL Apr-18	ACTUAL May-18	ACTUAL Jun-18	ACTUAL Jul-18	BUDGET Aug-18	BUDGET Sep-18	BUDGET Oct-18	BUDGET Nov-18
880000	Gas Distribution-Other Expense	1,681,295	188,819	166,621	121,759	192,018	113,930	82,649	130,277	95,752	148,502	146,821	145,338	148,809
887000	Maintenance of Mains	1,597,693	73,442	109,971	92,696	264,147	175,126	133,653	76,734	77,299	141,243	164,182	172,939	116,261
889000	Maint-Meas/Reg Stn Equip-Gas	44,438	3,548	314	1,670	4,869	1,692	0	1,387	5,602	6,245	6,781	7,817	4,513
892000	Maintenance of Services	624,682	109,962	7,046	3,374	16,258	23,539	87,762	89,311	82,570	47,840	49,170	57,123	50,727
893000	Maint - Meters And House Reg	371,948	35,205	44,902	17,293	30,061	23,726	44,478	36,973	32,821	26,230	28,479	32,827	18,953
894000	Maint-Other Distribution Equip	(64,244)	(46,691)	(7,168)	(14,731)	(7,724)	2,054	(4,085)	1,415	(7,599)	4,997	5,425	6,253	3,610
901000	Supervision-Cust Accts	397,587	61,958	45,049	42,255	36,449	52,074	37,806	38,015	20,916	19,376	14,563	14,563	14,563
902000	Meter Reading Expense	248,731	35,301	28,767	39,983	32,366	25,221	36,830	20,596	24,244	1,808	1,205	1,205	1,205
903000	Cust Records & Collection Exp	1,537,688	94,661	268,404	52,240	151,571	188,525	172,513	115,865	161,796	84,298	80,074	87,911	79,830
903100	Cust Contracts & Orders-Local	244,982	15,089	6,912	10,221	29,270	8,672	8,522	12,524	3,332	43,356	36,707	35,835	34,542
903200	Cust Billing & Acct	757,823	52,646	58,631	132,827	80,200	49,451	61,230	40,024	42,130	71,821	57,246	56,529	55,088
903300	Cust Collecting-Local	219,011	12,626	8,900	10,373	25,158	8,810	9,695	11,572	8,474	35,733	29,983	29,342	28,345
903400	Cust Receiv & Collect Exp-Edp	36,837	2,457	2,293	2,070	2,205	2,648	2,458	1,772	3,114	4,316	4,862	4,312	4,330
903891	IC Collection Agent Revenue	(33,668)	(4,482)	(5,074)	(4,344)	(3,924)	(3,670)	(3,585)	(4,372)	(4,217)	0	0	0	0
904001	BAD DEBT EXPENSE	7,713	(398)	4,427	0	0	3,159	525	0	0	0	0	0	0
904003	Cust Acctg-Loss On Sale-A/R	189,482	0	0	0	0	0	0	0	0	52,936	40,020	48,483	48,043
905000	Misc Customer Accts Expenses	210	23	0	21	39	28	41	28	30	0	0	0	0
908000	Cust Asst Exp-Conservation Pro	12	0	3	0	2	0	3	4	0	0	0	0	0
908160	Cust Assist Exp-General	144,888	9,828	13,638	12,948	13,568	12,632	13,845	13,924	13,937	9,993	10,849	12,506	7,220
909650	Misc Advertising Expenses	1,258	0	437	138	0	0	0	0	683	0	0	0	0
910000	Misc Cust Serv/Inform Exp	185,335	22,954	13,229	13,933	14,932	15,496	15,432	14,375	15,707	13,925	16,351	15,049	13,952
910100	Exp-Rs Reg Prod/Svces-CstAccts	103,950	16,178	13,415	3,512	1,185	7,173	3,954	4,624	6,337	11,986	11,862	11,862	11,862
911000	Supervision	7,105	19	0	26	45	73	0	41	37	1,716	1,716	1,716	1,716
912000	Demonstrating & Selling Exp	145,638	7,489	8,361	10,759	8,901	10,479	15,954	12,079	11,160	15,102	15,100	15,103	15,151
913001	Advertising Expense	6,519	1,747	0	522	1,660	500	989	951	150	0	0	0	0
920000	A & G Salaries	2,143,958	183,696	171,446	171,897	124,598	189,431	188,496	250,780	192,451	184,165	135,786	180,304	170,908
921100	Employee Expenses	108,499	3,076	14,946	25,711	12,216	8,722	10,380	3,427	(1,645)	5,697	6,326	6,548	13,095
921101	Employee Exp - NC	14	0	2	0	0	0	12	0	0	0	0	0	0
921110	Relocation Expenses	385	5	373	0	7	0	0	0	0	0	0	0	0
921200	Office Expenses	197,638	34,661	1,660	17,305	(32,915)	77,041	10,061	20,854	(9,965)	18,998	19,916	19,664	20,358
921300	Telephone And Telegraph Exp	16	0	2	0	3	2	5	2	2	0	0	0	0
921400	Computer Services Expenses	228,608	20,048	7,492	13,663	65,269	(25,545)	19,697	9,225	37,790	20,014	19,267	18,546	23,142
921540	Computer Rent (Go Only)	124,221	14,004	16,396	16,270	15,624	15,127	13,098	17,877	15,717	27	27	27	27
921600	Other	577	11	126	52	187	16	86	4	15	20	20	20	20
921980	Office Supplies & Expenses	424,871	37,765	30,742	34,496	39,228	33,288	51,264	34,049	34,902	32,206	32,322	32,290	32,319
922000	Admin Exp Transfer	295	287	0	0	0	0	0	0	8	0	0	0	0
923000	Outside Services Employed	1,236,483	103,817	69,414	120,884	138,779	81,423	158,852	255,095	139,408	43,055	40,398	36,507	48,851
923980	Outside Services Employee &	(2,425)	661	(1,640)	(1,461)	2,581	(3,304)	2,365	(855)	(1,092)	80	80	80	80
924000	Property Insurance	525	(82)	19	80	(78)	48	1	(162)	699	0	0	0	0
924050	Inter-Co Prop Ins Exp	9,021	5,977	292	292	292	292	292	292	292	250	250	250	250
924980	Property Insurance For Corp.	54,535	4,605	4,390	4,390	4,390	4,390	4,390	4,390	4,390	4,800	4,800	4,800	4,800
925000	Injuries & Damages	18,600	6,827	1,471	1,476	1,506	907	1,183	1,021	880	1,145	728	728	728
925050	INTER-CO NON-PROP EXP	1,251	0	0	0	0	0	0	0	0	0	417	417	417
925051	INTER-CO GEN LIAB EXP	81,857	22,825	5,100	5,100	5,100	5,100	5,100	5,100	5,100	5,833	5,833	5,833	5,833
925200	Injuries And Damages-Other	1,616	170	189	217	186	222	227	196	209	0	0	0	0
925300	Environmental Inj & Damages	99,946	439	0	0	13,568	0	0	85,939	0	0	0	0	0
925980	Injuries And Damages For Corp.	3,403	358	363	363	363	363	363	363	363	396	36	36	36
926000	EMPL PENSIONS AND BENEFITS	2,064,308	605,558	138,845	125,945	150,301	136,037	126,568	198,205	126,528	118,538	101,113	118,310	118,360
926430	Employees'Recreation Expense	495	23	0	0	10	0	31	1	34	99	99	99	99
926600	Employee Benefits-Transferred	838,252	164,772	119,296	85,252	71,508	52,263	63,893	59,016	79,532	16,592	39,842	32,174	54,112
926999	Non Serv Pension (ASU 2017-07)	(202,658)	0	260	(44,677)	(22,209)	(38,064)	(26,172)	(26,172)	(26,172)	(4,863)	(4,863)	(4,863)	(4,863)
928006	State Reg Comm Proceeding	191,571	15,471	15,471	15,471	15,471	15,471	15,471	15,471	15,694	16,895	16,895	16,895	16,895
928053	Travel Expense	0	0	0	93	(93)	0	0	0	0	0	0	0	0
929000	Duplicate Chrgs-Enrgy To Exp	(52,391)	(4,156)	(7,693)	(24,497)	(6,867)	(5,679)	(3,182)	(268)	(49)	0	0	0	0
929500	Admin Exp Transf	(125,857)	(15,871)	(10,299)	(17,912)	(17,369)	(12,376)	(16,312)	(11,094)	(19,770)	(502)	(3,348)	(502)	(502)
930150	Miscellaneous Advertising Exp	29,048	2,504	(814)	462	7,742	2,801	2,654	922	272	3,107	3,184	3,107	3,107
930200	Misc General Expenses	180,263	5,225	108,492	(11,176)	38,364	11,534	(8,392)	14,231	5,998	3,563	4,155	3,987	4,282
930210	Industry Association Dues	19,329	0	19,308	0	21	0	0	0	0	0	0	0	0
930220	Exp Of Servicing Securities	134	(23)	(9)	(20)	(16)	(17)	243	(16)	(8)	0	0	0	0
930230	Dues To Various Organizations	23,256	4,670	1,923	8,209	175	0	(81)	0	656	2,366	2,658	1,327	1,353
930240	Director'S Expenses	15,181	1,972	2,066	81	203	1,618	7,632	11	1,598	0	0	0	0
930250	Buy\Sell Transf Employee Homes	2,048	587	305	131	596	116	(87)	206	10	46	46	46	46
930700	Research & Development	620	367	143	(279)	38	5	93	235	18	0	0	0	0
930940	General Expenses	807	96	51	78	92	35	49	58	348	0	0	0	0
931001	Rents-A&G	65,664	5,868	5,603	11,773	8,997	5,045	5,239	4,745	6,592	2,745	2,758	3,541	2,758

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: "X" ORIGINAL UPDATED REVISED

KyPSC Case No. 2018-00261
STAFF-DR-01-046 Attachment

WITNESS RESPONSIBLE:
S. E. LAWLER

			ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	BUDGET	BUDGET	BUDGET	BUDGET
Account	Description	Total	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
931008	A&G Rents-IC	271,222	20,943	26,072	18,525	22,333	22,834	22,454	22,572	23,597	22,973	22,973	22,973	22,973
932000	Maintenance Of Gen Plant-Gas	7,771	502	0	0	3,658	0	44	3,424	143	0	0	0	0
935001	Inactive O&M and A&G	1,080	0	0	0	0	0	0	0	0	0	360	360	360
935100	Maint General Plant-Elec	(299)	(366)	(766)	28	738	3,144	51	(3,195)	15	13	13	13	13
935200	Cust Infor & Computer Control	1,736	43	1	136	845	342	174	593	(398)	0	0	0	0
		187,429,014	28,551,164	29,590,213	22,700,988	19,899,836	15,320,913	7,870,754	7,888,936	7,638,280	8,049,445	9,794,285	11,073,180	19,051,020

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: "X" ORIGINAL UPDATED REVISED

			ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	BUDGET	BUDGET	BUDGET	BUDGET
Account	Description	Total	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
	Revenues	100,520,487	15,867,330	17,381,420	13,232,488	11,372,501	8,547,970	3,602,595	3,458,142	3,449,777	3,533,248	4,395,878	5,375,922	10,303,216
	OperatingExpenses													
	Gas Purchased Expense	42,023,156	7,174,317	7,389,916	6,370,503	5,245,290	3,729,002	958,429	745,917	711,651	839,287	1,740,208	1,973,149	5,145,487
	Operation													
	Production	2,613,729	480,834	1,409,993	202,243	80,677	55,473	51,167	34,349	90,667	48,553	50,704	55,141	53,928
	Customer Accounts	3,744,985	280,449	431,438	300,482	366,782	350,123	341,543	252,526	276,831	317,210	268,352	283,887	275,362
	Customer Service & Information	442,548	48,979	40,722	30,557	29,732	35,374	33,234	32,968	36,701	37,620	40,778	41,133	34,750
	Sales Expense	152,157	9,236	8,361	11,281	10,561	10,979	16,943	13,030	11,310	15,102	15,100	15,103	15,151
	Transmission	246	0	0	0	0	0	0	88	158	0	0	0	0
	Distribution	6,682,896	697,639	511,045	475,022	473,715	431,414	298,211	409,730	555,977	717,627	760,433	706,709	645,374
	A&G	8,064,037	1,247,658	741,803	578,194	663,859	579,146	656,017	969,144	634,545	498,245	452,078	503,504	539,844
	Other	(908,965)	561,463	(233,576)	(329,245)	(355,219)	(402,968)	(42,090)	(10,616)	(96,714)	0	0	0	0
	Maintenance													
	Production	143,025	18,522	21,371	5,900	3,226	16,962	4,177	39,688	3,775	8,266	5,909	6,379	8,850
	Transmission	0	0	0	0	0	0	0	0	0	0	0	0	0
	Distribution	2,574,517	175,466	155,065	100,302	307,611	226,137	261,808	205,820	190,693	226,555	254,037	276,959	194,064
	A&G	1,437	(323)	(765)	164	1,583	3,486	225	(2,602)	(383)	13	13	13	13
	Operation & Maintenance Expense	23,510,612	3,519,923	3,085,457	1,374,900	1,582,527	1,306,126	1,621,235	1,944,125	1,703,560	1,869,191	1,847,404	1,888,828	1,767,336
	Depreciation Expense	14,343,093	1,133,527	1,139,751	1,158,972	1,163,091	1,180,401	1,142,993	1,182,505	1,217,670	1,239,950	1,240,651	1,271,963	1,271,619
	Amortization of Deferred Expenses													
	Taxes Other Than Income Taxes	3,591,625	332,544	328,531	298,987	271,289	292,276	280,364	293,109	290,484	302,631	305,006	298,180	298,224
	Income Taxes	3,440,041	523,523	265,138	265,138	265,138	265,138	265,138	265,138	265,138	265,138	265,138	265,138	265,138
	Operating Income	13,611,960	3,183,496	5,172,627	3,763,988	2,845,166	1,775,027	(665,564)	(972,652)	(738,726)	(982,949)	(1,002,529)	(321,336)	1,555,412
	Operating Income - Before Income Taxes	17,052,001	3,707,019	5,437,765	4,029,126	3,110,304	2,040,165	(400,426)	(707,514)	(473,588)	(717,811)	(737,391)	(56,198)	1,820,550

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-047

REQUEST:

Provide the amount of excess deferred federal income taxes resulting from the reductions in the corporate tax rate in 1979 and 1986, as of the end of the most recent calendar year. Show the amounts associated with the 1979 reduction separately from the amounts associated with the 1986 reduction.

RESPONSE:

The total amount of federal excess deferred taxes relating to the reductions in the corporate tax rate in 1979 and 1986 is less than $500k at 12/31/2017. We maintain our deferred taxes in PowerTax. PowerTax maintains one record for each asset that shows the total book vs. tax timing difference and the associated deferred taxes for that one record. Each time a federal tax rate change occurs the balance of deferred taxes for that records is updated to the new balance including the total amount of the excess deferred taxes. Each individual tax rate change is not stored separately on this record. Therefore we do not maintain a balance of excess deferred taxes distinguished by the year of the tax rate change.

PERSON RESPONSIBLE: John R. Panizza

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-048
(As to Attachments (a)(2) and (a)(3) Only)

REQUEST:

Provide the following tax data for the most recent calendar year:

a. Income taxes:

1) Federal operating income taxes deferred – accelerated tax depreciation.

2) Federal operating income taxes deferred – other (explain).

3) Federal income taxes – operating.

4) Income credits resulting from prior deferrals of federal income taxes.

5) Investment tax credit net.

(a) Investment credit realized.

(b) Investment credit amortized – Pre-Revenue Act of 1971.

(c) Investment credit amortized – Revenue Act of 1971.

6) The information in Item 48a(1-4) for state income taxes.

7) A reconciliation of book to federal taxable income as shown in Schedule 48a(1) and a calculation of the book federal income tax expense for the base period using book taxable income as the starting point.

8) A reconciliation of book to state taxable income as shown in Schedule 48a(2) and a calculation of the book state income tax expense for the base period using book taxable income as the starting point.

9) A copy of federal and state income tax returns for the most recent tax year, including supporting schedules.

10) A schedule of franchise fees paid to cities, towns, or municipalities during the test year, including the basis of these fees.

b. An analysis of Kentucky Other Operating Taxes as shown in Schedule 48b.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachments (a)(2) and (a)(3) Only)

a. 1) through 8) See STAFF-DR-01-048(a)(1) Attachment which provides a reconciliation of book to federal and state taxable income and a calculation of federal and state income tax expense in the format provided for the 12 months ended December 31, 2017. Similar information for the base period can be found in Schedule E-1.

9) See STAFF-DR-01-048(a)(2) Confidential Attachment and STAFF-DR-01-048(a)(3) Confidential Attachment which are the 2017 federal and state income tax returns, respectively for Duke Energy Kentucky. These attachments are being filed under the seal of a Petition for Confidential Treatment. The Kentucky Corporation Income Tax Return is filed on a consolidated basis with Duke Energy Kentucky's affiliated companies.

10) See STAFF-DR-01-048(a)(4) Attachment for the franchise fees paid. The basis of school and franchise taxes are gross receipts.

b. See STAFF-DR-01-048(b) Attachment which provides the Kentucky Other Operating Taxes information requested in the format provided.

PERSON RESPONSIBLE: John R. Panizza

STAFF-DR-01-048 (a)(1) EXCEL ATTACHMENT

PROVIDED ON CD

STAFF-DR-01-048a(7)

Duke Energy Kentucky, Inc.
Case No. 2018-00261
Reconciliation of Book Net Income and Federal Taxable Income
12 Months Ended December 31, 2017

Line No.	Item (a)	Total Company (b)	Total Company Non-Operating (c)	Operating: Kentucky Retail - Gas U (d)	Operating: Other Jurisdictional (e)
1	Net income per books	59,398,928	23,768,916	7,614,732	28,015,280
2	Add income taxes:				
3	Federal income tax - current	(13,441,872)	1,848,320	(7,656,112)	(7,634,080)
4	Federal income tax - deferred depreciation	7,830,647	(3,167,245)	13,191,369	(2,193,477)
5	Federal income tax - deferred other	1,913,117	(20,056,033)	(1,825,085)	23,794,235
6	Investment tax credit adjustment	(87,352)	(8,911)	(67,351)	(11,090)
7	Federal income taxes charged to other income and deductions				
8	State income taxes	2,624,353	(22,302)	454,093	2,192,562
9	State income taxes charged to other income and deductions	0			
10	Total	58,237,821	2,362,745	11,711,646	44,163,430
11	Flow through items:				
12	Add (itemize)				
13	Deduct (itemize) AFUDC - Equity	(4,658,166)	(4,658,166)	0	0
14	Book taxable income	53,579,655	(2,295,421)	11,711,646	44,163,430
15	Differences between book taxable income and taxable income per tax return:				
16	Add (itemize)				
	Book Depreciation/Amortization	47,666,813	9,560,287	13,014,115	25,092,411
	Reg Asset - Accr Pension FAS158 - FAS87Qual	22,515,608		5,053,735	17,461,873
	Adjustment To Book Depreciation	8,878,680	5,001,105	0	3,877,575
	Reg Asset - Accr Pension FAS158 - FAS 106/112	6,593,562	0	1,722,783	4,870,779
	ASSET RETIREMENT OBLIGATION	6,018,830	0	1,530,972	4,487,858
	Tax Interest Capitalized	2,498,533	0	308,258	2,190,275
	Asset Retirement Costs - Coal Ash	2,284,895	0	0	2,284,895
	UNBILLED REVENUE - FUEL	1,847,679	0	1,847,679	0
	Impairment of Plant Assets	1,190,000		0	1,190,000
	Other	3,809,403	360,271	334,867	3,114,265
	Total Additions	**103,304,003**	**14,921,663**	**23,812,409**	**64,569,931**
17	Deduct (itemize)				
	Tax Depreciation/Amortization	(79,291,005)		(27,903,613)	(51,387,392)
	Reg Asset-Pension Post Retirement PAA-FAS87Qual and Oth	(24,680,956)		(5,605,288)	(19,075,668)
	Regulatory Asset - Deferred Plant Costs	(19,304,977)	(5,001,105)	0	(14,303,872)
	Equipment Repairs - Annual Adj	(17,000,000)		0	(17,000,000)
	T & D Repairs - Annual Adj.	(13,000,000)		0	(13,000,000)
	Reg Asset/Liab Def Revenue	(5,780,245)		0	(5,780,245)
	ARO Regulatory Asset - Coal Ash	(5,308,593)		0	(5,308,593)
	ARO Regulatory Asset	(4,778,786)		(354,495)	(4,424,291)
	Tax Gains/Losses	(4,400,000)		(1,400,000)	(3,000,000)
	Asset Retirement Obligation - Coal Ash	(4,259,409)		0	(4,259,409)
	Reg Asset - Transition from MISO to PJM	(3,086,364)		0	(3,086,364)
	Reg Asset-Pension Post Retirement PAA-FAS 106 and Oth	(2,330,194)		(617,143)	(1,713,051)
	Retirement Plan Expense - Underfunded	(1,537,936)		(56,548)	(1,481,388)
	Asset Retirement Costs - ARO	(1,240,045)		(1,176,477)	(63,568)
	Reg Asset - Accr Pension FAS158 - FAS87NQ	(1,172,016)		(161,543)	(1,010,473)
	Other	(5,432,662)	(455,553)	(1,438,755)	(3,538,354)
	Total Deductions	**(192,603,188)**	**(5,456,658)**	**(38,713,862)**	**(148,432,668)**
18	Taxable income per return	(35,719,530)	7,169,584	(3,189,807)	(39,699,307)

Computation of Tax:	(b)	(c)	(d)	(e)
Provision for Federal Income Tax at 35%	(12,501,836)	2,509,354	(1,116,432)	(13,894,757)
True Up Entries	2,526,313	(661,035)	(6,551,948)	9,739,296
Other Benefits	142,965		12,269	130,696
NOLs	(3,609,315)			(3,609,315)
Total Federal Income Tax Provision	(13,441,873)	1,848,319	(7,656,111)	(7,634,080)

Note: (1) Provide a calculation of the amount shown on Lines 3 through 7 above.
(2) Provide a workpaper supporting each calculation including the depreciation for straight-line tax and accelerated tax depreciation.
(3) Provide a schedule setting forth the basis of allocation of each item of revenue or cost allocated above.

