7. The SMAT team will meet, at a minimum, once a year or when deemed necessary to address issues or concerns that have arisen.

8. Any deviations to these guidelines must be brought to the SMAT team for review before implementation at that station.

9. Woodsdale Station, because of the unique organizational structure, will not be able to meet the requirements of the guidelines on many occasions.

    - On the "off shifts", there will seldom be any management personnel on site. This will not allow for the station to follow the guidelines as far as having both a bargaining unit and a management person access the storeroom together. For this reason, when removing material only, Woodsdale personnel will be allowed to access the storeroom alone when the Material Specialist on duty is off site or on uncovered off shifts. The rest of the guidelines will need to be followed as written.

    - The previous bullet point deals with the removal of material only. This is a Material Specialist duty and if material needs to be unloaded when a Material Specialist is unavailable, bargaining unit Woodsdale personnel may do so at the dock, up until 3:00 PM. Most deliveries after 3:00 PM are to be sent away. If there is a question about a particular after hours delivery, the Stores Supervisor should be contacted.

    - Procedures will be put into place to allow for the review of the Access Logs as there is no on-site Store's Supervisor at the station.

10. If a contractor on site needs material on the second or third shifts, the Production Team Supervisor, along with an IBEW 1347 union member, will access the storeroom and the IBEW 1347 union member will remove the needed material. The contractor will not remove material from the storeroom. The daily log will also be filled out at this time.

Duke Energy.

DUKE ENERGY CORPORATION
139 East Fourth St.
P. O. Box 960
Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Clarification of Vacation Bank/Pension

Dear Mr. Feldhaus:

During the 2006 negotiations, the Company and the Union clarified future administration for including the vacation bank payment in the final average pay calculation for purposes of determining an employee's pension.

Vacation bank earnings will be included in the calculation of the earnings in the final 36 consecutive months of employment. If these earnings are not higher than any three consecutive calendar years of earnings in the last 10 years of employment, then the vacation bank earnings will be added to the earnings that are the highest three consecutive calendar years in the last 10 years of employment.

This administration of the vacation bank pension enhancement as described above will be effective January 1, 2007.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

Duke Energy

DUKE ENERGY CORPORATION
139 East Fourth St.
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Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Working Overtime During Vacation

Dear Mr. Feldhaus:

During the 2006 negotiations, the Union and the Company discussed the intent of Article IV, Section 1(k) of the Agreement, with respect to working overtime while on vacation and the release of employees at the start of vacations.

As set forth in that section, employees can request in writing, prior to beginning their vacation, to be considered for work on what would have been their normal off days at the beginning or end of their scheduled vacations. Also as set forth in that section, employees' vacations are considered to have started when they are released from duty on their last regularly scheduled working day prior to the scheduled vacation and are considered ended at the start of their first regularly scheduled working day following the scheduled vacation. It is the Company's understanding that, while on vacation, employees will be considered for overtime work only after all eligible employees have been offered the overtime assignment.

Additionally, the Union expressed concern over hardship that may be caused when employees are not released at their normally scheduled quitting time on their last day of work prior to vacation. During the discussions, the Company reinforced its need to maintain its right to assign the work as necessitated by business needs, including holding employees beyond their normal quitting time. However, the Company assured the Union that employees, who make it known in advance of special travel arrangements needed on their last day of work, should be released from work on time in the absence of an emergency situation.

It is hoped that the above will serve to alleviate the Union's concerns.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

Duke Energy

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139 East Fourth St.
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August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
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4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: 12-Hour Shifts

Dear Mr. Feldhaus:

During the 2006 negotiation meetings, the committees for the Company and the Union discussed the utilization of 12-hour shifts for Production Team Members and Material Services Team Members in the Electric Generating Stations.

As discussed, in order to meet work requirements, the use of 12-hour shifts for employees in the Production Team Member and Material Services Team Member job classifications in the Electric Generating Stations will be at the discretion of the Company.

Except in cases of emergency, the Company will not institute or change a 12-hour group schedule until affording the Union the opportunity to discuss and review the schedule. The Company will base any change in schedule upon new or changed work requirements or the requirements of efficient operations. These matters will be discussed thoroughly with the representatives of the Company and the Union considering the viewpoint and suggestions of the other.

It was also agreed that the administration of the 12-hour schedules will be in accordance with the attached fact sheet.

It is thought that this letter adequately describes the discussion concerning this matter.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

12- HOUR FACT SHEET

1. **Personal Days:** Employees are entitled to a total of four twelve-hour personal days (including Diversity Day).

2. **Shift Definition:** A shift is defined as working 6:00 AM to 6:00 PM or 7:00 AM to 7:00 PM on a single day or 6:00 PM to 6:00 AM or 7:00 PM to 7:00 AM bridging over 2 days.

3. **Payroll Week Definition:** A payroll week is defined by each individual station to accommodate the schedule at that particular location. This will allow the generating stations the flexibility to utilize a four team rotation on a 36 hour – 48 hour schedule rotation. This is not intended to limit the Company from adopting other types of rotations.

4. **Overtime:** All hours worked greater than 40 in a payroll week and all hours worked outside of an employee's regular schedule. Double time hours shall be the last 24-hour period an employee is available to work. For clarification, an