STAFF-DR-01-048 (a)(4)
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky
Franchise Tax Payments
Year 2017

School Tax

Filing Period of Return	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Month Paid	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Beechwood	21,989	21,400	18,023	17,036	11,732	12,175	13,334	15,748	14,810	12,763	10,989	15,153
Boone	381,439	460,081	389,015	356,957	318,642	285,398	303,961	342,426	337,672	319,774	282,443	316,078
Bracken	10	22	17	11	11	5	3	1	2	1	1	6
Campbell	100,294	136,810	114,009	101,575	92,755	80,218	85,767	101,562	107,297	95,972	84,916	88,088
Erlanger	49,687	51,423	42,349	40,860	30,035	28,090	32,407	39,438	35,736	30,726	27,627	35,465
Ft Thomas	42,077	60,819	50,030	42,635	36,567	29,252	28,615	41,537	38,183	34,061	29,946	31,165
Gallatin	2,189	2,573	1,975	1,833	875	630	450	439	398	406	373	1,389
Grant	22,933	23,081	19,253	18,867	15,008	14,750	15,886	19,422	17,347	15,836	13,661	20,136
Kenton	279,745	304,389	252,472	237,539	190,571	182,363	203,337	235,060	220,039	200,245	187,220	214,654
Ludlow	12,990	13,950	9,084	11,459	5,961	8,055	7,008	9,664	8,115	6,915	6,077	9,698
Pendleton	5,634	8,082	5,853	5,214	4,269	2,524	2,183	2,194	2,032	2,163	1,654	3,581
Silver Grove	12,276	12,465	11,035	11,096	11,380	10,904	11,001	13,162	12,945	11,811	10,603	12,349
Southgate	4,584	7,004	5,476	4,751	4,162	3,226	3,289	4,189	4,299	3,566	3,194	3,441
Walton Verona	14,894	15,259	13,141	11,575	9,591	9,012	10,271	12,343	11,247	10,207	9,278	11,256
Williamstown	2,428	3,319	2,604	2,249	1,586	930	772	730	665	638	697	1,337
Total School Tax	953,169	1,120,677	934,336	863,657	733,145	667,532	718,284	837,915	810,787	745,084	668,679	765,796

Franchise Tax

Filing Period of Return	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Month Paid	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Bellevue	17,679	25,389	18,758	16,149	14,803	10,690	12,171	15,554	15,282	13,141	11,765	12,047
Bromley	1,156	1,182	975	1,003	770	830	808	964	828	769	696	1,061
Covington	136,855	169,345	126,237	123,846	94,024	84,282	92,471	111,572	104,636	93,600	83,571	97,998
Crescent Springs	13,994	12,947	11,479	11,004	8,474	8,468	10,056	10,567	10,052	9,361	7,883	12,981
Crestview Hills	0	0	0	0	0	11,305	12,710	14,857	13,447	12,285	11,311	12,562
Crittenden	0	0	0	0	0	0	0	0	0	4,501	3,795	5,620
Dayton	12,727	18,963	13,956	12,577	10,201	8,050	9,031	10,977	10,850	9,597	8,312	9,004
Dry Ridge	0	0	0	0	0	0	0	0	0	2,973	1,304	2,830
Erlanger	50,129	51,881	43,196	42,046	32,134	30,280	33,816	40,515	36,778	32,420	29,503	37,487
Ft Thomas	4,267	4,267	4,267	4,267	4,267	4,267	4,267	4,267	4,267	4,267	4,267	4,267
Glencoe	150	137	133	140	62	43	43	32	30	16	23	91
Independence	34,878	43,139	34,777	31,463	24,452	22,483	24,519	27,222	26,501	23,970	25,022	23,100
Latonia Lakes	0	0	0	0	0	0	0	0	0	0	0	9,497
Ludlow	12,668	13,601	8,834	11,149	5,779	7,889	6,893	9,469	8,003	6,795	5,942	37,401
Newport	49,031	71,004	56,203	49,049	44,535	36,707	36,754	45,055	46,859	41,228	35,928	1,882
Southgate	2,385	3,367	2,605	2,322	1,962	1,652	1,692	2,155	2,230	1,846	1,641	15,821
Taylor Mill	17,718	22,354	17,229	15,611	13,185	11,181	12,770	15,451	14,241	12,964	11,590	13,744
Wilder	14,296	16,947	14,694	13,998	12,610	12,261	13,078	14,957	15,429	13,967	12,481	1,446
Williamstown	2,382	3,264	2,537	2,195	1,538	906	750	693	714	663	741	304
Woodlawn	455	700	456	405	342	261	293	374	368	321	251	98
Total Franchise Tax	370,770	458,487	356,336	337,224	269,138	251,555	272,112	324,681	310,515	284,684	256,026	299,241
Total Payments	1,323,939	1,579,164	1,290,672	1,200,881	1,002,283	919,087	990,396	1,162,596	1,121,302	1,029,768	924,705	1,063,037

A. The tax rate for the Kentucky School tax is 3% of Taxable Gross Receipts. Tax bases can be calculated by dividing the school tax payments above by the 3% tax rate.

B. The franchise fee rate for the majority of listed entities is 3% except for the localities listed below. The franchise fee base can be calculated by dividing the franchise fee payments above by 3.0%.

City of Bromley is 1.0%
City of Southgate is 1.0%
Town of Dry Ridge is 5%
Ft. Thomas is a flat fee of $4,266.67

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-049

REQUEST:

Provide the following information with regard to uncollectible accounts for the three most recent calendar years for gas operations:

a. Reserve account balance at the beginning of the year;

b. Charges to the reserve account (accounts charged off);

c. Credits to the reserve account;

d. Current year provision;

e. Reserve account balance at the end of the year; and

f. Percent of the provision to total revenue.

RESPONSE:

See STAFF-DR-01-049 Attachment.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-049
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC.
Reserve for Uncollectible Accounts - Account 144
Years 2015 through 2017

		2015	2016	2017
a.	Balance - Beginning of Year	$ -	$ -	$ -
b.	Charge Offs	$ -	$ -	$ -
c.	Recoveries	$ -	$ -	$ -
d.	Provision	$ -	$ -	$ -
e.	Balance - End of Year	$ -	$ -	$ -
f.	Provision - Gas Operations	$ -	$ -	$ -
f.	Percent of Gas Revenue	0.000%	0.000%	0.000%

Note:
(a) All retail accounts receivable are sold to Cinergy Receivables LLC, therefore transferring the risk of uncollectibility to the purchaser and eliminating the need for a reserve for uncollectible accounts on Duke Energy Kentucky.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-050
(As to Attachment Only)

REQUEST:

Provide Duke Kentucky's written policies on the compensation of outside attorneys, auditors, consultants, and all other professional service providers. Include a schedule of fees, per diems, and other compensation in effect during the base period. Include all agreements, contracts, memoranda of understanding, and any other documentation that explains the nature and type of reimbursement paid for professional services. Indicate if any changes have occurred since the test year of Duke Kentucky's last base rate case, the effective date of these changes, and the reason for these changes.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment Only)

Objection. This document request seeks to elicit documents protected by attorney-client privilege and work product or that is otherwise considered confidential and privileged. Without waiving said objection and to the extent discoverable, due to the voluminous nature of the information requested, please see STAFF-DR-01-050 Confidential Attachment for copies of the Company's purchasing controls policies, delegation of authority, standard terms and conditions for professional services, and master agreement templates, as well as, confidential agreements and other documentation for professional services. This attached is being filed under the seal of a Petition for Confidential Treatment.

PERSON RESPONSIBLE: N/A

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-051
(As to Attachment Only)

REQUEST:

Provide a detailed analysis of expenses for professional services during the most recent 12-month period for which information is available at the time the application is filed, as shown in Schedule 51, and all work papers supporting the analysis. At a minimum, the work papers should show the payee, dollar amount, reference (i.e., voucher no., etc.), account charged, hourly rates and time charged to the company according to each invoice, and a description of the services provided.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment Only)

See STAFF-DR-01-051 Confidential Attachment, which is being filed under the seal of a Petition for Confidential Treatment. The line items in which the vendor is blank or unknown is a charge resulting from an allocation. The Company can provide detail behind individual line items but it is a manual process for each line item to research the allocation pool to go back to the original invoice and vendor. This analysis excludes contractor labor which has been charged to the 923 account.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-051
EXCEL
ATTACHMENT

PROVIDED ON CD

STAFF-DR-01-052

REQUEST:

Provide the following information. If any amounts were allocated, show a calculation of the factor used to allocate each amount.

a. A detailed analysis of charges booked for advertising expenditures during the most recent 12-month period for which information is available at the time the application is filed. Include a complete breakdown of Account No. 913 – Advertising Expenses, and any other advertising expenditures included in any other expense accounts, as shown in Schedule 52a. The analysis should specify the purpose of the expenditure and the expected benefit to be derived.

b. An analysis of Account No. 930 - Miscellaneous General Expenses for the most recent 12-month period for which information is available at the time the application is filed. Include a complete breakdown of this account as shown in Format 52b and provide detailed work papers supporting this analysis. At a minimum, the analysis should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and a brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule 52b.

c. An analysis of Account No. 426 - Other Income Deductions for the most recent 12-month period for which information is available at the time the application is filed. Include a complete breakdown of this account as shown in Schedule 52c, and

provide detailed work papers supporting this analysis. At a minimum, the analysis should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and a brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule 52c.

RESPONSE:

a. See STAFF-DR-01-052(a) Attachment. Advertising expenses have not been included in the forecasted test period revenue requirement.

b. See STAFF-DR-01-052(b) Attachment.

c. See STAFF-DR-01-052(c) Attachment. All amounts in Account No. 426 are charged below the line and, thus, not included in the forecasted test period revenue requirement.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-052(a) EXCEL ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky, Inc.
Case No. 2018-00261
Analysis of Advertising Expenses
(Including Account No. 913)
For the 12 months Ended June 30, 2018

LINE NO.	ITEM (A)	SALES OR PROMOTIONAL ADVERTISING (B)	INSTITUTIONAL ADVERTISING (C)	CONSERVATION ADVERTISING (D)	SAFETY (E)	RATE CASE (F)	OTHER (G)	TOTAL (H)
1	Newspaper							-
2								
3	Magazines and Other						600	600
4								
5	Television							-
6								
7	Radio							-
8								
9	Direct Mail						708	708
10								
11	Sales Aids						3,644	3,644
12								
13	Undetermined						23,182	23,182
14								
15	**Total**	-	-	-	-	-	28,134	28,134
16								
17	**Amount Assigned to**							
18	**KY Retail**	-	-	-	-	-	-	-

Note: For informational purposes only. Duke Energy Kentucky has excluded these costs in their application to increase rates.

* This analysis of advertising expenses includes amounts reflected in account 0930150, which are also reflected in DR 52B, which is an analysis of 930 accounts.

*This analysis excludes contractor labor

STAFF-DR-01-052(b)
EXCEL
ATTACHMENT

PROVIDED ON CD

DuJe Energy Kentucky, Inc.
Case No. 2018-00261
Analysis of Account No. 930 - Miscellaneous General Expenses
For the 12 Months Ended June 30, 2018

Line No.	Item (a)	Amount (b)
1	Industry Association Dues	78,495
2	Stockholder and Debt Service Expenses	81
3	Institutional Advertising	
4	Conservation Advertising	
5	Rate Department Load Expenses	
6	Directors' Fees and Expenses	17,666
7	Dues and Subscriptions	119,408
8	Miscellaneous	108,687
9	Total	324,337
10	Amount Assigned to Kentucky Jurisdictional	324,337

* This schedule includes amounts in 0930150 and 0930700 accounts, which are also represented in DR 52a and DR 58.

STAFF-DR-01-052(c)
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky, Inc.
Case No. 2018-00261
Analysis of Account No. 426 - Other Income Deductions
For the 12 Months Ended June 30, 2018

Line No.	Item (a)	Amount (b)
1	Donations	146,845
2	Civic Activities	-
3	Political Activities	196,815
4	Other	428,334
5	Total	771,994

Note: For informational purposes only.
Duke Energy Kentucky has excluded these costs in their application to increase rates.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-053
(As to Attachment (c) Only)

REQUEST:

Regarding Duke Kentucky's employee compensation policy:

a. Provide Duke Kentucky's written compensation policy as approved by the Board of Directors.

b. Provide a narrative description of the compensation policy, including the reasons for establishing the policy and Duke Kentucky's objectives for the policy.

c. Explain whether the compensation policy was developed with the assistance of an outside consultant. If the compensation policy was developed or reviewed by a consultant, provide any study or report provided by the consultant.

d. Explain when Duke Kentucky's compensation policy was last reviewed or given consideration by the Board of Directors.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment (c) Only)

a. The Compensation Committee of the Board of Directors establishes and reviews the overall compensation philosophy of the Corporation, confirms that our policies and philosophy do not encourage excessive or inappropriate risk-taking by our employees, reviews and approves the salaries and other compensation of certain employees, including all executive officers of Duke Energy, reviews and approves compensatory agreements with executive officers, approves equity grants and reviews the

effectiveness of, and approves changes to, compensation programs. See STAFF-DR-01-53(a) Attachment to reference the Compensation Committee Charter.

b. Our compensation philosophy is described on pages 6-12 of Renee Metzler's direct testimony.

c. The Compensation Committee has engaged FW Cook as its independent compensation consultant. The compensation consultant generally attends each committee meeting and provides advice to the committee at the meetings, including reviewing and commenting on market compensation data used to establish the compensation of the executive officers and directors. The consultant has been instructed that it shall provide completely independent advice to the Compensation Committee and is not permitted to provide any services to Duke Energy other than at the direction of the Compensation Committee. See STAFF-DR-01-53(c) Confidential Attachment, which is the annual review conducted by FW Cook in 2018 is being filed under the seal of a Petition for Confidential Treatment.

d. Annually, our compensation philosophy is described in detail in the Compensation Discussion and Analysis (CD&A) of the proxy statement. The Compensation Committee discusses the CD&A with management and, based on such review and discussions, recommends that the CD&A be included in the proxy statement.

PERSON RESPONSIBLE: Renee H. Metzler

CHARTER OF THE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF DUKE ENERGY CORPORATION

(Amended and Restated as of May 2, 2013)

I. General Focus

The Compensation Committee (the "Committee") shall discharge the responsibilities of the Board of Directors (the "Board") with respect to the Corporation's compensation programs and compensation of the Corporation's executives.

II. Structure and Operations

The Committee shall be comprised of three or more members of the Board, each of whom is determined by the Board to be "independent" under the rules of the New York Stock Exchange, Inc. ("NYSE"). At least two members must satisfy the requirements of a "non-employee director" for purposes of Rule 16b-3 under the Securities Exchange Act of 1934, as amended, and the requirements of an "outside director" for purposes of Section 162(m) of the Internal Revenue Code. The Board shall select members based upon their knowledge and experience in compensation matters and with care to avoid any conflicts of interest.

Each member of the Committee shall be appointed by the Board and shall serve until such member's successor is duly elected and qualified or until such member's earlier resignation or removal. The members of the Committee may be removed, with or without cause, by majority vote of the Board.

The Board shall elect the Chair of the Committee. The Chair will approve the agendas for Committee meetings.

In fulfilling its responsibilities, the Committee shall be entitled to delegate any or all of its responsibilities to a subcommittee of the Committee, including to a subcommittee comprised solely of one director. The Committee also shall be entitled to delegate its authority to one or more directors (whether or not such directors serve on the Committee) as the Committee deems appropriate, provided, however, that the Committee shall not delegate any power or authority required by law, regulation or listing standard to be exercised by the Committee as a whole.

III. Meetings

The Committee shall meet as frequently as circumstances dictate. The Chair of the Committee or a majority of the members of the Committee may call a special meeting of the Committee.

All non-management directors who are not members of the Committee may attend meetings of the Committee, but may not vote. Additionally, the Committee may invite to its meetings any director, member(s) of management of the Corporation and such other persons as it deems appropriate in order to carry out its responsibilities. The Committee may also exclude from its meetings any person it deems appropriate in order to carry out its responsibilities.

A majority of the Committee members, but not less than two, will constitute a quorum. A majority of the Committee members present at any Committee meeting at which a quorum is present may act on behalf of the Committee. The Committee may meet by telephone or videoconference and may take action by unanimous written consent.

The Committee shall appoint a person, who need not be a member, to act as secretary, and minutes of the Committee's proceedings shall be kept in minute books provided for that purpose. The agenda of each Committee meeting will be prepared by the secretary and, whenever reasonably practicable, circulated to each Committee member prior to each meeting.

IV. Responsibilities and Duties

The following functions shall be the common recurring activities of the Committee in carrying out its responsibilities outlined in Section I of this Charter. These functions should serve as a guide with the understanding that the Committee may carry out additional functions and adopt additional policies and procedures as may be appropriate in light of changing business, legislative, regulatory, legal or other conditions. The Committee shall also carry out any other responsibilities and duties delegated to it by the Board from time to time related to the purposes of the Committee outlined in Section I of this Charter.

The Committee, in discharging its oversight role, is empowered to study or investigate any matter of interest or concern that the Committee deems appropriate and shall have the sole authority to retain or terminate outside counsel or other experts for this purpose, including the sole authority to approve the fees payable to such counsel or experts and any other terms of retention.

<u>Setting Compensation for Executive Officers and Directors</u>

1. Establish and review the overall compensation philosophy of the Corporation.

2. Based upon input from the Corporate Governance Committee regarding the performance of the Chief Executive Officer and other executive officers, review and approve the annual salary, bonus, stock options and other benefits, direct and indirect, of the Chief Executive Officer and other executive officers.

3. In connection with executive compensation programs:

   (i) Review and recommend to the full Board, or approve, new executive compensation programs;

(ii) Review on a periodic basis the operations of the Corporation's executive compensation programs to determine whether they are properly coordinated and achieving their intended purpose(s), including whether the Corporation's compensation programs encourage excessive risk-taking and discuss, at least annually, the relationship between risk management policies and practices and compensation, and evaluate compensation policies and practices that could mitigate any such risk;

(iii) Review on a periodic basis the aggregate amount of compensation paid or potentially payable to the Chief Executive Officer and other executive officers through the use of tally sheets or such other method as the Committee may determine; and

(iv) Take steps to modify any executive compensation program that yields payments and benefits that are not reasonably related to executive and corporate performance.

(v) The Committee shall consider the results of shareholder advisory votes regarding named executive officer compensation when evaluating and determining executive compensation (and shall recommend the frequency with which the Corporation shall conduct future shareholder advisory votes regarding executive compensation).

4. Review and recommend to the full Board compensation of directors.

5. Review and make recommendations to the full Board, or approve, any contracts or other transactions with executive officers of the Corporation, including consulting arrangements, employment contracts and severance or termination arrangements, or any revisions thereto. Notwithstanding any other provision of this Charter, the Committee shall review and make recommendations to the Board for approval of any consulting arrangement, employment contract, severance or termination arrangement with the Chief Executive Officer, or any revision thereto.

6. Review and approve annual performance goals for performance-based compensation that is intended to be tax deductible under Section 162(m) of the Internal Revenue Code and determine whether the performance goals and objectives are attained.

<u>Monitoring Incentive and Equity-Based Compensation Plans</u>

7. Review the Corporation's executive compensation plans, including incentive-compensation and equity-based plans, in light of the goals and objectives of these plans, and amend, or recommend that the Board amend, these plans if the Committee deems it appropriate.

8. Administer any short-term incentive plan covering executive officers of the Corporation; determine whether performance targets have been met and determine the amounts and terms of any awards.

9. Review and recommend for Board approval all equity compensation plans to be submitted for shareholder approval under the NYSE listing standards; provided, however, that any equity compensation plan that satisfies an exception to the NYSE's listing standards shall not be required to be approved by the Corporation's shareholders.

10. Review and make recommendations to the Board, or approve, all awards of shares, share options or other awards pursuant to the Corporation's equity-based plans; provided that the authority to issue such awards to employees who are not executive officers may be delegated as above described.

Reports

11. Review and discuss with management the Corporation's compensation discussion and analysis ("CD&A"), and based on that review and discussion, recommend to the Board that the CD&A be included in the Corporation's annual proxy statement or annual report on Form 10-K, and prepare the Compensation Committee Report in accordance with the rules and regulations of the Securities and Exchange Commission for inclusion in the Corporation's annual proxy statement or annual report on Form 10-K.

12. Report regularly to the Board (i) following meetings of the Committee, (ii) with respect to such other matters as are relevant to the Committee's discharge of its responsibilities and (iii) with respect to such recommendations as the Committee may deem appropriate. The report to the Board may take the form of an oral report by the Chair or any other member of the Committee designated by the Committee to make such report.

13. Maintain minutes or other records of meetings and activities of the Committee.

Advisors

14. The Committee has the sole authority to select, oversee and terminate compensation consultants, legal counsel or other advisors to advise the Committee, and to approve the terms of any such engagement and the fees of any such compensation consultant, legal counsel or other advisor. In selecting a compensation consultant, legal counsel or other advisor, the Committee shall take into account factors (including factors related to the independence of such compensation consultant, legal counsel or other advisor) it considers appropriate or as may be required by applicable law or NYSE listing standards. The Committee shall receive appropriate funding from the Corporation for the payment of compensation to the compensation consultants, legal counsel or other advisors retained by the Committee pursuant to the provisions of this Charter.

V. Annual Performance Evaluation

The Committee shall perform a review and evaluation, at least annually, of the performance of the Committee and its members, including a review of the compliance of the Committee with this Charter. In addition, the Committee shall review and reassess, at least annually, the adequacy of this Charter and recommend to the Board any modifications to this Charter that the Committee considers necessary or valuable. The Committee shall conduct such evaluations and reviews in such manner as it deems appropriate.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-054

REQUEST:

Explain whether Duke Kentucky's expenses for wages, salaries, benefits and other compensation included in the base period; and any adjustments to the base period are compliant with the Board of Director's compensation policy.

RESPONSE:

The Compensation Committee has approved an executive compensation program that is designed to: (1) link pay to performance, (2) attract and retain talented executive officers and key employees, (3) emphasize performance-based compensation to motivate executives and key employees, (4) reward individual performance and (5) encourage long-term commitment to Duke Energy and align the interests of executives with shareholders.

We meet these objectives through the appropriate mix of compensation, including base salary, short-term incentives and long-term incentives. Our base pay programs are described in detail on pages 12-16 and the incentive pay programs are described on pages 16-29 of Renee Metzler's direct testimony.

PERSON RESPONSIBLE: Renee H. Metzler

STAFF-DR-01-055

REQUEST:

Explain whether, prior to reflecting any adjustments to wages, salaries, benefits, and other compensation in the rate application, Duke Kentucky, through an outside consultant or otherwise, performed a study or survey to compare its wages, salaries, benefits, and other compensation to those of other utilities in the region, or to other local or regional enterprises.

a. If comparisons were performed, provide and discuss the results of such comparisons. Include the results of the study or survey with your response, including all work papers.

b. If comparisons were not performed, explain why such comparisons were not performed.

RESPONSE:

As discussed throughout the direct testimony of Renee Metzler, Duke Energy places a priority on attracting and retaining a diverse, high-performing workforce. An important way we do this is by providing a comprehensive, competitive total rewards package of pay and benefits that includes base pay, incentive pay opportunities and benefits. Duke Energy employs a market-based strategy, meaning that comparisons are made against similar large-revenue companies within the industries we operate. Rarely are those comparisons made at the local level; however, because skilled labor jobs are

typically recruited at a regional level, comparisons are made regionally for competitive pay purposes for those positions. For most other positions, the strategy for pay uses annual compensation surveys to establish salary ranges and ensure jobs are paid competitively in base and in total direct compensation (base + incentives) as compared to jobs at companies that are similar to Duke Energy in size and revenue. The data from these surveys is analyzed to determine the targeted level of pay for jobs throughout the Companies. As referenced in the response to Question 35 of the Staff's First Request, a complete list of the salary surveys Duke Energy is currently participating in is reflected in Attachment RHM-4 to Mrs. Metzler's testimony. As discussed in its response to STAFF-DR-035, Duke Energy's survey documents are voluminous in nature and are considered to be proprietary by the vendor and subject to licensing agreements. As a result, to the extent permitted by these vendors, the Company will make available for the Commission's review, any of the surveys at a time and place that is convenient to the Commission and the Company. See also, Attachments RHM-1 through RHM-5 for other analysis already provided.

Because survey data is analyzed, Duke Energy believes that its base pay, short-term and long-term incentive compensation programs are market competitive, reasonable and necessary to attract, retain and motivate qualified employees that Duke Energy needs to provide safe, reliable, effective, efficient and economical natural gas service to Duke Energy Kentucky's retail customers. In addition, Duke Energy routinely examines its benefits to confirm how we compare with national trends among comparable employers, and we consider the most effective ways to serve our diverse workforce who reside in over 25 states. We benchmark our programs against other large employers from both the

utility industry and general industry, so that we are positioned to attract and retain qualified employees needed to support our customers. Duke Energy leverages its consultants, vendor partners and nationally recognized surveys to evaluate the competitiveness of its benefits and costs. These surveys indicate that Duke Energy's benefit plans and employee contributions are in line with its utility industry and general industry peers, making them reasonable and necessary in order to compete with other employers for qualified talent.

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-056

REQUEST:

List all present or proposed research efforts dealing with the pricing of natural gas and the current status of such efforts.

RESPONSE:

The following research efforts deal with the pricing of natural gas.

- First, the Company monitors the rates of our peer companies in Kentucky and rate activities affecting these companies. The Company expects to continue to monitor these natural gas pricing activities in the future.
- Second, the Company subscribes to industry publications which report on pricing of natural gas; for example, the AGA Bill Comparison Report. The Company expects to continue to subscribe to the same or similar publications in the future.

PERSON RESPONSIBLE: William Don Wathen, Jr.
Bruce Sailers

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-057

REQUEST:

Provide an analysis of Duke Kentucky's expenses for research and development activities for the base period and the three most recent calendar years. The analysis should include the following:

a. Basis of fees paid to research organizations and Duke Kentucky's portion of the total revenue of each organization. Where the contribution is monthly, provide the current rate and the effective date.

b. Details of the research activities conducted by each organization.

c. Details of services and other benefits provided to Duke Kentucky by each organization.

d. Annual expenditures of each organization with a basic description of the nature of costs incurred by the organization.

e. Details of the expected benefits to Duke Kentucky.

RESPONSE:

See STAFF-DR-01-057 Attachment.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-057
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky, Inc.
Case No. 2018-00261
Analysis of R&D Activities
For the 3 Most Recent Calendar Years and Base Period

Year NO.	Costs Incurred Internally (A) [1, 4]	Costs Incurred Externally (B) [1, 4]	Sum
2015	46	1,236	1,282
2016	86	1,761	1,847
2017	247	1,074	1,321
Base Period	(96)	464	368
	283	4,535	4,818

Notes:

1) For 2015-2017, columns A and B are reflected in FERC Form 2; page 335, line 2b. These costs have been allocated to DEK

2) This analysis represents amounts in account 0930700 which are also represented in DR 52B, which is an analysis of 930 accounts.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-058

REQUEST:

Provide the following information concerning the costs for the preparation of this case:

a. A detailed schedule of expenses incurred to date for the following categories:

(1) Accounting;

(2) Engineering;

(3) Legal;

(4) Consultants; and

(5) Other Expenses (Identify separately).

For each category, the schedule should include the date of each transaction, check number or other document references, the vendor, the hours worked, the rates per hour, amount, a description of the services performed, and the account number in which the expenditure was recorded. Provide copies of contracts or other documentation that support charges incurred in the preparation of this case. Identify any costs incurred for this case that occurred during the base period.

b. An itemized estimate of the total cost to be incurred for this case. Expenses should be broken down into the same categories as identified in (a) above, with an estimate of the hours to be worked and the rates per hour. Include a detailed

explanation of how the estimate was determined, along with all supporting work papers and calculations.

c. Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in (a) above. Updates will be due when Duke Kentucky files its monthly financial statements with the Commission, through the month of the public hearing.

RESPONSE:

a. Objection to the extent this request includes information that is protected under the doctrine of attorney client privilege. Without waiving said objection, please see STAFF-DR-01-058 Attachment 1 (Section A: Expenses incurred to date) for a schedule of actual rate case expenses incurred to date. STAFF-DR-01-058 Attachment 2 - Invoices contains supporting invoice documentation for non-privileged expenses incurred to date. STAFF-DR-01-058 Attachment 3 contains supporting contracts and letters of arrangement. All actual costs incurred to date have occurred during the base period.

b. STAFF-DR-01-058 Attachment 1 also includes estimated remaining costs to be incurred (Section B: Itemized estimates of total costs to be incurred) with a total estimated cost to be incurred for this case. Estimates for the depreciation study, demolition study and rate of return were based on information received from the expert witnesses. The other expenses were estimated by reviewing the actual expenses incurred in the Company's most recent two rate cases filed with this Commission and applying professional judgement and knowledge of the issues involved in this case. A comparison of the current case estimate with the actual and estimated expenses of the prior two cases is included in the filing on Schedule F-6.

c. Monthly updates of actual costs incurred in conjunction with this rate case will be included along with the monthly financial statements filed with the Commission through the month of the public hearing.

PERSON RESPONSIBLE: Sarah E. Lawler

STAFF-DR-01-058
EXCEL
ATTACHMENT 1

PROVIDED ON CD

Duke Energy Kentucky, Inc.
Gas Rate Case Expense
Case No. 2018-00261
Account 0186028

Document/ Journal Entry No.	Invoice Date	Payment Date	Vendor Name / Description	Hours Worked	Rate Per Hour	Accounting	Engineering	Legal	Consultants: Depreciation Study	Consultants: Rate of Return	Consultants: Demolition Study	Publish Legal Notices	Transport/ Lodging/Meals	Misc.	Total
A) EXPENSES INCURRED TO DATE															
March 2018															
APACR51908	5-Mar-18	15-Mar-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	3.00	$260.00				780.00						780.00
APACR51908	5-Mar-18	15-Mar-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	12.00	$170.00				2,040.00						2,040.00
APACR51908	5-Mar-18	15-Mar-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	2.00	$110.00				220.00						220.00
APACR51908	5-Mar-18	15-Mar-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	8.00	$100.00				800.00						800.00
EXACCT0836	31-Mar-18	31-Mar-18	Employee 1 & 2 Travel	N/A - Travel	N/A - Travel								846.02		846.02
EXACCT5498	31-Mar-18	31-Mar-18	Employee 1 & 2 Travel	N/A - Travel	N/A - Travel								499.28		499.28
Total March 2018						0.00	0.00	0.00	3,840.00	0.00	0.00	0.00	1,345.30	0.00	5,185.30
Total Actual Costs to Date						0.00	0.00	0.00	3,840.00	0.00	0.00	0.00	1,345.30	0.00	5,185.30
April 2018															
APACR51908	20-Apr-18	25-Apr-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	12.00	$260.00				3,120.00						3,120.00
APACR51908	20-Apr-18	25-Apr-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	13.50	$170.00				2,295.00						2,295.00
APACR51908	20-Apr-18	25-Apr-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	1.00	$110.00				110.00						110.00
APACR51908	20-Apr-18	25-Apr-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	5.00	$100.00				500.00						500.00
APACR51908	20-Apr-18	25-Apr-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	N/A - Travel	N/A - Travel				429.62						429.62
EXACCT1167	30-Apr-18	30-Apr-18	Employee 2 Travel	N/A - Travel	N/A - Travel								12.89		12.89
Total April 2018						0.00	0.00	0.00	6,454.62	0.00	0.00	0.00	12.89	0.00	6,467.51
Total Actual Costs to Date						0.00	0.00	0.00	10,294.62	0.00	0.00	0.00	1,358.19	0.00	11,652.81
May 2018															
Total May 2018						0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Actual Costs to Date						0.00	0.00	0.00	10,294.62	0.00	0.00	0.00	1,358.19	0.00	11,652.81
June 2018															
Total June 2018						0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Actual Costs to Date						0.00	0.00	0.00	10,294.62	0.00	0.00	0.00	1,358.19	0.00	11,652.81
July 2018															
APACR39286	19-Jun-18	20-Jul-18	Goss Samford | Professional Legal Services	1.00	$245.00			232.76							232.76
APACR39286	19-Jun-18	20-Jul-18	Goss Samford | Professional Legal Services	1.30	$175.00			216.11							216.11
APACR99646	20-Jul-18	26-Jul-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	19.00	$260.00				4,940.00						4,940.00
APACR99646	20-Jul-18	26-Jul-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	20.00	$170.00				3,400.00						3,400.00
APACR99646	20-Jul-18	26-Jul-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	3.00	$145.00				435.00						435.00
APACR99646	20-Jul-18	26-Jul-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	2.00	$110.00				220.00						220.00
APACR99646	20-Jul-18	26-Jul-18	Gannett Fleming Valuation and Rate Consultants, LLC | Consulting Work	N/A - Travel	N/A - Travel				2,894.00						2,894.00
Total July 2018						0.00	0.00	448.87	11,889.00	0.00	0.00	0.00	0.00	0.00	12,337.87
Total Actual Costs to Date						0.00	0.00	448.87	22,183.62	0.00	0.00	0.00	1,358.19	0.00	23,990.68
B) ITEMIZED ESTIMATE OF TOTAL COSTS TO BE INCURRED															
			Professional Legal Services	1,264.53	210.00			265,551.13							265,551.13
			Depreciation Study | Consulting Work	310.68	170.00				52,816.38						52,816.38
			Non Hour Based Costs	N/A	N/A					80,000.00	9,500.00	100,000.00	33,641.81	10,000.00	233,141.81
Total Estimate Costs to be Incurred						0.00	0.00	265,551.13	52,816.38	80,000.00	9,500.00	100,000.00	33,641.81	10,000.00	551,509.32
TOTAL PROJECTED EXPENSES ASSOCIATED WITH THE RATE CASE						**0.00**	**0.00**	**266,000.00**	**75,000.00**	**80,000.00**	**9,500.00**	**100,000.00**	**35,000.00**	**10,000.00**	**575,500.00**

INVOICE

Excellence Delivered As Promised

Gannett Fleming Valuation and Rate Consultants, LLC

ACH/EFT Payment Information:
ABA: 031312738
Account No.: 5003165655
Account Name: Gannett Fleming

Duke Energy Kentucky
Attn: Cynthia Lee, Director, Asset Accounting
Mail Code DEC 42A
P.O. Box 1321
Charlotte, NC 28201

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160
Philadelphia, PA 19182-9160

Project: 063648
Invoice No: 063648*3151
Invoice Date: March 5, 2018

Federal EIN: 46-4413705
Send Remit Info: AccountsReceivable@gfnet.com

Invoice Period: January 1, 2018 through February 2, 2018

Project Manager : John J. Spanos jspanos@gfnet.com 717 763-7211

Depreciation Study - Gas

Summary of Current Charges

Phase 000	- DEPR-GAS	$	3,840.00
	Total Charges		$ 3,840.00
	Total Due This Invoice		**$3,840.00**

Excellence Delivered **As Promised**

Project: 063648
Invoice No: 063648*3151
Invoice Date: March 5, 2018

Gannett Fleming Valuation and Rate Consultants, LLC

Phase 000 -- Depr-Gas

Labor Costs

Labor Classification	***Hours***	***Rate***	***Amount***	
Assistant Analyst I	8.00	$ 100.00	$ 800.00	
Analyst	12.00	170.00	2,040.00	
John J. Spanos	3.00	260.00	780.00	
Support Staff	2.00	110.00	220.00	
	Total Labor Costs			**$ 3,840.00**
	Total Phase -- 000			**$ 3,840.00**

View

Employee 1 expense report

Main Menu Travel and Expenses Sign out

All Search Advanced Search Add To Navigation

View Expense Report

Actions Choose an Action

Business Purpose General Expenses
Report Description Kentucky Gas Rate Case
Reference

Report 0001584955 Paid
Attachments (2)
Print Coversheet
Accounting Defaults

Expenses
Expand All Collapse All

Total 846.02

Line	*Date	*Expense Type	*Description	*Payment Type	*Amount
1	03/02/2018	Transportation Other	Employee 1 — Egencia Booking Fee for [redacted] Ticket (214 characters remaining)	MasterCard	3.00

Default Rate — Exchange Rate 1.00000000 — Base Currency Amount 3.00
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
Favorite Accounting		3.00	75088	3.00	USD	1.00000000	0186028	GDKY	9928	40000	

Line	*Date	*Expense Type	*Description	*Payment Type	*Amount
2	03/01/2018	Airfare	Employee 1 — Airfare for [redacted] Depreciation (193 characters remaining)	MasterCard	420.01

Ticket Number 00170529487043
Merchant AMERICAN 00170529487043

Default Rate — Exchange Rate 1.00000000 — Base Currency Amount 420.01
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
Favorite Accounting		420.01	75088	420.01	USD	1.00000000	0186028	GDKY	9928	40001	

Line	*Date	*Expense Type	*Description	*Payment Type	*Amount
1	03/02/2018	Transportation Other	Employee 2 — Egencia Fee for [redacted] Ticket (225 characters remaining)	MasterCard	

Default Rate — Exchange Rate 1.00000000 — Base Currency Amount 3.00
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
Favorite Accounting		3.00	75088	3.00	USD	1.00000000	0186028	GDKY	9928		

Line	*Date	*Expense Type	*Description	*Payment Type	*Amount
4	03/ 1/2018	Airfare	Employee 2 — Airfare for [redacted] Depreciation Study (198 characters remaining)	MasterCard	420.0

Ticket Number 00170529645610

Default Rate — Exchange Rate 1.00000000

Itinerary Receipt

Today's date: 3/9/2018
Itinerary number: 25622626122

Account holder: Employee 1 [redacted] ([redacted]y@duke-energy.com)
Booking ID: QBZOXG
Duke Energy Corporation HQ
550 Tryon Street
Charlotte, NC 28202-1803

Note: This receipt only includes transactions which were charged through Egencia. Please contact the vendor directly if you need additional receipts. Only transactions up to 3/8/2018 are included.

Flights

Transactions up to 2/25/2018 have been reconciled with the Airlines Reporting Corporation (ARC). ARC does not reconcile fee charges / refunds.

Flight purchase - Mar 1, 2018
Abernathy, Melissa - Ticket number: 7052946704

Company settings

Department:	Finance		
Employee ID:	249419	Rpt Fld 1:	Finance Technology
Rpt Fld 2:	Finance	Rpt Fld 3:	Controller
Rpt Fld 4:	US Asset Accounting	Rpt Fld 5:	NA

American Airlines 5281 (Mon Mar 12, 2018) - CLT-CVG, Economy/Coach Class (G)
American Airlines 5244 (Tue Mar 13, 2018) - CVG-CLT, Economy/Coach Class (G)

	Base fare	$365.50
	Taxes & airline fees	$54.51
	Mar 1, 2018 8:50 AM [MasterCard 3891]	$420.01
Egencia fee charge: Air booking fee	Mar 1, 2018 8:48 AM [MasterCard 3891]	$3.00
	Total flight charges	**$423.01**

Itinerary Receipt

Today's date: 3/9/2018
Itinerary number: 25622627901

Account holder: Employee Z [redacted]@duke-energy.com)
Booking ID: DSUNKA
Duke Energy Corporation HQ
550 Tryon Street
Charlotte, NC 28202-1803

Note: This receipt only includes transactions which were charged through Egencia. Please contact the vendor directly if you need additional receipts. Only transactions up to 3/8/2018 are included.

Flights

Transactions up to 2/25/2018 have been reconciled with the Airlines Reporting Corporation (ARC). ARC does not reconcile fee charges / refunds.

Flight purchase - Mar 1, 2018
Squire, Dylan - Ticket number: 7052964551

Company settings

Department:	Finance		
Employee ID:	470392	Rpt Fld 1	Finance Technology
Rpt Fld 2:	Finance	Rpt Fld 3	Controller
Rpt Fld 4:	US Asset Accounting	Rpt Fld 5	US Property Accounting

American Airlines 5281 (Mon Mar 12, 2018) - CLT-CVG, Economy/Coach Class (G)
American Airlines 5244 (Tue Mar 13, 2018) - CVG-CLT, Economy/Coach Class (G)

	Base fare	$365.50
	Taxes & airline fees	$54.51
	Mar 1, 2018 9:07 AM [MasterCard 3891]	$420.01
Egencia fee charge: Air booking fee	Mar 1, 2018 9:05 AM [MasterCard 3891]	$3.00
	Total flight charges	**$423.01**

Employee expense report

View Expense Report

Actions: Choose an Action

Business Purpose: General Expenses
Report Description: DEK Gas Depr Study Site Visit
Reference

Report 0001596694 Paid
Attachments (5)
Print Coversheet
Accounting Defaults

Expenses

Expand All | Collapse All

Total 499.28

Line	Date	Expense Type	Description	Payment Type	Amount
1	03/12/2018	Meal - 50% Deductible	Dinner while on DEK Gas Site Visit (220 characters remaining)	MasterCard	35.20

Location: Hebron KY
Merchant: CITY BBQ FLORENCE M
View Additional Attendees
Default Rate
Exchange Rate 1.00000000
Base Currency Amount 35.20
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
	35.20	75088	35.20	USD	1.00000000	0188028	GDKY	9928	41009	

Receipt Required
Favorite Accounting

Line	Date	Expense Type	Description	Payment Type	Amount
2	03/13/2018	Gasoline for travel	Gas for Rental Car (236 characters remaining)	MasterCard	17.09

Location: Hebron KY
Merchant: BP#9533597BURLINGTOOPS
Default Rate
Exchange Rate 1.00000000
Base Currency Amount 17.09
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
	17.09	75088	17.09	USD	1.00000000	0188028	GDKY	9928	40000	

Receipt Required
Favorite Accounting

Line	Date	Expense Type	Description	Payment Type	Amount
3	03/13/2018	Car Rental	Rental Car for DEK Gas Site Visit (221 characters remaining)	MasterCard	82.13

Location: Hebron KY
Merchant: ENTERPRISE RENT-A-CAR
Default Rate
Exchange Rate 1.00000000
Base Currency Amount 82.13
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
	82.13	75088	82.13	USD	1.00000000	0188028	GDKY	9928	40000	

Receipt Required
Favorite Accounting

Line	Date	Expense Type	Description	Payment Type	Amount
4	03/13/2018	Meal - 50% Deductible	Lunch for DEK Gas Site Visit (226 characters remaining)	MasterCard	58.50

Location: Hebron KY
Merchant: RED ROBIN NO 489
View Additional Attendees
Default Rate
Exchange Rate 1.00000000
Base Currency Amount 58.50
Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Prcs
Favorite Accounting		58 50	75088	58 50	USD	1 00000000	0186028	GDKY	9928	41000	

Line 7 — 03 12 2018 — Parking — Airport Parking DBK Gas Site Visit — 218 characters remaining — MasterCard — 14 00

Default Rate — Exchange Rate 1 00000000 — Base Currency Amount 14 00

Personal Expense

Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Prcs
Favorite Accounting		14 00	75088	14 00	USD	1 00000000	0186028	GDKY	9928	40000	

Line 8 — 03/12/2018 — Lodging — Hotel Wizard Lodging - Employee 2 — 218 characters remaining — MasterCard — 139 00

Location Hebron KY
Number of Nights 1
Merchant HAMPTON INN

Default Rate — Exchange Rate 1 00000000 — Base Currency Amount 139 00

Personal Expense

Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

✓ Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Prcs
Favorite Accounting		139 00	75088	139 00	USD	1 00000000	0186028	GDKY	9928	40000	

Line 9 — 03 12 2018 — Lodging — Hotel Wizard Lodging - Employee 2 — 218 characters remaining — MasterCard — 17 18

Location Hebron KY
Number of Nights 1
Merchant HAMPTON INN

Default Rate — Exchange Rate 1 00000000 — Base Currency Amount 17 18

Personal Expense

Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

✓ Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Prcs
Favorite Accounting		17 18	75088	17 18	USD	1 00000000	0186028	GDKY	9928	40000	

Line 10 — 03 12 2018 — Lodging — Hotel Wizard Lodging - Employee 1 — 213 characters remaining — MasterCard — 139 00

Location Hebron KY
Number of Nights 1
Merchant HAMPTON INN

Default Rate — Exchange Rate 1 00000000 — Base Currency Amount 139 00

Personal Expense

Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

✓ Receipt Required	Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Prcs
Favorite Accounting		139 00	75088	139 00	USD	1 00000000	0186028	GDKY	9928	40000	

Employee1

03 12 2018 Lodging | Hotel Wizard Lodging [redacted] | MasterCard | 17 18
Line 11 | 213 characters remaining

Location Hebron KY
Number of Nights 1
Merchant HAMPTON INN

Default Rate
Exchange Rate 1 00000000
Base Currency Amount 17 18

Personal Expense
Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Chartfields

✓ Receipt Required

Favorite Accounting

Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
	17 18	75086	17 18	USD	1 000000000	0186025	GDKY	9928	40030	

Expand All | Collapse All

Personal Prepaid Expenses 0.00
Total 499 28

Return to Search | Notify

WELCOME

9533597

DATE 03 13 18 15:32
TRAN# 9115511
PUMP# 11
SERVICE LEVEL SELF
PRODUCT: REGULAR
GALLONS: 6.706
PRICE G: $ 2.549
FUEL SALE $ 17.09
CREDIT $17.09

MC FLEET
XXXXXXXXXXXX3891
Auth #: 043616
Ref: 16602008
Resp Code: 000
Term ID: 00011
Stan: 05121400597

SITE ID: 9533597

RECARD
XXXXXXXXXXXX3891
Stan: 05121400597

THANK YOU
HAVE A NICE DAY

Charlotte Airport
cltairport.com
5550 Josh Birmingham Parkway
28208 Charlotte, NC

Receipt 2415/0602/602 03/13/18 19:38:55

010100 Pay Parking Ticket 14.00
03/12/18 16:07 - 03/13/18 19:38
Length of stay: 1 Dy. 3 Hr. 31 Min.
02993087103011028071580430??

Total Amount $ 14.00

Credit Mastercard$ 14.00

Mastercard
Employee I
0
Customer No. >;;;; =289 4392 3891
Amount = $ 14.00

** Thank you **
** Open 24 hours **

ityt bq.com/rewards

City Barbeque Florence - Store # 14
8026 Burlington Pike
(859) 818-0003

T2474

Host: madison 03/12/2018
T2474 8:27 PM
20174

Tell us about your visit and get
$5 off a $30 order with claim code
Expires 12/31/18
Survey Online: www.tellcitybbq.com
Write survey claim code here________
See Terms at www.citybbq.com/terms

City Sampler	19.24
Brisket-Regular-CS	
Turkey- CS	
Pork- CS	
Sausage- CS	
Pt Mac&Cheese-CS	2.50
Pt Collard Greens-CS	2.50
Cornbread-CS	
Regular Soda-PSI	1.99
Regular Soda IS	.99
Cobbler Peach-IS	4.99

Subtotal	33.21
Tax	1.99

DINE IN Total 35.20

Hampton Inn Cincinnati Airport-North
755 Petersburg Road • Hebron, KY 41048
Phone (859) 689-1960 • Fax (859) 689-1730

Employee 1
CHARLOTTE NC 28214
UNITED STATES OF AMERICA

name
address

room number: 101/NKRUG
arrival date: 3/12/2018 9:18:00 PM
departure date: 3/13/2018
adult/child: 1/0
room rate: 139.00
~~Rate Plan: LV0~~
HH #: BLUE
AL:
Car:

If the debit/credit card you are using for check-in is attached to a bank or checking account, a hold will be placed on the account for the full anticipated dollar amount to be owed to the hotel, including estimated incidentals, through your date of check-out and such funds will not be released for 72 business hours from the date of check-out or longer at the discretion of your financial institution.

Confirmation Number: 87253829

3/13/2018

Rates subject to applicable sales, occupancy, or other taxes. Please do not leave any money or items of value unattended in your room. A safety deposit box is available for you in the lobby. I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part or the full amount of these charges. In the event of an emergency, I, or someone in my party require special evacuation assistance due to a physical disability. Please indicate yes by checking here ☐

signature:

date	reference	description	amount
3/12/2018	868727	GUEST ROOM	$139.00
3/12/2018	868727	SALES TAX 6.00%	$8.34
3/12/2018	868727	TRANSIENT TAX 5%	$6.95
3/12/2018	868727	LODGING TAX 1.00%	$1.39
3/12/2018	868727	SALE TAX - OTHER 0.36%	$0.50
3/13/2018	868854	MC *3891	($156.18)
		BALANCE	$0.00

EXPENSE REPORT SUMMARY

	3/12/2018	STAY TOTAL
ROOM AND TAX	$156.18	$156.18
DAILY TOTAL	$156.18	$156.18

for reservations call **1.800.hampton** or visit us online at **hampton.com**

thanks.

account no: MC *3891	date of charge: 3/13/2018	folio/check no.: 355033 A
card member name:	authorization: 061384	initial
establishment no. and location (establishment agrees to transmit to card holder for payment)	purchases & services	
	taxes	
	tips & misc	
signature of card member: X	**total** amount	-156.18

Hampton Inn Cincinnati Airport North
755 Petersburg Road • Hebron, KY 41048
Phone (859) 689-1960 • Fax (859) 689-1730

Employee 2

CHARLOTTE NC 28214
UNITED STATES OF AMERICA

name
address

room number: 327/KXTD
arrival date: 3/12/2018 9:21:00 PM
departure date: 3/13/2018
adult/child: 1/0
room rate: 139.00
Rate Plan: LV0
HH #: BLUE
AL:
Car:

If the debit/credit card you are using for check-in is attached to a bank or checking account, a hold will be placed on the account for the full anticipated dollar amount to be owed to the hotel, including estimated incidentals, through your date of check-out and such funds will not be released for 72 business hours from the date of check-out or longer at the discretion of your financial institution.

Confirmation Number: 83856229

3/13/2018

Rates subject to applicable sales, occupancy, or other taxes. Please do not leave any money or items of value unattended in your room. A safety deposit box is available for you in the lobby. I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part or the full amount of these charges. In the event of an emergency, I, or someone in my party require special evacuation assistance due to a physical disability. Please indicate yes by checking here ☐

signature:

date	reference	description	amount
3/12/2018	868800	GUEST ROOM	$139.00
3/12/2018	868800	SALES TAX 6.00%	$8.34
3/12/2018	868800	TRANSIENT TAX 5%	$6.95
3/12/2018	868800	LODGING TAX 1.00%	$1.39
3/12/2018	868800	SALE TAX - OTHER 0.36%	$0.50
3/13/2018	868853	MC *3891	($156.18)
		BALANCE	$0.00

EXPENSE REPORT SUMMARY

	3/12/2018	STAY TOTAL
ROOM AND TAX	$156.18	$156.18
DAILY TOTAL	$156.18	$156.18

You have earned approximately 2085 Hilton Honors points for this stay. Hilton Honors(R) stays are posted within 72 hours of checkout.
To check your earnings or book your next stay at more than 4,900 h

Hampton hotels are all over the world. Find us in Canada, Costa Rica, Ecuador, Germany, India, Mexico, Poland, Turkey, United Kingdom, and United States of America. Coming soon in Italy and Romania

for reservations call **1.800.hampton** or visit us online at **hampton.com** **thanks.**

account no.	date of charge	folio/check no.	
MC *3891	3/13/2018	355034 A	
card member name	authorization		initial
	001005		
establishment no. and location — establishment agrees to transmit to card holder for payment	purchases & services		
	taxes		
	tips & misc.		
signature of card member X	**total** amount	-156.18	

Thank You For Dining!
Red Robin Gourmet Burgers
7250 Houston Road
Florence, KY 41042
(859) 282-9444

Server: Laura   DOB: 03/13/2018
03:19 PM   03/13/2018
Table 13/1   1/10011

SALE

MASTERCRD   1048595
Card #XXXXXXXXXXXX3891
Magnetic card present:
Card Entry Method: S

Approval: 067412

Amount: $ 49.50

+ Tip: 9.00

= Total: 58.50

Thank You For Dining!
Red Robin Gourmet Burgers
7250 Houston Road
Florence, KY 41042
(859) 282-9444

Server: Laura	03/13/2018
Table 13/1	3:19 PM
Guests: 4	10011
Reprint #: 1	
ICED TEA	2.99
SPICY SRIRACHA TAVERN	6.99
W/SWEET POTATO FRIES	1.49
SODA	2.99
TACO TAVERN	6.99
W/SWEET POTATO FRIES	1 [illegible]
CHEESE BURGER	9. [illegible]
W/SWEET POTATO FRIES	1 49
BBQ CHICKEN BURGER	10.99
W/SWEET POTATO FRIES	1.49
Subtotal	46.70
Tax	2.80
Total	49.50
MASTERCRD #XXXXXXXXXXXX3891	49.50
Auth:067412	
Balance Due	0.00

Want free stuff? Ask a Team Member about joining our Red Robin Royalty program.

RA 639058628 B[illegible]
Rental 12-MAR-2018 08:07 PM
CINCINNATI INTL ARPT
Return 13-MAR-2018 03:46 PM
CINCINNATI INTL ARPT

Vehicle # JH085368
Model SANTE FE
Class Driven SRAR Class Charged FCAR
License# 7H12Y2 State/Province IN
M/Kms Driven 172
M/Kms Out 6966
M/Kms In 7138

DUKE ENERGY - NATIONAL ACCOUNT

Charges	No Unit	Price	Amount
CDW/LDW	1 Days		0 [illegible]
RAP	1 Days	99	[illegible] 99
[illegible] S H	1 Days	[illegible] 00	39 00
UNLIM M/KM	0 M/Kms		0 00
KY U-DRIVE IT TAX			2 28
BOONE COUNTY LIC FEE			1 14
CONCESSION RECOUP FEE			5 12
VLC RECOVERY FEE			1 [illegible]

INVOICE

*Excellence Delivered **As Promised***

Gannett Fleming Valuation and Rate Consultants, LLC

ACH/EFT Payment Information:
ABA: 031312738
Account No.: 5003165655
Account Name: Gannett Fleming

Duke Energy Kentucky
Attn: Cynthia Lee, Director, Asset Accounting
Mail Code DEC 42A
P.O. Box 1321
Charlotte, NC 28201

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160
Philadelphia, PA 19182-9160

Project: 063648
Invoice No: 063648*3288
Invoice Date: April 20, 2018

Federal EIN: 46-4413705
Send Remit Info: AccountsReceivable@gfnet.com

Invoice Period: March 3, 2018 through March 30, 2018

Project Manager : John J. Spanos jspanos@gfnet.com 717 763-7211

Depreciation Study - Gas

Summary of Current Charges

Phase 000	- DEPR-GAS	$ 6,454.62
	Total Charges	$ 6,454.62
	Total Due This Invoice	**$6,454.62**

Excellence Delivered As Promised

Project: 063648
Invoice No: 063648*3288
Invoice Date: April 20 2018

Gannett Fleming Valuation and Rate Consultants, LLC

Phase 000 -- Depr-Gas

Labor Costs

Labor Classification	Hours	Rate	Amount	
Assistant Analyst I	5 00	$ 100 00	$ 500 00	
Analyst	13 50	170 00	2,295 00	
John J Spanos	12 00	260 00	3,120 00	
Support Staff	1 00	110 00	110 00	
	Total Labor Costs			**$ 6,025.00**

Expenses

Other Transportation	47 60	
Meals	77 47	
Lodging	304 55	
Total Expenses		**$ 429.62**
Total Phase -- 000		**$ 6,454.62**

EMPLOYEE ELECTRONIC EXPENSE REPORT

Co/Org: 003/331050 **Acct Month:** 2018/03 **Exp Rpt No:** ER00270207

Emp No: 07249 **Emp Name:** John J. Spanos **From Date:** 3/5/2018 **Thru Date:** 3/28/2018

Description: marchexpenses

Trans Date	Category	Cat Description	Co.	Project	Phase	Task	Org	Rate	Units	Amount	Reimburse Amt	Curr	Rct
3/12/2018	PRJDINNER	Project- Dinner	003	063648	000	****	331050			$53.02	$53.02	US	10
		Exp Description:	Dinner for John Spanos and Melissa Howard										
3/12/2018	PRJLODG	Project- Lodging	003	063648	000	****	331050			$148.37	$148.37	US	12
3/12/2018	PRJLUNCH	Project- Lunch	003	063648	000	****	331050			$6.50	$6.50	US	NR
		Exp Description:	no receipt										
3/12/2018	PRJTAXI	Project- Taxi	003	063648	000	****	331050			$5.00	$5.00	US	NR
		Exp Description:	Airport Shuttle from Airport to Hotel for John Spanos and Melissa Howard										
3/12/2018	PRJTOLLS	Project- Tolls	003	063648	000	****	331050			$2.60	$2.60	US	NR
		Exp Description:	Field visit for Duke Energy Kentucky Gas assets - Erlanger, KY - no receipt										
3/13/2018	PRJDINNER	Project- Dinner	003	063648	000	****	331050			$8.99	$8.99	US	NR
		Exp Description:	no receipt										
3/13/2018	PRJPARKNG	Project- Parking	003	063648	000	****	331050			$40.00	$40.00	US	11

Employee 2

View Expense Report

Actions: Choose an Action

Business Purpose: External Business Meeting
Report Description: Uber related to site visits
Reference

Report: 0001605084 Paid
Attachments (1)
Print Coversheet
Accounting Defaults

Expenses

Expand All | Collapse All

Total 12.89

*Date	*Expense Type	Description	*Payment Type	*Amount
03/13/2018	Car Rental	Uber from Airport Site visits with Consultant	Out of Pocket	12.89

207 characters remaining

Line

Location: Charlotte, NC
Merchant: Uber

☑ Default Rate — Exchange Rate: 1.00000000
☐ Non-Reimbursable — Base Currency Amount: 12.89
☐ Subject to Foreign Corrupt Practices Act (FCPA)

Accounting Details

Receipt Required

Favorite Accounting

Chartfields

Work Order ID	Amount	GL Unit	Monetary Amount	Currency Code	Exchange Rate	Acct	Oper Unit	Resp Ctr	Res Type	Proj
	12.89	75088	12.89	USD	1.00000000	0188028	GO#	9552	40000	

Expand All | Collapse All

Personal Prepaid Expenses 0.00
Total 12.89

Return to Search | Notify

Employee 2

From:
Sent: Wednesday, March 14, 2018 8:21 AM
To: Squire, Dylan T.
Subject: Fwd: Your Tuesday evening trip with Uber

*** Exercise caution. This is an EXTERNAL email. DO NOT open attachments or click links from unknown senders or unexpected email. ***

---------- Forwarded message ----------
From: "Uber Receipts" <uber.us@uber.com>
Date: Mar 13, 2018 7:55 PM
Subject: Your Tuesday evening trip with Uber
To: < >
Cc:

$12.89

Thanks for choosing Uber Dylan

March 13 2018 | uberX

07:40pm | 5501 Josh Birmingham Pkwy, Charlotte, NC

07:55pm | 2001 S Tryon St, Charlotte, NC

You rode with Tony

6.67	00:15:05	uberX
miles	Trip time	Car

Add a tip

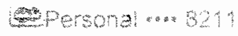
Did you know you can order food delivery through Uber? Try Uber Eats and get 20% off your first order with the code 20ubereats. Download the app today.

[ ]

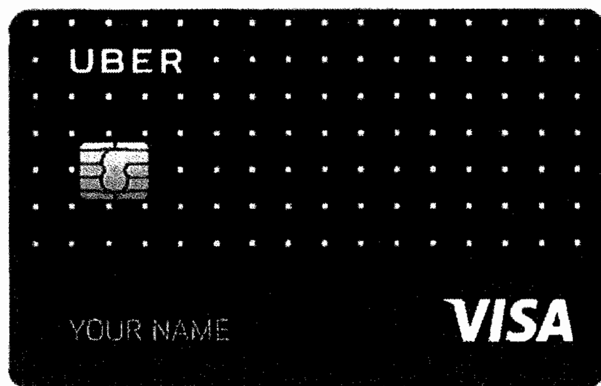
Your Fare

Trip fare	12.89
Subtotal	$12.89

CHARGED


Personal •••• 8211

$12.89



Earn 4% back on dining, 3% back on hotel & airfare, 2% back on online purchases, and more with the Uber Visa

Excellence Delivered **As Promised**

INVOICE

Gannett Fleming Valuation and Rate Consultants, LLC

ACH/EFT Payment Information:
ABA: 031312738
Account No.: 5003165655
Account Name: Gannett Fleming

Duke Energy Kentucky
Attn: Cynthia Lee, Director, Asset Accounting
Mail Code DEC 42A
P.O. Box 1321
Charlotte, NC 28201

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160
Philadelphia, PA 19182-9160

Project: 063648
Invoice No: 063648*3473
Invoice Date: July 20, 2018

Federal EIN: 46-4413705
Send Remit Info: AccountsReceivable@gfnet.com

Invoice Period: April 1, 2018 through June 29, 2018

Project Manager : John J. Spanos **jspanos@gfnet.com** **717 763-7211**

Depreciation Study - Gas

Summary of Current Charges

Phase 000	- DEPR-GAS	$ 11,889.00
	Total Charges	$ 11,889.00
	Total Due This Invoice	**$11,889.00**

Excellence Delivered **As Promised**

Project: 063648
Invoice No: 063648*3473
Invoice Date: July 20 2018

Gannett Fleming Valuation and Rate Consultants, LLC

Phase 000 -- Depr-Gas

Labor Costs

Labor Classification	*Hours*	*Rate*	*Amount*	
Analyst	20 00	$ 170 00	$ 3 400 00	
Assistant Analyst	3 00	145 00	435 00	
John J Spanos	19 00	260 00	4 940 00	
Support Staff	2 00	110 00	220 00	
	Total Labor Costs			**$ 8,995.00**

Expenses

Transportation Airfare (delayed billing)	2 894 00	
Total Expenses		**$ 2,894.00**
Total Phase -- 000		**$ 11,889 00**

RECEIVED
JAN 11 2018
VAL AND RATE

Mailing Address:
139 East Fourth Street
1303-Main
Cincinnati, Ohio 45202
o 513-287-4320
f 513-287-4385

Rocco.D'Ascenzo@duke-energy.com
Rocco O. D'Ascenzo
Associate General Counsel

VIA OVERNIGHT MAIL

January 9, 2018

John Spanos
Gannett Fleming Valuation and Rate Consultants, LLC
P.O. Box 67100
Harrisburg, PA 17106-7100

Re: Depreciation Study for potential Duke Energy Kentucky natural gas distribution rate filing *In the Matter of An Adjustment of the Natural Gas Rates of Duke Energy Kentucky, Inc., Approval of New Tariffs, and for Certificates of Public Convenience and Necessity, Case No. 2018-XXXXX*

Dear John:

This letter of agreement is to formalize the retention of Gannett Fleming Valuation and Rate Consultants, LLC. (Gannett Fleming), and representatives of Gannett Fleming (collectively, "Gannett Fleming") to serve as a testifying expert on behalf of Duke Energy Kentucky, Inc. (Duke Energy Kentucky or the Company) in connection with the above-referenced matter filed before the Kentucky Public Service Commission (Commission). The terms of this proposal are as follows:

1. Duke Energy Kentucky, through its Office of General Counsel, is retaining Gannett Fleming to serve as a testifying expert regarding depreciation expense in this matter. The fees and other amounts charged by you with respect to this engagement shall be the responsibility of the Company.

2. As a testifying expert, you will make yourself reasonably available to testify on behalf of Duke Energy Kentucky in deposition, hearings, trials, and other proceedings as Duke Energy Kentucky may require in connection with this case, and you may also be required to perform other related services such as responding to discovery requests. It is understood that documents you send, receive, and generate may become discoverable in litigation, including drafts and notes prepared prior to the time that your opinion, report, or pre-filed testimony is finalized. Gannett Fleming therefore agrees to preserve any written materials (including e-mails) that are sent, received, or generated in connection with this engagement.

3. You agree to perform services as directed by me or another attorney within the Office of General Counsel of the Company. You agree to keep Duke Energy Kentucky seasonably apprised of the services which you anticipate will be necessary to carry out this engagement. You agree to provide services in a professional and timely manner, recognizing that Commission deadlines are involved and that time is of the essence. We will keep you apprised of deadlines and

give you as much advance notice as practicable in order to facilitate scheduling and minimize conflicts.

4. Duke Energy Kentucky will pay Gannett Fleming in accordance with the fee schedule attached hereto as "Attachment A."

In addition, Duke Energy Kentucky will reimburse the direct, out-of-pocket expenses Gannett Fleming incurs in the course of performing services in connection with this engagement, such as travel expenses, copy charges, research costs, and long-distance telephone charges.

5. Gannett Fleming acknowledges and agrees that all information (whether printed, electronic, oral, or otherwise) that Gannett Fleming sends, generates, and receives in the course of this engagement shall be confidential, and shall not be disclosed to any third party without the express consent of Duke Energy Kentucky or its attorneys. Gannett Fleming will use such confidential information solely in connection with this engagement, and for no other purpose.

6. You may also be receiving certain confidential documents produced in discovery in this matter. If a protective order is entered governing the use of such documents, you agree that you and your staff will abide by its terms.

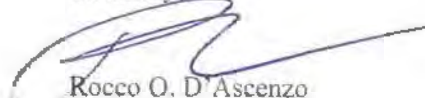
7. Duke Energy Kentucky may terminate this agreement at any time by providing Gannett Fleming with written notice of termination, in which event Gannett Fleming will be paid for amounts owed through the date of termination. Because of the importance of Gannett Fleming's services to Duke Energy Kentucky in relation to cases as a testifying expert, Gannett Fleming may only terminate this engagement for good cause and by giving Duke Energy Kentucky at least thirty (30) days prior written notice and opportunity to cure any curable default that may exist. The confidentiality provisions of this agreement survive any termination hereof.

8. Gannett Fleming will act as an independent contractor. Gannett Fleming's compensation is not contingent in any way upon its conclusions.

To accept this proposal, please execute this letter where indicated below and return it to me via my e-mail address listed above. Please do not hesitate to contact me if you have any questions, or if there are any further issues we need to discuss.

Thank you for your assistance in this matter and I look forward to working with you.

Sincerely,



Rocco O. D'Ascenzo

cc: John Spanos (w/enclosures)

AGREED AND ACCEPTED:

Gannett Fleming Valuation and Rate Consultants, LLC

JOHN J. SPANOS, SENIOR VICE PRESIDENT
DATE: JANUARY 12, 2018

626270

ATTACHMENT A
Page 1 of 1

GANNETT FLEMING VALUATION AND RATE CONSULTANTS, LLC

BILLING RATES

Personnel	Hourly Rate
SUPERVISORY STAFF	
W. M. Stout, Principal Consultant	$300.00
P. R. Herbert, Chairman and President	265.00
J. J. Spanos, Senior Vice President and Treasurer	260.00
C. R. Clarke, Director, Western U.S. Services	255.00
H. Walker, III, Manager, Financial Studies	235.00
J. F. Wiedmayer, Jr., Project Manager, Depreciation	210.00
C. E. Heppenstall, Project Manager, Rate Studies	185.00
N. W. Allis, Project Manager, Depreciation & Technical Development	185.00
STAFF	
Analysts and Engineers	170.00
Associate Analysts and Engineers	160.00
Assistant Analysts and Engineers	145.00
Senior Technicians	110.00
Support Staff	110.00

Matter Assignment

Pursuant to Outside Counsel Services Agreement Dated 12-10-2014

Date: May 11, 2018

To: David Samford
Firm: Goss Samford, PLLC
Address: 2365 Harrodsburg Road, Suite B-325
Lexington, KY 40504

Subject: Matter Assignment – KyPSC Case No. 2018-XXX Gas Rate Case
Duke Energy Matter Reference No.: 2018-LIT-009417

The Firm is retained to represent Duke Energy Corporation's interest and render advice with respect to the following:

Scope of Services: Expertise in Litigating Rate Cases before PSC

Modifications to the terms and conditions of Outside Counsel Engagement Agreement (if any):

Duke Energy Attorney: Rocco D'Ascenzo

Address:
139 East Fourth Street
Cincinnati, Ohio 45202

Email: rocco.d'ascenzo@duke-energy.com
Phone #:513-287-4320
Fax #:513-287-4385

Signature: ______________________

Agreed to and accepted by:

Goss Samford PLLC (the "Firm")

By: ______________________ (the "Firm Attorney")
Printed Name: David Samford
Email: david@gosssamfordlaw.com
Phone #: 859-368-7740
Fax #: 859-806-6567
Date: 5-15-18

UTILITY RESEARCH INTERNATIONAL

Utility Financial Consultants

Roger A. Morin
PO Box 13003
Jekyll Island, GA 31527

912-635-3233 office
404-229-2857 cell
profmorin@mac.com

July 10th, 2018

Duke Energy Kentucky

ATT.: Rocco O. D'Ascenzo

Associate General Counsel

Dear Rocco:

Following our recent telephone conversations, I am delighted that you have decided to retain my professional services to assist you and your company in your upcoming 2018 retail filing in the State of Kentucky on behalf of Duke Energy Kentucky. My mandate will consist of submitting expert testimony in the determination of a fair and reasonable rate of return on equity (ROE) for use in the Company's electric utility business in the State of Kentucky under current capital market conditions.

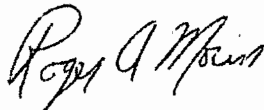
My professional honorarium for this expert testimony is a flat fee of $60,000. In the eventuality of a settlement prior to formal hearings and prior to the submission of rebuttal testimony, a rebate of $15,000 is applicable for a net fee of $45,000. In the eventuality of a settlement prior to formal hearings but after the completion of rebuttal testimony, a rebate of $10,000 is applicable for a net fee of $50,000. Traveling, computer databases, and clerical expenses will be compensated as well. The all-in fee includes: review of the company's financial situation, review of current docket and witness filings, analysis of prior relevant commission orders and policies, preparation of rate of return testimonies and exhibits, preparation of rebuttal testimony of one or two witnesses, assistance to legal counsels in cross-examination, and testimonial time. Updates to the filed testimony, rebuttal testimonies of more than two witnesses, and sur-rebuttal testimony, if required, will be billed on a per diem basis at the rate of $3,000.

It is my normal practice to require an immediate partial retainer payment (statement enclosed) of roughly one half of total estimated billing inclusive of expenses, or $31,000, and the balance upon the completion of the work.

It is understood that the work I perform was requested by you will be submitted to you as Associate General Counsel for Duke Energy Kentucky in preparation of litigation and thus will be subject to the applicable protections and confidentiality. It is also understood that any information you provide to me will be treated as confidential and privileged as part of the preparation of the legal proceeding in Kentucky. Upon the conclusion of this proceeding, I will return the written materials provided to me on behalf of Duke Energy Kentucky. Alternatively, I will properly dispose of the materials and provide you with written confirmation of their destruction.

With enthusiasm and anticipation, I look forward to working with you and your excellent staff. I welcome the opportunity and the challenges of working in the Kentucky jurisdiction again where I have enjoyed professional successes in past years. I trust the enclosed meets with your satisfaction. I look forward to meeting you and the rate case team in person.

Sincerely,



Roger A. Morin, PhD
Emeritus Professor of Finance
Distinguished Professor of Finance for Regulated Industry

STAFF-DR-01-059

REQUEST:

Provide the following information for the most recent calendar year concerning Duke Kentucky and any affiliated service corporation or corporate service division/unit:

a. A schedule detailing the costs, those directly charged, and those allocated by, Duke Kentucky to the service corporation. Indicate Duke Kentucky's accounts where these costs were originally recorded. For costs that are allocated, include a description of the allocation factors utilized.

b. A schedule detailing the costs, those directly charged, and those allocated by, the service corporation to Duke Kentucky. Identify Duke Kentucky's accounts where these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

RESPONSE:

a. There were no charges from Duke Kentucky to the Service Corporation.

b. See STAFF-DR-01-059(b) Attachment.

PERSON RESPONSIBLE: Jeffrey R. Setser

STAFF-DR-01-059(b)
EXCEL
ATTACHMENT

PROVIDED ON CD

2017 DEBS to DE Kentucky Gas

Account	Method	Allocated	Direct	Grand Total
107000	Customers	190,859.94		190,859.94
	Direct		11,822,654.98	11,822,654.98
108620	Direct		24,947.54	24,947.54
163110	Direct		138,244.20	138,244.20
	Procurement	219,110.23		219,110.23
183000	Direct		96.03	96.03
186120	Direct		(1,609,838.65)	(1,609,838.65)
408040	Three Factor Formula	28,478.82		28,478.82
408120	Three Factor Formula	11.39		11.39
408121	Three Factor Formula	135.73		135.73
408151	Three Factor Formula	121.24		121.24
408205	Three Factor Formula	39.84		39.84
408470	Three Factor Formula	4,623.64		4,623.64
408800	Three Factor Formula	161.13		161.13
408820	Three Factor Formula	2.71		2.71
408851	Three Factor Formula	(66.86)		(66.86)
408960	Construction	3.13		3.13
	CPU Seconds (MIPS)	1,514.51		1,514.51
	Customers	49,376.48		49,376.48
	Direct		174,939.60	174,939.60
	Employees	5,591.45		5,591.45
	Procurement	1,409.84		1,409.84
	Sales	199.72		199.72
	Servers	4,271.38		4,271.38
	Square Footage	2,387.35		2,387.35
	Three Factor Formula	28,771.16		28,771.16
	Workstations	7,407.89		7,407.89
415100	Direct		(400.00)	(400.00)
417000	Square Footage	(1.57)		(1.57)
417007	Employees	11.90		11.90
	Square Footage	(413.88)		(413.88)
417310	Direct		(74,489.81)	(74,489.81)
417320	Customers	293.41		293.41
	Square Footage	2.96		2.96
419040	Interest	(5.84)		(5.84)
419240	Interest	(15.23)		(15.23)
421940	Three Factor Formula	(1,048.87)		(1,048.87)
426100	Customers	58.94		58.94
	Customers and Employees	-		-

Account	Allocation			
	Direct		150,336.95	150,336.95
	Employees	79.77		79.77
	Procurement	165.62		165.62
	Square Footage	1.79		1.79
	Three Factor Formula	2,653.62		2,653.62
426300	Three Factor Formula	0.87		0.87
426400	Customers and Employees	3,933.73		3,933.73
	Direct		172,392.74	172,392.74
	Square Footage	33.48		33.48
	Three Factor Formula	18,957.81		18,957.81
426510	Direct		34,850.00	34,850.00
426512	Direct		26,421.02	26,421.02
426540	Direct		735.90	735.90
	Employees	-		-
	Three Factor Formula	6.54		6.54
431000	Three Factor Formula	56.73		56.73
431400	Three Factor Formula	1,490.83		1,490.83
431550	Interest	29,662.36		29,662.36
432000	Three Factor Formula	(95.07)		(95.07)
454400	Employees	(277.98)		(277.98)
	Square Footage	(0.01)		(0.01)
500000	Employees	0.10		0.10
	Square Footage	0.17		0.17
	Three Factor Formula	75.59		75.59
	Workstations	0.04		0.04
506000	Direct		-	-
	Procurement	0.03		0.03
	Servers	0.98		0.98
	Three Factor Formula	248.89		248.89
	Workstations	11.42		11.42
511000	Three Factor Formula	3.00		3.00
514000	Three Factor Formula	21.34		21.34
520000	Three Factor Formula	0.03		0.03
524000	Employees	0.02		0.02
	Workstations	0.08		0.08
532100	Direct		311.00	311.00
	Three Factor Formula	1.47		1.47
535000	Three Factor Formula	4.81		4.81
539000	Three Factor Formula	0.18		0.18
542000	Three Factor Formula	0.29		0.29
546000	Employees	0.37		0.37
	Three Factor Formula	0.08		0.08
549000	Three Factor Formula	91.24		91.24
556000	Three Factor Formula	3.40		3.40
557000	Customers	41.27		41.27
	Direct		3,704.96	3,704.96

Account	Allocation			
	Square Footage	4.53		4.53
	Three Factor Formula	5.35		5.35
566000	Customers	11.02		11.02
	Square Footage	0.09		0.09
	Three Factor Formula	32.50		32.50
	Workstations	0.52		0.52
569100	Servers	74.32		74.32
	Workstations	107.51		107.51
569200	Direct		-	-
	Employees	0.22		0.22
	Servers	-		-
	Three Factor Formula	5.22		5.22
	Workstations	2.05		2.05
571000	Square Footage	11.14		11.14
	Three Factor Formula	2.95		2.95
580000	Workstations	0.07		0.07
581004	Employees	1.05		1.05
586000	Customers	513.29		513.29
587000	Direct		33.12	33.12
588100	Customers	70,306.11		70,306.11
	Direct		25,623.50	25,623.50
	Employees	1.09		1.09
	Three Factor Formula	51.22		51.22
	Workstations	38.75		38.75
589000	Square Footage	0.06		0.06
593000	Direct		5,840.86	5,840.86
	Three Factor Formula	0.30		0.30
717000	Direct		11,039.40	11,039.40
735000	Direct		7,377.74	7,377.74
742000	Direct		39,653.09	39,653.09
800000	Direct		156.78	156.78
807000	Direct		391,620.61	391,620.61
813001	Direct		0.00	0.00
850001	Direct		2,715.93	2,715.93
871000	Direct		155,691.51	155,691.51
874000	Direct		1,194,525.96	1,194,525.96
875000	Direct		95.81	95.81
876000	Direct		20,753.81	20,753.81
878000	Direct		1,773,591.84	1,773,591.84
879000	Direct		381,342.24	381,342.24
880000	Direct		1,428,131.78	1,428,131.78
885000	Three Factor Formula	0.20		0.20
887000	Direct		451,649.35	451,649.35
889000	Direct		41,327.83	41,327.83
892000	Direct		423,645.91	423,645.91
893000	Direct		264,027.92	264,027.92

Account	Allocation			
894000	Direct		16,972.21	16,972.21
901000	Direct		3,144.43	3,144.43
902000	Direct		75,642.91	75,642.91
903000	Construction	48.97		48.97
	Customers	1,074,657.78		1,074,657.78
	Direct		186,114.31	186,114.31
	Employees	6.38		6.38
	Square Footage	9.66		9.66
	Three Factor Formula	1,027.78		1,027.78
	Workstations	(53.35)		(53.35)
903100	Customers	2,059.61		2,059.61
	Direct		24,039.98	24,039.98
903200	Customers	51,267.21		51,267.21
	Direct		11,504.33	11,504.33
	Three Factor Formula	251.97		251.97
	Workstations	1.34		1.34
903300	Customers	1,599.75		1,599.75
	Direct		2,322.48	2,322.48
	Workstations	2.14		2.14
903400	Customers	1,671.60		1,671.60
	Three Factor Formula	0.85		0.85
904000	Direct		(1,391.00)	(1,391.00)
904001	Direct		83.51	83.51
	Square Footage	0.13		0.13
905000	Customers	75.52		75.52
908000	Employees	0.12		0.12
	Three Factor Formula	1.08		1.08
	Workstations	0.24		0.24
908160	Direct		139,341.48	139,341.48
909650	Direct		1,308.73	1,308.73
	Three Factor Formula	1.40		1.40
910000	Customers	5,698.25		5,698.25
	Direct		4,959.63	4,959.63
910100	Customers	10,977.74		10,977.74
	Direct		104,773.52	104,773.52
	Employees	116.09		116.09
	Three Factor Formula	239.46		239.46
	Workstations	1.58		1.58
911000	Workstations	18.79		18.79
912000	Customers	3.94		3.94
	Direct		65,863.02	65,863.02
	Square Footage	0.04		0.04
	Three Factor Formula	350.00		350.00
913001	Customers	1.23		1.23
	Three Factor Formula	1.31		1.31
920000	CPU Seconds (MIPS)	26,565.53		26,565.53

Account	Allocation			
	Customers	45,154.87		45,154.87
	Direct		504,705.33	504,705.33
	Employees	103,594.63		103,594.63
	Procurement	31,954.50		31,954.50
	Sales	3,292.32		3,292.32
	Servers	73,987.01		73,987.01
	Square Footage	41,115.52		41,115.52
	Three Factor Formula	640,950.46		640,950.46
	Workstations	127,765.63		127,765.63
921100	CPU Seconds (MIPS)	271.84		271.84
	Customers	6,385.96		6,385.96
	Customers and Employees	19.25		19.25
	Direct		31,195.98	31,195.98
	Employees	9,034.62		9,034.62
	Procurement	1,247.98		1,247.98
	Sales	1,246.30		1,246.30
	Servers	2,401.53		2,401.53
	Square Footage	9,201.61		9,201.61
	Three Factor Formula	34,034.71		34,034.71
	Workstations	4,502.64		4,502.64
921101	Square Footage	0.42		0.42
921110	Direct		964.12	964.12
	Employees	6.14		6.14
	Three Factor Formula	0.37		0.37
	Workstations	13.68		13.68
921200	CPU Seconds (MIPS)	12.55		12.55
	Customers	4,128.44		4,128.44
	Customers and Employees	69.46		69.46
	Direct		9,043.65	9,043.65
	Employees	61,330.37		61,330.37
	Procurement	279.32		279.32
	Sales	130.84		130.84
	Servers	5,754.77		5,754.77
	Square Footage	11,437.63		11,437.63
	Three Factor Formula	51,505.28		51,505.28
	Workstations	8,633.47		8,633.47
921300	Employees	63.74		63.74
921400	CPU Seconds (MIPS)	73,864.48		73,864.48
	Customers	14,217.43		14,217.43
	Direct		27,813.08	27,813.08
	Employees	5,340.35		5,340.35
	Procurement	3,109.59		3,109.59
	Sales	1.55		1.55
	Servers	66,039.55		66,039.55
	Square Footage	273.74		273.74
	Three Factor Formula	39,022.23		39,022.23

	Workstations	20,586.22		20,586.22
921540	CPU Seconds (MIPS)	28,665.82		28,665.82
	Customers	1,983.03		1,983.03
	Direct		920.29	920.29
	Employees	12,847.67		12,847.67
	Procurement	2,141.40		2,141.40
	Servers	79,671.93		79,671.93
	Square Footage	26.35		26.35
	Three Factor Formula	10,796.86		10,796.86
	Workstations	21,200.47		21,200.47
921600	Customers	713.82		713.82
	Servers	0.40		0.40
	Square Footage	4.51		4.51
	Three Factor Formula	35.75		35.75
921980	Customers	16.55		16.55
	Square Footage	67.91		67.91
	Three Factor Formula	439,094.14		439,094.14
	Workstations	0.30		0.30
922000	Employees	287.49		287.49
	Procurement	43.19		43.19
923000	CPU Seconds (MIPS)	4,583.10		4,583.10
	Customers	34,400.92		34,400.92
	Customers and Employees	122.73		122.73
	Direct		266,387.14	266,387.14
	Employees	39,396.95		39,396.95
	Procurement	709.38		709.38
	Sales	25.72		25.72
	Servers	37,823.25		37,823.25
	Square Footage	21,175.13		21,175.13
	Three Factor Formula	566,661.12		566,661.12
	Workstations	77,366.07		77,366.07
923980	Square Footage	(19,058.70)		(19,058.70)
924000	Three Factor Formula	1,262.39		1,262.39
924980	Three Factor Formula	55,265.40		55,265.40
925000	Direct		19,972.70	19,972.70
	Three Factor Formula	2,253.34		2,253.34
925200	Three Factor Formula	2,484.46		2,484.46
925980	Three Factor Formula	4,296.60		4,296.60
926000	Customers	280.52		280.52
	Direct		-	-
	Employees	4.40		4.40
	Procurement	2,602.53		2,602.53
	Sales	34.35		34.35
	Square Footage	40.62		40.62
	Three Factor Formula	72,242.80		72,242.80
	Workstations	18.60		18.60

Account	Allocation			
926420	Three Factor Formula	10.94		10.94
926600	Construction	8.64		8.64
	CPU Seconds (MIPS)	4,388.34		4,388.34
	Customers	137,369.37		137,369.37
	Direct		503,881.57	503,881.57
	Employees	16,020.72		16,020.72
	Procurement	4,072.42		4,072.42
	Sales	563.18		563.18
	Servers	12,388.15		12,388.15
	Square Footage	6,851.33		6,851.33
	Three Factor Formula	77,587.19		77,587.19
	Workstations	21,183.57		21,183.57
928006	Direct		194,195.25	194,195.25
930150	Direct		1,871.07	1,871.07
	Three Factor Formula	5,551.04		5,551.04
930200	CPU Seconds (MIPS)	(4,089.38)		(4,089.38)
	Customers	40.94		40.94
	Direct		128,675.08	128,675.08
	Employees	(50,573.37)		(50,573.37)
	Gov OH	204,014.53		204,014.53
	Procurement	(2,341.28)		(2,341.28)
	Servers	(58,734.48)		(58,734.48)
	Square Footage	(15,446.65)		(15,446.65)
	Three Factor Formula	(15,306.93)		(15,306.93)
	Workstations	(70,793.77)		(70,793.77)
930210	Customers and Employees	21,983.19		21,983.19
930220	Three Factor Formula	(184.74)		(184.74)
930230	Direct		9,572.23	9,572.23
	Employees	169.44		169.44
	Three Factor Formula	771.51		771.51
930240	Employees	0.59		0.59
	Three Factor Formula	18,147.01		18,147.01
	Workstations	1.05		1.05
930250	Employees	55.75		55.75
	Procurement	184.30		184.30
	Servers	426.07		426.07
	Square Footage	4.29		4.29
	Three Factor Formula	7,052.16		7,052.16
	Workstations	685.82		685.82
930700	Three Factor Formula	1,320.70		1,320.70
930940	Direct		-	-
	Employees	9.64		9.64
	Square Footage	25.36		25.36
	Three Factor Formula	625.95		625.95
	Workstations	21.09		21.09
931001	Customers	188.75		188.75

	Direct		113,150.51	113,150.51
	Employees	15,378.28		15,378.28
	Procurement	1.26		1.26
	Square Footage	11,838.85		11,838.85
	Three Factor Formula	21,238.47		21,238.47
	Workstations	318.87		318.87
931008	Direct		277,546.33	277,546.33
935100	Direct		(2,358.66)	(2,358.66)
	Employees	7.52		7.52
	Square Footage	167.76		167.76
	Three Factor Formula	(504.94)		(504.94)
	Workstations	630.22		630.22
935200	Employees	377.18		377.18
	Workstations	0.71		0.71
Grand Total		5,225,520.01	20,205,966.66	25,431,486.67

STAFF-DR-01-060

REQUEST:

For the most recent calendar year, concerning all affiliate-related activities not identified in response to Item 59:

a. Provide the names of affiliates that provided some form of service to Duke Kentucky and the type of service Duke Kentucky received from each affiliate.

b. Provide the names of affiliates to whom Duke Kentucky provided some form of service and the type of service Duke Kentucky provided to each affiliate.

c. Identify the service agreement with each affiliate, state whether the service agreement has been previously filed with the Commission, and identify the proceeding in which it was filed. Provide each service agreement that has not been previously filed with the Commission.

RESPONSE:

a. Please refer to FERC Form 2 Page 358 included as STAFF-DR-01-060 Attachment.

b. Please refer to FERC Form 2 Page 358 included as STAFF-DR-01-060 Attachment.

c. Please refer to the direct testimony of Jeffrey Setser and the Cost Allocation Manual included with our application

PERSON RESPONSIBLE: Michael Covington – a., b.
Jeffrey R. Setser – c.

Name of Respondent	This Report Is:	Date of Report (Mo, Da, Yr)	Year/Period of Report
Duke Energy Kentucky, Inc.	(1) [X] An Original (2) [ ] A Resubmission	04/12/2018	End of 2017/Q4

Transactions with Associated (Affiliated) Companies

1. Report below the information called for concerning all goods or services received from or provided to associated (affiliated) companies amounting to more than $250,000.
2. Sum under a description "Other", all of the aforementioned goods and services amounting to $250,000 or less.
3. Total under a description "Total", the total of all of the aforementioned goods and services.
4. Where amounts billed to or received from the associated (affiliated) company are based on an allocation process, explain in a footnote the basis of the allocation.

Line No.	Description of the Good or Service (a)	Name of Associated/Affiliated Company (b)	Account(s) Charged or Credited (c)	Amount Charged or Credited (d)
1	Goods or Services Provided by Affiliated Company			
2	Services provided by Duke Energy Business Services	Duke Energy Business Services, LLC	Various	128,253,754
3	Customer and Market Services	Duke Energy Ohio, Inc.	Various	1,576,137
4	Gas Distribution Services	Duke Energy Ohio, Inc.	Various	3,996,945
5	Other Goods and Services	Duke Energy Ohio, Inc	Various	30,144
6	Transmission and Distribution Services	Duke Energy Ohio, Inc.	Various	12,879,391
7	Customer and Market Services	Duke Energy Florida, LLC	Various	66,892
8	Generation Services	Duke Energy Florida, LLC	Various	37,560
9	Other Goods and Services	Duke Energy Florida, LLC	Various	54,931
10	Transmission and Distribution Services	Duke Energy Florida, LLC	Various	92,963
11	Customer and Market Services	Duke Energy Carolinas, LLC	Various	5,447,988
12	Generation Services	Duke Energy Carolinas, LLC	Various	13,030,245
13	Other Goods and Services	Duke Energy Carolinas, LLC	Various	1,796,092
14	Transmission and Distribution Services	Duke Energy Carolinas, LLC	Various	2,642,573
15	Customer and Market Services	Duke Energy Progress, LLC	Various	299,400
16	Generation Services	Duke Energy Progress, LLC	Various	317,354
17	Other Goods and Services	Duke Energy Progress, LLC	Various	210,846
18	Transmission and Distribution Services	Duke Energy Progress, LLC	Various	262,275
19				
20	Goods or Services Provided for Affiliated Company			
21	Customer and Market Services	Duke Energy Florida, LLC	Various	43,870
22	Gas Distribution Services	Duke Energy Florida, LLC	Various	42,400
23	Generation Services	Duke Energy Florida, LLC	Various	4,782
24	Transmission and Distribution Services	Duke Energy Florida, LLC	Various	466,354
25	Customer and Market Services	Duke Energy Indiana, LLC	Various	106
26	Gas Distribution Services	Duke Energy Indiana, LLC	Various	20,188
27	Generation Services	Duke Energy Indiana, LLC	Various	1,237,556
28	Other Goods and Services	Duke Energy Indiana, LLC	Various	73
29	Transmission and Distribution Services	Duke Energy Indiana, LLC	Various	(23,341)
30	Customer and Market Services	Duke Energy Ohio, Inc.	Various	220,255
31	Gas Distribution Services	Duke Energy Ohio, Inc.	Various	815,197
32	Generation Services	Duke Energy Ohio, Inc.	Various	277
33	Other Goods and Services	Duke Energy Ohio, Inc.	Various	493,000
34	Transmission and Distribution Services	Duke Energy Ohio, Inc.	Various	1,005,967
35	Duke Energy Kentucky Provided Services to KO Transmission Company	KO Transmission Company	Various	1,403,981
36				
37				
38				
39				
40				

Name of Respondent Duke Energy Kentucky, Inc.	This Report Is: (1) [X] An Original (2) [ ] A Resubmission	Date of Report (Mo, Da, Yr) 04/12/2018	Year/Period of Report End of 2017/Q4

Transactions with Associated (Affiliated) Companies (continued)

Line No.	Description of the Good or Service (a)	Name of Associated/Affiliated Company (b)	Account(s) Charged or Credited (c)	Amount Charged or Credited (d)
1	Goods or Services Provided by Affiliated Company			
2	Customer and Market Services	Duke Energy Indiana, LLC	Various	170,328
3	Generation Services	Duke Energy Indiana, LLC	Various	12,485,079
4	Other Goods and Services	Duke Energy Indiana, LLC	Various	54,151
5	Transmission and Distribution Services	Duke Energy Indiana, LLC	Various	42,792
6				
7	Gas Distribution Services	Piedmont Natural Gas Company, Inc.	Various	545,803
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20	Goods or Services Provided for Affiliated Company			
21				
22				
23				
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26				
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38				
39				
40				

Name of Respondent	This Report is:	Date of Report (Mo, Da, Yr)	Year/Period of Report
Duke Energy Kentucky, Inc.	(1) X An Original (2) _ A Resubmission	04/12/2018	2017/Q4

FOOTNOTE DATA

Schedule Page: 358 Line No.: 2 Column: a

When an employee of the Service Company performs services for a Client Company, costs will be directly assigned or distributed or allocated. For allocated services, the allocation method will be on a basis reasonably related to the service performed. The Service Company Utility Service Agreement prescribes 23 Service Company functions and approximately 20 allocation methods.

Functions and Allocation Methods:

Information Systems
- Number of Central Processing Unit Seconds Ratio/Millions of Instructions per Second
- Number of Personal Computer Workstations Ratio
- Number of Information Systems Servers Ratio
- Number of Employees Ratio

Meters
- Number of Customers Ratio

Transportation
- Number of Employees Ratio
- Three Factor Formula

Electric System Maintenance
- Circuit Miles of Electric Transmission Lines Ratio
- Circuit Miles of Electric Distribution Lines Ratio

Marketing and Customer Relations and Grid Solutions
- Number of Customers Ratio

Electric Transmission & Distribution Engineering & Construction
- Electric Transmission Plant's Construction - Expenditures Ratio
- Electric Distribution Plant's Construction - Expenditures Ratio

Power Engineering & Construction
- Electric Production Plant's Construction - Expenditures Ratio

Human Resources
- Number of Employees Ratio

Supply Chain
- Procurement Spending Ratio
- Inventory Ratio

Facilities
- Square Footage Ratio

Accounting
- Three Factor Formula
- Generating Unit MW Capability Ratio

Power Planning and Operations
- Electric Peak Load Ratio
- Weighted Avg of the Circuit Miles of Electric Distribution Lines Ratio and the Electric Peak Load Ratio
- Sales Ratio
- Weighted Avg of the Circuit Miles of Electric Transmission Lines Ratio and the Electric Peak Load Ratio
- Generating Unit MW Capability Ratio

Public Affairs
- Three Factor Formula
- Weighted Avg of Number of Customers Ratio and Number of Employees Ratio

Legal
- Three Factor Formula

Rates
- Sales Ratio

Finance
- Three Factor Formula

Rights of Way
- Circuit Miles of Electric Transmission Lines Ratio

Name of Respondent	This Report is:	Date of Report	Year/Period of Report
Duke Energy Kentucky, Inc.	(1) X An Original (2) _ A Resubmission	(Mo, Da, Yr) 04/12/2018	2017/Q4

FOOTNOTE DATA

- Circuit Miles of Electric Distribution Lines Ratio
- Electric Peak Load Ratio

Internal Auditing

- Three Factor Formula

Environmental, Health and Safety

- Three Factor Formula
- Sales Ratio

Fuels

- Sales Ratio

Investor Relations

- Three Factor Formula

Planning

- Three Factor Formula

Executive

- Three Factor Formula

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-061

REQUEST:

Describe Duke Kentucky's lobbying activities and provide a schedule showing the name, salary, and job title of each individual whose job function involves lobbying on the local, state, or national level.

RESPONSE:

Duke Energy Business Services (DEBS) employs lobbyists, some of whom are registered lobbyists with the Kentucky Legislative Ethics Commission. The following DEBS employees charge a portion of their time to lobbying activities:

Name	Title	Registered Lobbyist
Amy Spiller	President Duke Energy Ohio and Kentucky	No
Patrick Keal	Senior Government Affairs Specialist	Yes
Chuck Session	VP Government Affairs	Yes

These employees also have other job responsibilities so only a portion of their time is charged to lobbying activities. Duke Energy Kentucky's gas business is allocated labor expense for these employees based on the amount of time they devote to Duke Energy Kentucky gas-related matters.

Duke Energy Kentucky has also retained third party consultants to provide lobbying activities on its behalf.

Any charge related to lobbying activities is recorded to Duke Energy Kentucky's below-the-line expense and therefore is not included in the forecasted test period in this case.

PERSON RESPONSIBLE: William Don Wathen Jr.

STAFF-DR-01-062

REQUEST:

Regarding demand-side management, conservation, and energy-efficiency programs, provide the following:

a. A list of all programs currently offered by Duke Kentucky.

b. The total cost incurred for these programs by Duke Kentucky in each of the three most recent calendar years.

c. The total energy and demand reductions realized through these programs in each of the three most recent calendar years, the total cost for these programs included in the proposed forecasted test period, and the expected energy reductions to be realized therefrom.

RESPONSE:

a. Gas DSM and other gas-related programs currently offered are:

- Low Income Services
- Home Energy Assistance Pilot Program

b. Duke Energy Kentucky's DSM programs operate on a July – June cost cycle. The DSM program costs that were allocated to gas from the three most recent DSM filings are:

- 7/2016 to 6/2017: $354,668
- 7/2015 to 6/2016: $389,296

- 7/2014 to 6/2015: $381,836

c. Duke Energy Kentucky does not calculate or estimate gas savings resulting from its gas-related DSM programs.

The costs of these programs are not included in the forecasted test period.

PERSON RESPONSIBLE: James E. Ziolkowski

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-063

REQUEST:

Regarding what are commonly referred to as smart grid initiatives:

a. Identify all smart-grid costs Duke Kentucky has incurred since the start of the test year in its last general rate case. Identify the specific projects Duke Kentucky has undertaken and the accounts in which the costs have been recorded, and state whether the costs were expensed or capitalized.

b. Provide the level of smart-grid costs Duke Kentucky has included in its forecasted test period and the amounts to be expensed and capitalized.

RESPONSE:

a. See Pages 1 and 2 of STAFF-DR-01-063 Attachment for gas smart grid costs that Duke Energy Kentucky incurred from the start of the test year in its last general rate case (February 2010) through the end of June 2018.

b. See Page 3 of STAFF-DR-01-063 Attachment for gas smart grid costs that Duke Energy Kentucky has included in its forecasted test period.

PERSON RESPONSIBLE: Robert H. "Beau" Pratt
Gary J. Hebbeler

STAFF-DR-01-063
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy KY - Gas $ in Millions	**Capital** Feb 2010 - June 2018	**O&M** Feb 2010 - June 2018
Duke Energy Kentucky Gas Smart Grid Costs	8.85	0.36
GS AMI	8.85	0.08
Smart Grid Operations Support Costs	0.00	0.28

* Costs did not begin until 2015.

Duke Energy Kentucky Gas Smart Grid Costs by Account — February 2010 - June 2018

Projects	Project Short Descr CB	107000 SCHM Cwip	408960 Allocated Payroll Taxes	419110 Afudc Equity Component	432000 Afudc Debt Component	588100 Misc Distribution Exp-Other	593000 Maint Overhd Lines-Other-Dist	880000 Gas Distribution-Other Expense	920000 A & G Salaries	921100 Employee Expenses	921200 Office Expenses	921400 Computer Services Expenses	923000 Outside Services Employed	926600 Employee Benefits-Transferred	930200 Misc General Expenses	930250 Buy\Sell Transf Employee Homes	Grand Total
GS AMI	DEE Openway Security Enhancements	6,381.08	23.32			139.63								10.08			**6,554.11**
	ITRON SG Solutions Program	0.07															**0.07**
	MDM Operational Enhancements		23.21			409.05					0.31			32.53			**465.10**
	Systems Adjustments to AFUDC for Asset In-Servicing			(73,208.87)													**(73,208.87)**
	SG 358 - DEE MDM Scale - SGG Licens	21,188.53	0.17			56.58											**21,245.28**
	SG 358 - DEE MDM Scale CA Lisa SW	5,351.31	1.00			760.18								2.77			**6,115.26**
	SG 358 - DEE MDM Scale Hardware 16	72,533.24	202.69			5,648.21					1.47			352.62			**78,738.23**
	SG 358 - MDM Scale Hardware Phase 3	70,730.14	158.03			2,834.83			81.12	2.73			131.56	244.81			**74,183.22**
	SG DEE MDM SCALE 358 - Agility Cost		20.08			236.56			0.27				0.10	15.01			**272.02**
	SG DEE MDM Scale HWre Phase 4 - 358	1,589.94	5.57			3.51			6.01				20.77	0.34			**1,626.14**
	SG DEE MDM Scale Sftwre Phs 4 - 358	4,800.35	35.36			116.88			200.42	18.35			60.69	43.14			**5,275.19**
	SG DEE MDM Scale Software 1	16,330.53	281.00			15,987.83								221.16			**32,820.52**
	SG DEE Openway AMI Scale - 489	18,415.26	101.53			2,689.20			76.60					15.63			**21,298.22**
	SG DEE Openway Scale 2016 - Servers	2,369.93	2.71			42.10											**2,414.74**
	SG DEE Openway Scale Servers	26,960.19	3.20			38.32								0.92			**27,002.63**
	SG Grid Strategy		24.63			1,001.16				22.87				41.40			**1,090.06**
	SG KY AMI Gas Meters - 169	8,669,437.92	5.73				46,304.32			129.09				13.86			**8,715,890.92**
	SG MDM Mass Market Project 2	534.62				0.01											**534.63**
	SG MDM Mass Market Software	0.10				0.02											**0.12**
	SG MDM Usage Hub Software	0.04															**0.04**
	SG NINT1021A - SERVERS	5.79															**5.79**
	SG Openway Software Upgrade to 6.1	7,303.31															**7,303.31**
	Smart Grid to SG Capital - PMO	(662.79)															**(662.79)**
GS AMI Total		**8,923,269.56**	**888.23**	**(73,208.87)**	**-**	**29,964.07**	**46,304.32**	**-**	**364.42**	**173.04**	**1.78**	**-**	**213.12**	**994.27**	**-**	**-**	**8,928,963.94**
Smart Grid Operations Support Costs	Grid Solutions Base O&M		2,340.85			1,590.97			36,124.68	8,709.95	7,402.40	831.72	28,626.05	6,297.88		292.28	**92,216.78**
	GL Account Corrections		2,115.07		(24,656.19)	(304,568.16)	(46,594.73)	177,768.21	33,454.88	1,948.70	1,704.10	781.18	14,481.49	6,217.89	173,431.11	1,740.69	**37,824.24**
	SG Grid Strategy O&M		120.93			1,112.92				26.34				223.29			**1,483.48**
	SG IT Development Kentucky Gas		3.92			64.70								7.10			**75.72**
	SG Reporting & Support		4,452.24			87,950.72			767.61	14.76	9.41		454.43	12,725.48			**106,374.65**
	Smart Grid Development O&M		113.65						1,821.71	111.87			423.69	242.70			**2,713.62**
	Smart Grid IT O&M - DEK Gas					15,244.69											**15,244.69**
	Smart Grid to SG O&M (PMO)		360.30						4,793.04	124.63	30.67	2.48	14,963.63	875.43			**21,150.18**
	Smart Grid Transitional Serv O&M		129.13						2,156.37	32.95		(2,427.92)	(1,205.40)	328.78			**(986.09)**
Smart Grid Operations Support		**-**	**9,636.09**	**-**	**(24,656.19)**	**(198,604.16)**	**(46,594.73)**	**177,768.21**	**79,118.29**	**10,969.20**	**9,146.58**	**(812.54)**	**57,743.89**	**26,918.55**	**173,431.11**	**2,032.97**	**276,097.27**
Grand Total		8,923,269.56	10,524.32	(73,208.87)	(24,656.19)	(168,640.09)	(290.41)	177,768.21	79,482.71	11,142.24	9,148.36	(812.54)	57,957.01	27,912.82	173,431.11	2,032.97	9,205,061.21

Duke Energy KY - Gas	**Capital**	**O&M**
$ in Millions	12 Months	12 Months
Duke Energy Kentucky Gas Smart Grid Costs	0.33	0.23
GS AMI	0.00	0.00
Smart Grid Operations Support Costs	0.00	0.23
Gas System Control and Distribution Automation (SCADA) System	0.33	0.00

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-064

REQUEST:

To the extent not included in other responses, provide all work papers, calculations, and assumptions Duke Kentucky used to develop its forecasted test period financial information.

RESPONSE:

Refer to FR 16(7)(c) in the Company's Application in this proceeding for the assumptions used to develop the forecasted test period financial information [Vol. 1, Tab 23].

Refer to Volume 12 of Duke Energy Kentucky's Application in this proceeding for the work papers used to develop its forecasted test period financial information.

PERSON RESPONSIBLE: Sarah E. Lawler
Robert H. "Beau" Pratt
Cynthia S. Lee

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-065
(As to Attachment Only)

REQUEST:

Provide the information requested in Schedule 65 for yearly salary and benefit information for each corporate officer and as a group in total by category of Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly for the years 2013 through 2016 and the base period (in gross dollars-not hourly or monthly rates). Commission Staff will provide Schedule 65 in Excel format by electronic mail to Counsel for all parties.

a. Regular salary or pay.

b. Overtime pay.

c. Excess vacation payout.

d. Standby/Dispatch pay.

e. Bonus and incentive pay.

f. Any other forms of incentives (may include stock options or forms of deferred compensation).

g. Other amounts paid and reported on the employees' W-2 (specify).

h. Healthcare benefit cost for employees.

(1) Amount paid by the employer.

(2) Amount paid by the employee.

i. Dental benefits cost for employees.

(1) Amount paid by the employer.

(2) Amount paid by the employee.

j. Vision benefits cost for employees.

(1) Amount paid by the employer.

(2) Amount paid by the employee.

k. Life insurance cost for employees.

(1) Amount paid by the employer.

(2) Amount paid by the employee.

l. Accidental death and disability benefits.

(1) Amount paid by the employer.

(2) Amount paid by the employee.

m. Defined Contribution - 401 (k) or similar plan cost for employees. Provide the amount paid by the employer.

n. Defined Benefit Retirement cost for employees.

(1) Amount paid by the employer.

(2) Amount paid by the employee.

o. Cost of any other benefit available to an employee (specify).

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment Only)

See STAFF-DR-01-065 Confidential Attachment, which is being filed under seal of a Petition for Confidential Treatment.

PERSON RESPONSIBLE: Renee H. Metzler

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2018-00261
Salary & Benefit Data by Employee　　*Year*　*2013*

Employee Name	Title	Regular	Overtime	Excess Vacation Payroll	Standby	Bonus	Other	**Sub-Total**
Corporate Officers								
Total Amount		$ 5,894,870.62	$ -	$ -	$ -	$ 3,780,559.80	$ 11,693,049.08	$ 21,368,479.50
Andrea Bertone	President Duke Energy Intl							
William E Currens, Jr	VP Investor Relations							
Stephen G DeMay	VP Treasurer	$ 307,642.04						
Douglas F Esamann	State President-IN							
Lynn J Good	Pres, CEO & Vice Chair of BOD	$ 929,166.68	$ -	$ -	$ -	$ 648,400.98	$ 2,492,787.93	$ 4,070,355.59
James P Henning	State President-OH/KY	$ 235,750.00						
Dhiaa M Jamil	Exec VP DE & Pres DE Nuclear	$ 633,333.48	$ -	$ -	$ -	$ 558,004.38	$ 1,764,287.94	$ 2,955,625.80
Julia S Janson	EVP & Chief Legal Officer	$ 460,000.08						
A R Mullinax	VP Chief Information Officer	$ 405,622.48						
Brian D Savoy	VP ChiefAcctingOff&Controller	$ 231,863.44						
Jennifer L Weber	Exec VP&ChiefHumanResourcesOff	$ 500,833.40	$ -	$ -	$ -	$ 400,304.49	$ 1,312,068.22	$ 2,213,206.11
Gregory C Wolf	President DE Renewables							
Lloyd M Yates	Exec VP Regulated Utilities	$ 581,461.55	$ -	$ -	$ -	$ 372,516.09	$ 1,058,802.36	$ 2,012,780.00
Steven K Young	EVP & CFO	$ 409,764.39	$ -	$ -	$ -	$ 208,789.17	$ 592,133.84	$ 1,210,687.40
$ Allocated to Kentucky								
Andrea Bertone	President Duke Energy Intl	$ -	$ -	$ -	$ -	$ -	$ -	$ -
William E Currens, Jr	VP Investor Relations	$ 2,213.57	$ -	$ -	$ -	$ 1,105.50	$ 2,413.92	$ 5,733.00
Stephen G DeMay	VP Treasurer	$ 3,507.12	$ -	$ -	$ -	$ 2,229.05	$ 5,271.78	$ 11,007.95
Douglas F Esamann	State President-IN	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lynn J Good	Pres, CEO & Vice Chair of BOD	$ 10,592.50	$ -	$ -	$ -	$ 7,391.77	$ 28,417.78	$ 46,402.05
James P Henning	State President-OH/KY	$ 16,493.07	$ -	$ -	$ -	$ 5,636.07	$ 8,694.67	$ 30,823.81
Dhiaa M Jamil	Exec VP DE & Pres DE Nuclear	$ 4,040.67	$ -	$ -	$ -	$ 3,560.07	$ 11,256.16	$ 18,856.89
Julia S Janson	EVP & Chief Legal Officer	$ 5,244.00	$ -	$ -	$ -	$ 2,521.29	$ 8,555.90	$ 16,321.19
A R Mullinax	VP Chief Information Officer	$ 7,666.26	$ -	$ -	$ -	$ 5,359.95	$ 21,305.35	$ 34,331.57
Brian D Savoy	VP ChiefAcctingOff&Controller	$ 2,643.24	$ -	$ -	$ -	$ 1,311.43	$ 2,709.15	$ 6,663.82
Jennifer L Weber	Exec VP&ChiefHumanResourcesOff	$ 3,505.83	$ -	$ -	$ -	$ 2,802.13	$ 9,184.48	$ 15,492.44
Gregory C Wolf	President DE Renewables	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lloyd M Yates	Exec VP Regulated Utilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Steven K Young	EVP & CFO	$ 4,671.31	$ -	$ -	$ -	$ 2,380.20	$ 6,750.33	$ 13,801.84
KY Jurisdictional Retail Amount		$ 60,577.58	$ -	$ -	$ -	$ 34,297.45	$ 104,559.53	$ 199,434.56
Managers								
Total Amount								
KY Jurisdictional Retail Amount								
Supervisors								
Total Amount		$ 504,058.18	$ -	$ -	$ -	$ 59,552.05	$ -	$ 563,610.23
KY Jurisdictional Retail Amount		$ 504,058.18	$ -	$ -	$ -	$ 59,552.05	$ -	$ 563,610.23
Exempt								
Total Amount		$ 192,895.08	$ -	$ -	$ -	$ 19,545.72	$ -	$ 212,440.80
KY Jurisdictional Retail Amount		$ 192,895.08	$ -	$ -	$ -	$ 19,545.72	$ -	$ 212,440.80
Non-Exempt								
Total Amount								
KY Jurisdictional Retail Amount								
Union								
Total Amount		$ 12,006,042.38	$ 3,271,318.46	$ 2,642.52	$ -	$ 384,591.49	$ 343,723.48	$ 16,008,318.33
KY Jurisdictional Retail Amount		$ 12,006,042.38	$ 3,271,318.46	$ 2,642.52	$ -	$ 384,591.49	$ 343,723.48	$ 16,008,318.33
Total Amount		$ 18,597,866.26	$ 3,271,318.46	$ 2,642.52	$ -	$ 4,244,249.06	$ 12,036,772.56	$ 38,152,848.86
KY Jurisdictional Retail Amount		$ 12,763,573.22	$ 3,271,318.46	$ 2,642.52	$ -	$ 497,986.71	$ 448,283.01	$ 16,983,803.92

Employee Name	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Benefit Retirement (401K)		Other Benefits		**Subtotal**	
	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	**Duke**	**Employee**
Total Amount	$ 2,375,678.19	$ 650,512.67	$ 173,899.44	$ 105,086.52	$ 354.65	$ 17,473.91	$ 47,167.01	$ 87,729.82	$ 4,423.36	$ 22,990.27	$ 745,780.82	$ 1,735,856.54	$ 94,118.53	$ 31,542.31	$ 3,441,422.00	$ 2,651,192.04
KY Jurisdictional Retail Amount	$ 2,375,678.19	$ 650,512.67	$ 173,899.44	$ 105,086.52	$ 354.65	$ 17,473.91	$ 47,167.01	$ 87,729.82	$ 4,423.36	$ 22,990.27	$ 745,780.82	$ 1,735,856.54	$ 94,118.53	$ 31,542.31	$ 3,441,422.00	$ 2,651,192.04

Benefit Costs:

(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.

(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.

(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.

(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2018-00261
Salary & Benefit Data by Employee *Year* *2014*

Employee Name	Title	Regular	Overtime	Excess Vacation Payroll	Standby	Bonus	Other	**Sub-Total**
Corporate Officers								
Total Amount		$ 6,469,861.60	$ -	$ -	$ -	$ 4,351,509.46	$ 13,191,323.03	$ 24,012,694.09
Andrea Bertone	President Duke Energy Intl	$ 349,344.36						
William E Currens, Jr	VP Investor Relations							
Stephen G DeMay	SVP Treasurer							
Douglas F Esamann	State President-IN							
Lynn J Good	Pres, CEO & Vice Chair of BOD	$ 1,200,000.00	$ -	$ -		$ 1,103,411.01	$ 2,595,318.96	$ 4,898,729.97
James P Henning	State President-OH/KY	$ 248,902.96						
Dhiaa M Jamil	EVP&Pres,Regulated Generation	$ 650,000.16	$ -	$ -		$ 528,048.11	$ 2,028,871.89	$ 3,206,920.16
Julia S Janson	EVP & Chief Legal Officer	$ 476,666.78						
A R Mullinax	EVP, Strategic Services	$ 429,321.38						
Brian D Savoy	SVP ChiefAcctingOff&Controller	$ 266,500.16						
Jennifer L Weber	EVP,Ext Affrs & Strtgc Policy	$ 505,000.08	$ -	$ -		$ 389,042.37	$ 1,330,000.68	$ 2,224,043.13
Gregory C Wolf	President DE Renewables							
Lloyd M Yates	EVP Mkt Sol & Pres,Carolinas	$ 585,833.38	$ -	$ -		$ 496,326.94	$ 2,666,165.45	$ 3,748,325.77
Steven K Young	EVP & CFO	$ 535,418.38	$ -	$ -		$ 265,839.90	$ 594,090.36	$ 1,395,348.64
$ Allocated to Kentucky								
Andrea Bertone	President Duke Energy Intl	$ -	$ -	$ -	$ -	$ -	$ -	$ -
William E Currens, Jr	VP Investor Relations	$ 2,311.38	$ -	$ -	$ -	$ 944.40	$ 1,400.21	**$ 4,655.98**
Stephen G DeMay	VP Treasurer	$ 3,513.92	$ -	$ -	$ -	$ 1,831.12	$ 4,893.77	**$ 10,238.81**
Douglas F Esamann	State President-IN	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lynn J Good	Pres, CEO & Vice Chair of BOD	$ 13,200.00	$ -	$ -	$ -	$ 12,137.52	$ 28,548.51	**$ 53,886.03**
James P Henning	State President-OH/KY	$ 27,429.11	$ -	$ -	$ -	$ 12,038.06	$ 9,750.89	**$ 49,218.06**
Dhiaa M Jamil	Exec VP DE & Pres DE Nuclear	$ 1,787.50	$ -	$ -	$ -	$ 1,452.13	$ 5,579.40	**$ 8,819.03**
Julia S Janson	EVP & Chief Legal Officer	$ 5,243.33	$ -	$ -	$ -	$ 3,737.52	$ 9,298.92	**$ 18,279.78**
A R Mullinax	VP Chief Information Officer	$ 12,793.78	$ -	$ -	$ -	$ 7,178.01	$ 28,172.16	**$ 48,143.94**
Brian D Savoy	VP ChiefAcctingOff&Controller	$ 2,931.50	$ -	$ -	$ -	$ 1,266.21	$ 1,603.55	**$ 5,801.26**
Jennifer L Weber	Exec VP&ChiefHumanResourcesOff	$ 3,535.00	$ -	$ -	$ -	$ 2,723.30	$ 9,310.00	**$ 15,568.30**
Gregory C Wolf	President DE Renewables	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lloyd M Yates	Exec VP Regulated Utilities	$ 6,444.17	$ -	$ -	$ -	$ 5,459.60	$ 29,327.82	**$ 41,231.58**
Steven K Young	EVP & CFO	$ 5,889.60	$ -	$ -	$ -	$ 2,924.24	$ 6,534.99	**$ 15,348.84**
KY Jurisdictional Retail Amount		$ 85,079.29	$ -	$ -	$ -	$ 51,692.10	$ 134,420.22	**$ 271,191.62**
Directors								
Total Amount								
KY Jurisdictional Retail Amount								
Managers								
Total Amount		$ 103,803.12	$ -	$ -		$ 15,699.55	$ -	**$ 119,502.67**
KY Jurisdictional Retail Amount		$ 103,803.12	$ -	$ -	$ -	$ 15,699.55	$ -	**$ 119,502.67**
Supervisors								
Total Amount		$ 521,529.76	$ 35,521.31	$ -		$ 56,647.66	$ 14,718.57	**$ 628,417.30**
KY Jurisdictional Retail Amount		$ 521,529.76	$ 35,521.31	$ -	$ -	$ 56,647.66	$ 14,718.57	**$ 628,417.30**
Exempt								
Total Amount		$ 381,451.12	$ 26,359.76	$ -		$ 28,878.22	$ -	**$ 436,689.10**
KY Jurisdictional Retail Amount		$ 381,451.12	$ 26,359.76	$ -	$ -	$ 28,878.22	$ -	**$ 436,689.10**
Non-Exempt								
Total Amount								
KY Jurisdictional Retail Amount								
Union								
Total Amount		$ 11,027,618.34	$ 3,582,179.67	$ 17,423.76		$ 216,342.27	$ 194,382.17	**$ 15,037,946.21**
KY Jurisdictional Retail Amount		$ 11,027,618.34	$ 3,582,179.67	$ 17,423.76	$ -	$ 216,342.27	$ 194,382.17	**$ 15,037,946.21**
Total Amount		$ 18,504,263.94	$ 3,644,060.74	$ 17,423.76	$ -	$ 4,669,077.16	$ 13,400,423.77	**$ 40,235,249.37**
KY Jurisdictional Retail Amount		$ 12,119,481.63	$ 3,644,060.74	$ 17,423.76	$ -	$ 369,259.80	$ 343,520.96	**$ 16,493,746.90**

Employee Name	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Benefit Retirement (401K)		Other Benefits		**Subtotal**	
	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	**Duke**	**Employee**
Total Amount	$ 1,813,841.94	$ 669,797.04	$ 109,537.14	$ 54,557.73	$ 170.39	$ 17,793.15	$ 26,540.55	$ 82,267.99	$ 2,399.25	$ 16,892.47	$ 734,373.17	$ 1,706,969.80	$ 75,683.47	$ 27,952.88	$ 2,762,545.91	$ 2,576,231.06
KY Jurisdictional Retail Amount	$ 1,813,841.94	$ 669,797.04	$ 109,537.14	$ 54,557.73	$ 170.39	$ 17,793.15	$ 26,540.55	$ 82,267.99	$ 2,399.25	$ 16,892.47	$ 734,373.17	$ 1,706,969.80	$ 75,683.47	$ 27,952.88	$ 2,762,545.91	$ 2,576,231.06

Benefit Costs:

(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.

(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.

(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.

(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2018-00261
Salary & Benefit Data by Employee

Year *2015*

Employee Name	Title	Regular	Overtime	Excess Vacation Payroll	Standby	Bonus	Other	Sub-Total
Corporate Officers								
Total Amount		$ 7,192,163.29	$ -	$ -	$ -	$ 3,705,872.98	$ 10,304,879.73	$ 21,202,916.00
Melissa H Anderson	SVP&ChiefHumanResourcesOff	$ 402,462.27						
Andrea Bertone	President Duke Energy Intl	$ 357,630.68						
William E Currens, Jr	VP Investor Relations							
Stephen G DeMay	SVP Treasurer	$ 329,546.16						
Douglas F Esamann	EVP & Pres, MW & FL Regions	$ 418,387.30						
Lynn J Good	Pres, CEO & Vice Chair of BOD	$ 1,225,757.66	$ -	$ -		$ 1,126,215.00	$ 2,752,908.01	$ 5,104,880.67
James P Henning	State President-OH/KY	$ 259,680.32						
Dhiaa M Jamil	EVP & Pres, Generation&Transm	$ 670,833.36	$ -	$ -		$ 387,634.09	$ 1,703,483.24	$ 2,761,950.69
Julia S Janson	EVP & Chief Legal Officer	$ 500,000.16						
A R Mullinax	EVP, Strategic Services	$ 450,000.00						
Brian D Savoy	SVP ChiefAcctingOff&Controller	$ 277,966.76						
Jennifer L Weber	EVP,Ext Affrs & Strtgc Policy	$ 505,000.08	$ -	$ -		$ 271,711.30	$ 1,127,146.12	$ 1,903,857.50
Gregory C Wolf	President Commercial Portfolio	$ 350,737.38						
Lloyd M Yates	EVP Mkt Sol & Pres,Carolinas	$ 631,666.80	$ -	$ -		$ 339,994.26	$ 733,713.77	$ 1,705,374.83
Steven K Young	EVP & CFO	$ 591,666.68	$ -	$ -		$ 292,495.48	$ 561,936.75	$ 1,446,098.91
$ Allocated to Kentucky								
Melissa H Anderson	SVP&ChiefHumanResourcesOff	$ 2,636.13	$ -	$ -	$ -	$ -	$ 2,383.28	**$ 5,019.41**
Andrea Bertone	President Duke Energy Intl	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
William E Currens, Jr	VP Investor Relations	$ 2,390.46	$ -	$ -	$ -	$ 796.52	$ 981.98	**$ 4,168.96**
Stephen G DeMay	VP Treasurer	$ 3,567.34	$ -	$ -	$ -	$ 1,331.17	$ 4,027.43	**$ 8,925.94**
Douglas F Esamann	State President-IN	$ 4,529.04	$ -	$ -	$ -	$ 1,539.44	$ 4,343.24	**$ 10,411.72**
Lynn J Good	Pres, CEO & Vice Chair of BOD	$ 13,268.83	$ -	$ -	$ -	$ 12,191.28	$ 29,800.23	**$ 55,260.33**
James P Henning	State President-OH/KY	$ 59,726.47	$ -	$ -	$ -	$ 20,491.95	$ 21,402.40	**$ 101,620.83**
Dhiaa M Jamil	Exec VP DE & Pres DE Nuclear	$ 1,815.44	$ -	$ -	$ -	$ 1,049.03	$ 4,610.05	**$ 7,474.53**
Julia S Janson	EVP & Chief Legal Officer	$ 5,412.50	$ -	$ -	$ -	$ 2,822.26	$ 6,475.82	**$ 14,710.59**
A R Mullinax	VP Chief Information Officer	$ 4,871.25	$ -	$ -	$ -	$ 2,029.40	$ 7,443.08	**$ 14,343.73**
Brian D Savoy	VP ChiefAcctingOff&Controller	$ 3,008.99	$ -	$ -	$ -	$ 1,403.58	$ 1,221.84	**$ 5,634.41**
Jennifer L Weber	Exec VP&ChiefHumanResourcesOff	$ 5,466.63	$ -	$ -	$ -	$ 2,941.27	$ 12,201.36	**$ 20,609.26**
Gregory C Wolf	President DE Renewables	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Lloyd M Yates	Exec VP Regulated Utilities	$ 6,837.79	$ -	$ -	$ -	$ 3,680.44	$ 7,942.45	**$ 18,460.68**
Steven K Young	EVP & CFO	$ 6,404.79	$ -	$ -	$ -	$ 3,166.26	$ 6,082.97	**$ 15,654.02**
KY Jurisdictional Retail Amount		$ 119,935.66	$ -	$ -	$ -	$ 53,442.62	$ 108,916.14	**$ 282,294.43**
Directors								
Total Amount								
KY Jurisdictional Retail Amount								
Managers								
Total Amount		$ 151,846.42	$ -	$ -		$ 26,772.57	$ -	**$ 178,618.99**
KY Jurisdictional Retail Amount		$ 151,846.42	$ -	$ -	$ -	$ 26,772.57	$ -	**$ 178,618.99**
Supervisors								
Total Amount		$ 444,149.81	$ -	$ -		$ 44,546.06	$ 6,320.77	**$ 495,016.64**
KY Jurisdictional Retail Amount		$ 444,149.81	$ -	$ -	$ -	$ 44,546.06	$ 6,320.77	**$ 495,016.64**
Exempt								
Total Amount		$ 523,790.69	$ 34,281.40	$ -		$ 43,954.15	$ -	**$ 602,026.24**
KY Jurisdictional Retail Amount		$ 523,790.69	$ 34,281.40	$ -	$ -	$ 43,954.15	$ -	**$ 602,026.24**
Non-Exempt								
Total Amount								
KY Jurisdictional Retail Amount								
Union								
Total Amount		$ 12,260,799.24	$ 3,639,010.22	$ 9,406.48		$ 389,926.87	$ 188,365.68	**$ 16,487,508.49**
KY Jurisdictional Retail Amount		$ 12,260,799.24	$ 3,639,010.22	$ 9,406.48	$ -	$ 389,926.87	$ 188,365.68	**$ 16,487,508.49**
Total Amount		$ 20,572,749.45	$ 3,673,291.62	$ 9,406.48	$ -	$ 4,211,072.63	$ 10,499,566.18	**$ 38,966,086.36**
KY Jurisdictional Retail Amount		$ 13,500,521.82	$ 3,673,291.62	$ 9,406.48	$ -	$ 558,642.27	$ 303,602.59	**$ 18,045,464.79**

Employee Name	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Benefit Retirement (401K)		Other Benefits		**Subtotal**	
	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	**Duke**	**Employee**
Total Amount	$ 1,979,822.39	$ 845,212.00	$ 115,544.83	$ 65,471.18	$ 147.15	$ 19,784.59	$ 17,063.17	$ 89,600.86	$ 1,635.06	$ 17,924.12	$ 853,916.03	$ 1,894,667.24	$ 57,380.80	$ 30,607.84	$ 3,025,509.43	$ 2,963,267.83
KY Jurisdictional Retail Amount	$ 1,979,822.39	$ 845,212.00	$ 115,544.83	$ 65,471.18	$ 147.15	$ 19,784.59	$ 17,063.17	$ 89,600.86	$ 1,635.06	$ 17,924.12	$ 853,916.03	$ 1,894,667.24	$ 57,380.80	$ 30,607.84	$ 3,025,509.43	$ 2,963,267.83

Benefit Costs:

(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.

(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.

(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.

(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2018-00261
Salary & Benefit Data by Employee *Year* *2016*

Employee Name	Title	Regular	Overtime	Excess Vacation Payroll	Standby	Bonus	Other	Sub-Total
Corporate Officers								
Total Amount		$ 7,256,444.53	$ -	$ 63,404.00	$ -	$ 5,717,153.30	$ 9,876,651.03	$ 22,913,652.86
Melissa H Anderson	EVP, Administration&ChiefHROff	$ 454,833.36						
Andrea Bertone	Interim Assignment - Leader	$ 366,425.32						
William E Currens, Jr	SVP ChiefAcctingOff&Controller							
Stephen G DeMay	SVP, Tax and Treasurer	$ 353,644.48						
Douglas F Esamann	EVP Energy Slns & Pres MW FL	$ 491,666.80						
Lynn J Good	Chairman, President & CEO	$ 1,291,666.76	$ -	$ -		$ 1,583,159.88	$ 3,782,291.33	$ 6,657,117.97
James P Henning	State President-OH/KY	$ 269,033.08						
Dhiaa M Jamil	EVP & Chief Operating Officer	$ 737,500.00	$ -	$ -		$ 532,794.91	$ 1,230,074.01	$ 2,500,368.92
Julia S Janson	EVP & Chief Legal Officer	$ 520,833.36	$ -	$ -		$ 388,714.32	$ 655,444.79	$ 1,564,992.47
A R Mullinax	Retiree/Survivor	$ 150,000.00						
Brian D Savoy	SVP, Bus Transformation & Tech	$ 338,333.48						
Jennifer L Weber	EVP,Ext Affrs & Strtgc Policy	$ 82,062.51						
Gregory C Wolf	President Commercial Portfolio	$ 192,070.03						
Lloyd M Yates	EVP Cust&Delivery Ops&Pres Car	$ 661,458.36	$ -	$ -		$ 490,963.70	$ 1,061,470.46	$ 2,213,892.52
Yoho,Frank	EVP & President, Natural Gas	$ 468,238.49						
Steven K Young	EVP & CFO	$ 625,000.00	$ -	$ -		$ 449,912.16	$ 474,445.75	$ 1,549,357.91
$ Allocated to Kentucky								
Melissa H Anderson	EVP, Administration&ChiefHROff	$ 3,502.22	$ -	$ -	$ -	$ 2,064.93	$ 1,183.76	**$ 6,750.91**
Andrea Bertone	Interim Assignment - Leader	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
William E Currens, Jr	SVP ChiefAcctingOff&Controller	$ 2,644.60	$ -	$ -	$ -	$ 838.39	$ 689.14	**$ 4,172.14**
Stephen G DeMay	SVP, Tax and Treasurer	$ 3,686.74	$ -	$ -	$ -	$ 1,586.81	$ 2,342.86	**$ 7,616.41**
Douglas F Esamann	EVP Energy Slns & Pres MW FL	$ 5,125.63	$ -	$ -	$ -	$ 2,492.43	$ 2,580.59	**$ 10,198.65**
Lynn J Good	Chairman, President & CEO	$ 13,465.63	$ -	$ -	$ -	$ 16,504.44	$ 39,430.39	**$ 69,400.45**
James P Henning	State President-OH/KY	$ 53,806.62	$ -	$ -	$ -	$ 20,994.04	$ 23,765.53	**$ 98,566.19**
Dhiaa M Jamil	EVP & Chief Operating Officer	$ 7,688.44	$ -	$ -	$ -	$ 5,554.39	$ 12,823.52	**$ 26,066.35**
Julia S Janson	EVP & Chief Legal Officer	$ 5,429.69	$ -	$ -	$ -	$ 4,052.35	$ 6,833.01	**$ 16,315.05**
A R Mullinax	Retiree/Survivor	$ 1,563.75	$ -	$ 313.50	$ -	$ 3,053.30	$ 4,678.71	**$ 9,609.26**
Brian D Savoy	SVP, Bus Transformation & Tech	$ 3,527.13	$ -	$ -	$ -	$ 1,445.89	$ 1,081.84	**$ 6,054.85**
Jennifer L Weber	EVP,Ext Affrs & Strtgc Policy	$ 855.50	$ -	$ 83.53	$ -	$ 3,915.98	$ 7,946.35	**$ 12,801.35**
Gregory C Wolf	President Commercial Portfolio	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Lloyd M Yates	EVP Cust&Delivery Ops&Pres Car	$ 6,895.70	$ -	$ -	$ -	$ 5,118.30	$ 11,065.83	**$ 23,079.83**
Yoho,Frank	EVP & President, Natural Gas	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Steven K Young	EVP & CFO	$ 6,515.63	$ -	$ -	$ -	$ 4,690.33	$ 4,946.10	**$ 16,152.06**
KY Jurisdictional Retail Amount		$ 114,707.26	$ -	$ 397.03	$ -	$ 72,311.58	$ 119,367.63	**$ 306,783.49**
Managers								
Total Amount		$ 114,667.58	$ -	$ -		$ 15,562.19	$ -	**$ 130,229.77**
KY Jurisdictional Retail Amount		$ 114,667.58	$ -	$ -	$ -	$ 15,562.19	$ -	**$ 130,229.77**
Supervisors								
Total Amount		$ 658,084.03	$ 16,241.93	$ -		$ 79,769.27	$ -	**$ 754,095.23**
KY Jurisdictional Retail Amount		$ 658,084.03	$ 16,241.93	$ -	$ -	$ 79,769.27	$ -	**$ 754,095.23**
Exempt								
Total Amount		$ 336,049.67	$ -	$ 5,115.22		$ 29,919.02	$ -	**$ 371,083.91**
KY Jurisdictional Retail Amount		$ 336,049.67	$ -	$ 5,115.22	$ -	$ 29,919.02	$ -	**$ 371,083.91**
Non-Exempt								
Total Amount								
KY Jurisdictional Retail Amount								
Union								
Total Amount		$ 12,474,953.60	$ 3,892,732.63	$ 5,148.72		$ 402,483.13	$ 322,479.26	**$ 17,097,797.34**
KY Jurisdictional Retail Amount		$ 12,474,953.60	$ 3,892,732.63	$ 5,148.72	$ -	$ 402,483.13	$ 322,479.26	**$ 17,097,797.34**
Total Amount		$ 20,840,199.41	$ 3,908,974.56	$ 73,667.94	$ -	$ 6,244,886.91	$ 10,199,130.29	**$ 41,266,859.11**
KY Jurisdictional Retail Amount		$ 13,698,462.14	$ 3,908,974.56	$ 10,660.97	$ -	$ 600,045.19	$ 441,846.89	**$ 18,659,989.74**

Employee Name	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Benefit Retirement (401K)		Other Benefits		**Subtotal**	
	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	**Duke**	**Employee**
Total Amount	$ 2,142,579.55	$ 902,523.89	$ 125,269.50	$ 69,380.10	$ (200.17)	$ 21,888.25	$ 19,783.02	$ 95,905.94	$ 1,938.60	$ 18,509.26	$ 912,724.17	$ 1,923,112.64	$ 72,982.67	$ 30,245.22	$ 3,275,077.34	$ 3,061,565.30
KY Jurisdictional Retail Amount	$ 2,142,579.55	$ 902,523.89	$ 125,269.50	$ 69,380.10	$ (200.17)	$ 21,888.25	$ 19,783.02	$ 95,905.94	$ 1,938.60	$ 18,509.26	$ 912,724.17	$ 1,923,112.64	$ 72,982.67	$ 30,245.22	$ 3,275,077.34	$ 3,061,565.30

Benefit Costs:

(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.

(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.

(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.

(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2018-00261
Salary & Benefit Data by Employee *Year* *2017*

Employee Name	Title	Allocating Operating Unit	Regular	Overtime	Excess Vacation Payroll	Standby	Bonus	Other	**Sub-Total**	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Benefit Retirement (401K)		Other Benefits		**Subtotal**	
										Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	**Duke**	**Employee**
Corporate Officers																									
Total Amount			$ 7,785,735.23	$ -	$ -	$ -	$ 10,674,580.63	$ 8,513,641.16	$ 26,973,957.02																$ -
Melissa H Anderson	EVP, Administration&ChiefHROff		$ 502,125.00																						$ -
Andrea Bertone	Retiree/Survivor																								
William E Currens, Jr	SVP ChiefAcctingOff&Controller		$ 299,925.00																						$ -
Stephen G DeMay	SVP, Tax and Treasurer		$ 370,080.84																						$ -
Douglas F Esamann	EVP Energy Slns & Pres MW FL		$ 570,833.36																						$ -
Lynn J Good	Chairman, President & CEO		$ 2,120,833.36	$ -	$ -	$ -	$ 5,352,929.28	$ 5,170,875.54	$ 12,644,638.18																$ -
James P Henning	State President-OH/KY		$ 293,004.28																						$ -
Dhiaa M Jamil	EVP & Chief Operating Officer		$ 781,250.00	$ -	$ -	$ -	$ 832,657.56	$ 651,094.26	$ 2,265,001.82																$ -
Julia S Janson	EVP Ext Affairs,CLO & Corp Sec		$ 608,333.40	$ -	$ -	$ -	$ 588,035.03	$ 356,835.94	$ 1,553,204.37																$ -
A R Mullinax	Retiree/Survivor																								$ -
Brian D Savoy	SVP, Bus Transformation & Tech																								$ -
Lloyd M Yates	EVP Cust&Delivery Ops&Pres Car		$ 683,419.20	$ -	$ -	$ -	$ 680,129.47	$ 530,262.79	$ 1,893,811.46																$ -
Yoho,Frank	EVP & President, Natural Gas		$ 508,847.43																						
Steven K Young	EVP & CFO		$ 682,500.00	$ -	$ -	$ -	$ 665,742.00	$ 444,869.28	$ 1,793,111.28																$ -
$ Allocated to Kentucky																									
Melissa H Anderson	EVP, Administration&ChiefHROff	DGHR	$ 3,514.88	$ -	$ -	$ -	$ 3,028.30	$ 1,727.81	**$ 8,270.99**																$ -
Andrea Bertone	Retiree/Survivor		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**																$ -
William E Currens, Jr	SVP ChiefAcctingOff&Controller	DGIR	$ 3,089.23	$ -	$ -	$ -	$ 2,416.01	$ 526.93	**$ 6,032.18**																$ -
Stephen G DeMay	SVP, Tax and Treasurer	DGFI	$ 3,811.83	$ -	$ -	$ -	$ 3,748.32	$ 1,073.32	**$ 8,633.47**																$ -
Douglas F Esamann	EVP Energy Slns & Pres MW FL	DGEX	$ 5,879.58	$ -	$ -	$ -	$ 5,419.81	$ 2,036.38	**$ 13,335.77**																$ -
Lynn J Good	Chairman, President & CEO	DGEX	$ 21,844.58	$ -	$ -	$ -	$ 55,135.17	$ 53,260.02	**$ 130,239.77**																$ -
James P Henning	State President-OH/KY	OHSK	$ 26,370.39	$ -	$ -	$ -	$ 23,919.50	$ 6,003.76	**$ 56,293.65**																$ -
Dhiaa M Jamil	EVP & Chief Operating Officer	DGEX	$ 8,046.88	$ -	$ -	$ -	$ 8,576.37	$ 6,706.27	**$ 23,329.52**																$ -
Julia S Janson	EVP Ext Affairs,CLO & Corp Sec	ENLE	$ 6,265.83	$ -	$ -	$ -	$ 6,056.76	$ 3,675.41	**$ 15,998.01**																$ -
A R Mullinax	Retiree/Survivor	ENMA	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**																$ -
Brian D Savoy	SVP, Bus Transformation & Tech	DGFI	$ 3,755.21	$ -	$ -	$ -	$ 3,967.46	$ 1,082.46	**$ 8,805.13**																$ -
Lloyd M Yates	EVP Cust&Delivery Ops&Pres Car	DGEX	$ 7,039.22	$ -	$ -	$ -	$ 7,005.33	$ 5,461.71	**$ 19,506.26**																$ -
Yoho,Frank	EVP & President, Natural Gas		$ -	$ -	$ -	$ -	$ -	$ -	**$ -**																$ -
Steven K Young	EVP & CFO	DGEX	$ 7,029.75	$ -	$ -	$ -	$ 6,857.14	$ 4,582.15	**$ 18,469.05**																$ -
KY Jurisdictional Retail Amount			$ 96,647.37	$ -	$ -	$ -	$ 126,130.18	$ 86,136.23	**$ 308,913.78**																
									$ -																
Managers																									
Total Amount			$ 215,655.84	$ -	$ -	$ -	$ 32,494.93	$ -	**$ 248,150.77**																$ -
KY Jurisdictional Retail Amount			$ 215,655.84	$ -	$ -	$ -	$ 32,494.93	$ -	**$ 248,150.77**																$ -
Supervisors																									
Total Amount			$ 672,217.52	$ 39.65	$ -	$ -	$ 73,094.02	$ 295.80	**$ 745,646.99**																$ -
KY Jurisdictional Retail Amount			$ 672,217.52	$ 39.65	$ -	$ -	$ 73,094.02	$ 295.80	**$ 745,646.99**																$ -
Exempt																									
Total Amount			$ 539,975.55	$ 33,700.45	$ -	$ -	$ 189,376.30	$ -	**$ 763,052.30**																$ -
KY Jurisdictional Retail Amount			$ 539,975.55	$ 33,700.45	$ -	$ -	$ 189,376.30	$ -	**$ 763,052.30**																$ -
Non-Exempt																									
Total Amount			$ 297,836.37	$ 33,233.60	$ 3,376.86	$ -	$ 15,858.38	$ 123,853.60	**$ 474,158.81**																
KY Jurisdictional Retail Amount			$ 297,836.37	$ 33,233.60	$ 3,376.86	$ -	$ 15,858.38	$ 123,853.60	**$ 474,158.81**																
Union																									
Total Amount			$ 12,599,957.89	$ 3,915,542.80	$ 1,605.60	$ -	$ 457,340.53	$ 12,915.57	**$ 16,987,362.39**																$ -
KY Jurisdictional Retail Amount			$ 12,599,957.89	$ 3,915,542.80	$ 1,605.60	$ -	$ 457,340.53	$ 12,915.57	**$ 16,987,362.39**																$ -
Total Amount			$ 22,111,378.40	$ 3,982,516.50	$ 4,982.46	$ -	$ 11,442,744.79	$ 8,650,706.13	**$ 46,192,328.28**	$ 2,256,335.40	$ 1,017,380.28	$ 124,039.00	$ 78,785.23	$ -	$ 24,880.49	$ 17,043.29	$ 106,000.43	$ 2,074.32	$ 18,400.44	$ 993,829.20	$ 1,997,241.19	$ 69,667.35	$ 36,875.52	**$ 3,462,988.55**	**$ 3,279,563.58**
KY Jurisdictional Retail Amount			$ 14,422,290.54	$ 3,982,516.50	$ 4,982.46	$ -	$ 894,294.34	$ 223,201.20	**$ 19,527,285.04**	$ 2,256,335.40	$ 1,017,380.28	$ 124,039.00	$ 78,785.23	$ -	$ 24,880.49	$ 17,043.29	$ 106,000.43	$ 2,074.32	$ 18,400.44	$ 993,829.20	$ 1,997,241.19	$ 69,667.35	$ 36,875.52	$ 3,462,988.55	$ 3,279,563.58

Benefit Costs:

(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.

(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.

(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.

(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2018-00261
Salary & Benefit Data by Employee

Year *201805*

Employee Name	Title	Allocating Operating Unit	Regular	Overtime	Excess Vacation Payroll	Standby	Bonus	Other	**Sub-Total**
Corporate Officers									
Total Amount			$ 3,221,192.87	$ -	$ -	$ -	$ 6,394,666.32	$ 917,990.75	$ 10,533,849.94
$ Allocated to Kentucky									
Melissa H Anderson	EVP, Administration&ChiefHROff	DGHR	$ 1,509.37	$ -	$ -	$ -	$ 2,789.91	$ 269.18	**$ 4,568.46**
Andrea Bertone	Retiree/Survivor		$ -	$ -	$ -	$ -	$ -	$ -	$ -
William E Currens, Jr	SVP ChiefAcctingOff&Controller	DGIR	$ 1,377.06	$ -	$ -	$ -	$ 1,532.53	$ 92.49	**$ 3,002.09**
Stephen G DeMay	SVP, Tax and Treasurer	DGFI	$ 1,636.87	$ -	$ -	$ -	$ 1,909.12	$ 167.12	**$ 3,713.11**
Douglas F Esamann	EVP Energy Slns & Pres MW FL	DGEX	$ 2,616.07	$ -	$ -	$ -	$ 4,666.88	$ 213.45	**$ 7,496.41**
Lynn J Good	Chairman, President & CEO	DGEX	$ 5,793.75	$ -	$ -	$ -	$ 21,740.58	$ 4,378.31	**$ 31,912.64**
James P Henning	State President-OH/KY	OHSK	$ 11,241.70	$ -	$ -	$ -	$ 11,548.41	$ 977.34	**$ 23,767.45**
Dhiaa M Jamil	EVP & Chief Operating Officer	DGEX	$ 3,430.38	$ -	$ -	$ -	$ 6,631.78	$ 1,101.32	**$ 11,163.49**
Julia S Janson	EVP Ext Affairs,CLO & Corp Sec	ENLE	$ 2,722.53	$ -	$ -	$ -	$ 5,116.33	$ 648.53	**$ 8,487.39**
Brian D Savoy	SVP, Bus Transformation & Tech	DGFI	$ 1,619.77	$ -	$ -	$ -	$ 1,883.67	$ 172.17	**$ 3,675.60**
Lloyd M Yates	EVP Cust&Delivery Ops&Pres Car	DGEX	$ 2,991.52	$ -	$ -	$ -	$ 5,480.34	$ 1,012.92	**$ 9,484.78**
Yoho,Frank	EVP & President, Natural Gas		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Steven K Young	EVP & CFO	DGEX	$ 3,018.74	$ -	$ -	$ -	$ 5,740.10	$ 802.24	**$ 9,561.07**
Spiller, Amy B	State President-OH/KY	OHSK	$ 8,586.39	$ -	$ -	$ -	$ 8,540.04	$ 168.37	**$ 17,294.80**
Jacobs, Dwight L	SVP ChiefAcctingOff&Controller	DGIR	$ 1,315.44	$ -	$ -	$ -	$ 1,373.47	$ 137.99	**$ 2,826.90**
KY Jurisdictional Retail Amount			$ 47,859.60	$ -	$ -	$ -	$ 78,953.16	$ 10,141.44	**$ 136,954.20**
									$ -
Managers									
Total Amount			$ 91,408.77	$ -	$ -	$ -	$ 34,938.96	$ -	**$ 126,347.73**
KY Jurisdictional Retail Amount			$ 91,408.77	$ -	$ -	$ -	$ 34,938.96	$ -	**$ 126,347.73**
Supervisors									
Total Amount			$ 364,552.32	$ 1,960.02	$ -	$ -	$ 95,069.97	$ 258.35	**$ 461,840.66**
KY Jurisdictional Retail Amount			$ 364,552.32	$ 1,960.02	$ -	$ -	$ 95,069.97	$ 258.35	**$ 461,840.66**
Exempt									
Total Amount			$ 169,382.96	$ 1,229.70	$ -	$ -	$ 35,768.52	$ 14,371.04	**$ 220,752.22**
KY Jurisdictional Retail Amount			$ 169,382.96	$ 1,229.70	$ -	$ -	$ 35,768.52	$ 14,371.04	**$ 220,752.22**
Non-Exempt									
Total Amount									$ -
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Union									
Total Amount			$ 5,831,582.19	$ 1,897,003.43	$ 2,278.96	$ -	$ 495,270.96	$ 71,218.00	**$ 8,297,353.54**
KY Jurisdictional Retail Amount			$ 5,831,582.19	$ 1,897,003.43	$ 2,278.96	$ -	$ 495,270.96	$ 71,218.00	**$ 8,297,353.54**
Total Amount			$ 9,678,119.11	$ 1,900,193.15	$ 2,278.96	$ -	$ 7,055,714.73	$ 1,003,838.14	**$ 19,640,144.09**
KY Jurisdictional Retail Amount			$ 6,504,785.84	$ 1,900,193.15	$ 2,278.96	$ -	$ 740,001.57	$ 95,988.83	**$ 9,243,248.35**

Employee Name	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Benefit Retirement (401K)		Other Benefits		**Subtotal**	
	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	**Duke**	**Employee**
Total Amount	$ 1,157,855.15	$ 436,047.69	$ 56,548.00	$ 32,362.49	$ -	$ 10,412.71	$ 6,677.97	$ 48,796.29	$ 814.53	$ 7,910.60	$ 509,925.76	$ 1,046,282.23	$ 25,793.25	$ 15,026.07	**$ 1,757,614.66**	**$ 1,596,838.08**
KY Jurisdictional Retail Amount	$ 1,157,855.15	$ 436,047.69	$ 56,548.00	$ 32,362.49	$ -	$ 10,412.71	$ 6,677.97	$ 48,796.29	$ 814.53	$ 7,910.60	$ 509,925.76	$ 1,046,282.23	$ 25,793.25	$ 15,026.07	$ 1,757,614.66	$ 1,596,838.08

Benefit Costs:

(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.

(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.

(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.

(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

STAFF-DR-01-066

REQUEST:

For each item of benefits listed in Item 65 above where an employee is required to pay part of the cost, provide a detailed explanation as to how the employee contribution rate was determined.

RESPONSE:

Please see Renee H. Metzler's direct testimony beginning on page 35.

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-067
(As to Attachment Only)

REQUEST:

Provide a listing of all health care plan categories, dental plan categories, and vision plan categories available to corporate officers individually, and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees (i.e., single, married no dependents, single parent with dependents, family, etc.) Include the associated employee contribution rates and employer contribution rates of the total premium cost for each category, and each plan's deductible(s) amounts.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment Only)

See STAFF-DR-01-067 Confidential Attachment, which is being filed under the seal of a Petition for Confidential Treatment.

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-068

REQUEST:

Provide a listing of all life insurance plan categories available to corporate officers individually, and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Include the associated employee contribution rates and employer contribution rates of the total premium cost for each plan category.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

PUBLIC STAFF-DR-01-069

REQUEST:

Provide a listing of all retirement plans categories available to corporate officers individually, and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Include the associated employee contribution rates, if any, and employer contribution rates of the total cost for each plan category.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-070

REQUEST:

Provide Duke Kentucky's current nepotism policy and indicate when it was most recently changed.

RESPONSE:

See STAFF-DR-01-070 Attachment, which is Duke Energy's Employment Policy, subject to any collective bargaining requirements. This policy contains multiple employment topics, including the employment of relatives. The policy was last revised on October 1, 2015, but the employment of relatives section specifically was last revised on January 1, 2013.

PERSON RESPONSIBLE: Renee H. Metzler

Employment Policy

Applicability:	*Applies to Duke Energy non-unionized employees in the United States*
Originator:	*Human Resources*
Approval:	*Executive Vice President & Chief Human Resources Officer*
Effective Date:	*03/14/1994*
Revision Date:	*10/01/2015*

THIS POLICY IS FOR INFORMATIONAL PURPOSES ONLY, AND IS NOT INTENDED TO CREATE A CONTRACT OF EMPLOYMENT BETWEEN AN EMPLOYEE AND DUKE ENERGY. THIS POLICY DOES NOT ALTER THE "AT-WILL" EMPLOYMENT STATUS OF DUKE ENERGY EMPLOYEES. "AT-WILL" EMPLOYMENT MEANS THAT EITHER AN EMPLOYEE OR DUKE ENERGY CAN TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME, FOR ANY OR NO REASON, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, SUBJECT TO RESTRICTIONS UNDER ANY APPLICABLE LAW. NOTHING IN THIS POLICY IS INTENDED TO CONFLICT WITH THE TERMS OF ANY APPLICABLE COLLECTIVE BARGAINING AGREEMENT ("CBA'). WHERE A CONFLICT EXISTS, THE TERMS OF THE APPLICABLE CBA SHALL CONTROL.

APPLIES TO DUKE ENERGY NON-UNIONIZED EMPLOYEES IN THE UNITED STATES

Purpose

Duke Energy staffs to meet normal business needs, and staffing levels are adjusted to reflect business changes and operational needs. Duke Energy fills open positions with qualified candidates who best meet the requirements of the job. Internal candidates may be identified through developmental planning efforts, the Job Postings Program, management's knowledge of candidates within and outside of the immediate work group, and employees returning from a leave of absence. However, management may consider both internal and external candidates when making the final decision.

The Company will not discriminate against any individual because of his/her race, color, sex, pregnancy, sexual orientation, gender identity, religion, marital status, national origin, ethnicity, citizenship, age, physical or mental disability, genetic information, military status, or protected veteran status, and complies with all legal requirements relating to reasonable accommodations, including those for disability, pregnancy, and religious beliefs and practices. Employees who are involved in hiring and selection decisions are expected to comply with Duke Energy's Equal Employment Opportunity and Affirmative Action Policy. Duke Energy will follow all applicable employment laws in the state which the employee is hired and will be working.

This policy defines certain employment classifications and summarizes some of the important requirements for employment with Duke Energy.

Former employees who left the Company in good standing may seek re-employment in vacant positions for which they are qualified under the terms and conditions of this Policy. Duke Energy does not guarantee any post-employment work opportunities at Duke Energy locations or properties to former employees.

Management is not authorized to and should not make any pre-arrangements, promises or representations related to post-employment work opportunities prior to an employee's separation. Former employees are solely responsible for considering any benefits and/or seniority impacts of choosing to pursue post-employment work opportunities at Duke Energy.

Definitions

Employment Policy

Duke Energy generally classifies each employee as either "regular full-time", "regular part-time", "temporary full-time," "temporary part-time", "fixed term" or in one of the student classifications defined below. Employment in any of the following classifications does not create a contract for employment, nor does it alter the at-will nature of the employment relationship.

Regular Full-time Employee

An employee who fills a regular, budgeted, full-time position and in most cases works at least 40 hours per week. In some cases, the work dictates a schedule of less than 40 hours; however, such positions are not common and must be approved by department management. Regular employees are eligible for benefits.

Regular Part-time Employee

An employee hired into a position that averages 39 hours or less per week and is expected to be employed longer than 180 days. Regular employees are eligible for benefits.

Temporary Full-time Employee

An employee hired to work at least 40 hours per week for a time period not expected to exceed 180 days. Temporary full-time employees are only eligible for benefits mandated by law.

Temporary Part-time Employee

An employee hired for a time period not expected to exceed 180 days in duration and whose normal schedule averages no more than 39 hours per week. Temporary part-time employees are only eligible for benefits mandated by law.

Intern

An Intern is a student enrolled in a 4-year accredited college/university or a 2-year associate craft/technical degree program who is employed on a temporary basis for a specific time period performing work related to his/her major course of study. Interns are expected to maintain a GPA of 2.75 or higher. Interns normally work during the summer months, but may work on a more frequent basis as needed. Interns may work a full-time (40 hours/week) or part-time (<40 hours/week) schedule. The age requirement for an internship is 18 years old by the point at which the intern would begin employment.

College Co-op

A College Co-op is a student enrolled in a 4-year accredited college/university who typically rotates between periods of school attendance and periods of employment after completing a minimum of 24 credit hours. College co-ops are expected to maintain a GPA of 2.75 or higher. College co-ops are employed to work a full time schedule in the work related to their major course of study for a minimum of three college terms. Co-op employment typically begins in January (spring session/quarter), May (summer session/quarter), or August (fall session/quarter).

Power Careers

The Power Careers Program is designed to attract the most promising high school and community college talent, provide students an introduction to the business of power plant operations, support students' completion of targeted two-year Associate Degrees and ultimately provide a career opportunity with Duke Energy. Students must be nominated by a member of the school faculty and meet certain academic requirements including a preferred GPA of 3.00 to participate in the Power Careers Program. Students must enroll in selected specialized two-year associate degree programs relevant to a career in power plant operations.

Employment Policy

Nominated students can apply for a Duke Energy scholarship awarded at $650 per semester for a qualifying student.

Technical School Co-op

A Technical Co-op is enrolled in a technical school program and works a minimum of 20 hours per week on a regular basis performing work in his/her major course of study while attending school. Full-time student classification must be maintained for the duration of the program. Technical co-ops are expected to maintain a GPA of 2.75 or higher. Technical co-ops must have completed 12 credit hours but no more than 52 credit hours before entering Duke's program. Participation is limited to 4 semesters/ school sessions. Depending on their school schedule, Technical co-ops may have a need to alternate work periods at times. Technical co-ops are considered part-time employees relative to benefits and headcount.

Fixed Term Employee

A fixed term employee is hired in a position for a specifically defined time frame or duration of a project, until services are no longer needed or until the work is completed. Before a fixed term candidate is hired, a written agreement is signed by the prospective employee and the hiring manager and approved by the Human Resources Business Partner. Fixed term employees are eligible for benefits on the same basis as regular full-time or part-time employees. However, fixed term employees are not eligible to participate in the Jobs Posting Program (even if they work for 12 consecutive months) or severance pay programs. Although fixed term employees may be provided with an expected duration of employment, they are considered to be at-will employees, and may resign or be subject to involuntary termination of employment with or without cause before the end of their expected term.

Staffing Options

Defined below are three alternative options for staffing a position.

Job Sharing

Two regular part-time employees share the duties of one full-time position. Such an arrangement requires management and human resources approval, as well as collaboration between the two employees. Job sharing is not an appropriate option in all situations and departments, and is dependent upon business needs.

Job Splitting

Two regular part-time employees split the work hours of one full-time position. Normally this job is easily divisible and requires little, if any, interaction between the employees. Job splitting requires management and human resources approval. Job splitting is not an appropriate option in all situations and departments, and is dependent upon business needs.

Job Swapping

Two regular full-time or part-time employees swap jobs in an effort to better meet personal, family or career needs. Both employees must meet the job requirements of their new positions. Job swapping requires management (of each employee) and human resources approval. Job swapping is not an appropriate option in all situations and departments, and is dependent upon business needs.

Minimum Requirements for Employment

Duke Energy does not hire anyone who is less than 18 years of age.

Employment Policy

Duke Energy verifies the eligibility of each new employee to work in the United States as required by the Immigration Reform and Control Act of 1986. The Company's pre-employment screening process requires candidates to satisfactorily complete and pass a 5-panel drug screen and undergo a background check. For some job classifications, additional requirements may include a satisfactory rating on professionally developed tests that have been validated and/or approved to demonstrate job proficiency, security clearance, and/or passing a physical examination.

Unless otherwise specified by governing regulations (e.g., NRC, DOT), temporary workers, and intern and college co-op employees will be required to complete an alcohol and drug screen as well as a background investigation, to include a criminal history check for the inactive period of time, upon each return from a break in service lasting more than 90 calendar days. Continuation of employment will be contingent on the results of the screenings.

Employment of Relatives

For the purpose of this policy, a relative is defined as an employee's spouse, domestic partner, brother, sister, parent, child, grandparent, grandchild, niece, nephew, aunt, uncle, including similar "step-relationships" and these same relationships of the employee's spouse or domestic partner. This list is not all-inclusive, and the restrictions outlined below may apply to more distant relatives than those covered in this policy's definition of relatives, as appropriate under the circumstances. Each situation will be evaluated on an individual basis.

Relatives may not be employed in positions where their duties may cause a conflict because of the close working relationship of the positions in which the relatives are employed and/or the nature of one of the positions. Business unit management (or his/her designee) and human resources will review situations involving relatives in close working relationships or sensitive positions to ensure that no conflict exists.

Relatives of top tier executives may not be employed in the business unit managed by their relative.

A supervisor or manager may not directly or indirectly manage his/her own relatives or those of his/her spouse or domestic partner (i.e., signature is required on performance management and/or salary actions). In addition, two or more relatives may not report to the same supervisor/manager.

Where two employees marry or enter into a domestic partner relationship, and the marriage or relationship has the potential to create a conflict as described in this policy, both employees are expected to notify their manager of the marriage/domestic partner relationship. Where the Company determines that a conflict exists (i.e. one employee supervises the other, both employees report to the same manager/supervisor, etc.), the Company normally requires one of the employees to pursue an internal transfer to a different position that eliminates the conflict, if such a position is available. The Company reserves the right in all cases to move one of the employees to a different vacant position for which the employee is qualified, or take other appropriate steps to alleviate the conflict. In most cases, any such transfers or other actions should take place within 180 days of entering into the marriage/domestic partnership.

Duke Energy does not guarantee re-employment to any former employee. Former employees may seek re-employment when there is a vacant position; they left the Company in good standing; and are qualified for the vacant position. There should be no promises or pre-arrangements to rehire any individual. Rehire of former employees is subject to the approval of the Business Unit Head, or designee, prior to rehire or assignment to Duke Energy as a contractor.

Re-Employment of Former Employees

Former employees may be considered for rehire at Duke Energy if they previously left the company in good standing, including employees who voluntarily resigned after providing appropriate notice and those employees whose involuntary separation occurred through no fault of their own (e.g., such as position elimination, restructuring, lack of work, and other similar reasons).

Employment Policy

Former employees who were involuntarily terminated for serious performance deficiencies or misconduct, as determined in the sole discretion of Duke Energy, generally are not eligible for rehire. For purposes of this Policy only, misconduct may include, but is not limited to: inappropriate behavior, harassment, violence or threats of violence, conviction of a felony, dishonesty, theft, safety violations, violations of the Code of Business Ethics or any other violation of company policy deemed to be serious enough to warrant involuntary discharge.
To be re-employed by Duke Energy as a regular full-time, part-time, fixed-term or temporary employee, the former employee:

- Must have left Duke Energy (or its predecessor) in good standing;
- Must apply for employment through Duke Energy Talent Acquisition, which can be accessed through www.Duke-Energy.com/careers
- Must satisfy such other lawful criteria as Duke Energy may establish in its sole discretion.

If the former employee received severance benefits in connection with his/her separation from Duke Energy (whether voluntary or involuntary), the former employee may be subject to applicable severance repayment requirements based on number of weeks of severance paid and length of break in service.

Required Level of Review and Approval: For all cases involving potential re-employment of former employees involuntarily terminated for cause and for any exceptions to the above requirements, review is required by the HR Business Partner Director and approval is required by the Senior Management Committee member or Designee for the hiring department.

Duke Energy does not guarantee any post-employment work opportunities at Duke Energy locations or properties to former employees.

Bridging of Service and Service Adjustments

When an employee separates from employment and later returns to work for the Company, there are two different dates that may require adjustment following an employee's return: 1) the employee's Service Date, and 2) the employee's Company Seniority Date. Where there has been a break in service, the Service Date is sometimes referred to as the Adjusted Employment Date. The Company Seniority Date may also be known as the Adjusted Retirement Participation Date or Credible Service Date. Each date is affected by different sets of guidelines and regulations. The Service Date is mainly governed by Company policy and the Company Seniority Date is determined by government regulation.

The Service Date is used to determine eligibility for certain non-ERISA benefits (e.g. vacation, service and retirement awards). Listed below are the categories of employees eligible to receive prior service credit where there has been a break in service or previous separation from employment. In such cases, the Service Date is adjusted by determining the length of the absence and subtracting that amount from the prior continuous service.

- Employees who were laid off and/or separate under a severance program - Employees with less than five years of service will receive credit for prior continuous service provided the employee returns within one year after separation. Employees with five or more years of service must return within two years after separation. Employees will not receive any credit for time between separation and reemployment.
- Inactive employees (LTD/Workers' Compensation) - Employees who not working but are instead receiving wage replacement, whether through LTD or Worker's Compensation, will continue to accrue service. No change will be made to the existing service date.
- Interns, College Co-Op and Power Careers students - When obtaining regular employment, interns and college co-ops will receive credit for the entire period of continuous employment immediately preceding the conversion to regular employment. In cases where a break in service occurs prior to the effective date of regular employment, credit for prior service as an intern or college co-op will not be provided.

Employment Policy

- Non-Military Leaves of Absence - No change is made to the existing service date if the leave is 12 weeks or less. For leaves longer than 12 weeks, the break period begins on the first day of the thirteenth week and continues until the employee returns from leave. For leaves longer than 12 weeks, the break period defined above will be subtracted from the existing service date.
- Military Absence - No change will be made to the existing service date provided the employee complies with the Uniformed Services Employment & Reemployment Rights Act (USERRA).
- Temporary or Fixed Term employees who later become regular full-time or part-time - Any period of continuous employment immediately preceding the change to regular full-time or part-time employment will be counted when determining the service date.
- Employees who move from Part-time status to Full-time status (or vice versa) - No change is made to the existing service date.

Credit for prior service is not available to:

- Employees who voluntarily resign from the Company
- Employees who are involuntarily terminated (other than those who are laid off and/or separate under a severance program)
- Contingent workers/contractors

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-071

REQUEST:

To the extent not included in other responses, provide a copy of all exhibits and schedules that were prepared in Duke Kentucky's rate application in Excel spreadsheet format with all formulas intact and unprotected and with all columns and rows accessible.

RESPONSE:

1. "Staff-DR-01-071 - KPSC Gas SFRs-2017" is an electronic copy of the Company's application, Volume 12, that satisfies 807 KAR 5:001 Section 16(8)(a) through (k).
2. Attachments "BWP-1 – Duke Kentucky Gas Sales History and Forecast" and "BWP-2 – Comparison of Weather Normal Forecasts to Actual Heating Degree Day forecasts, Annual, 2013-2016; Annual Degree Days, 1981-2015 Heating and Cooling" are electronic versions of the schedules provided in the written testimony of Company witness Benjamin Passty.
3. Attachments "BLS-2 – Cost of Service Study Customer Components and Customer Charge Calculation," "BLS-3 – WNA Bill Adjustment Example,"BLS-4 – WNA Impact Estimates," "BLS-5 – Reconnection Charge Calculation," "BLS-6 – Meter Pulse Service Charge Calculation," and "BLS-7 – Rate IMBS Monthly Imbalance Charge Calculation" are electronic versions of the schedules provided in the written testimony of Company witness Bruce L. Sailers. In

addition, electronic versions of Schedules M and N are provided in files "DEK Gas Sch M and N – Test Period with Riders – 2018-00261" and "DEK Gas Sch M and N – Base Period with Riders – 2018-00261".

4. Attachments "WDW-1 – Base Revenue Decline Since 2009 Rate Case," "WDW-2 – Revenue Requirement Using Rate Base vs. Capitalization," and "WDW-3 – Deferral for Impact of TCJA on Base Rates Since January 1, 2018" are electronic version of the schedules provided in the written testimony of Company witness William Don Wathen, Jr.
5. Attachment "JRP-1 Amortization of EDITs" is an electronic version of the schedule provided in the written testimony of Company witness Jon Panizza
6. Attachment "TB-1 Meter Testing Analysis" is an electronic version of the schedule provided in the written testimony of Tyler Barbare.

PERSON RESPONSIBLE: Sarah E. Lawler
Benjamin Passty
Bruce L. Sailers
William Don Wathen Jr.
John Panizza
Tyler Barbare

STAFF-DR-01-071
EXCEL
ATTACHMENT

PROVIDED ON CD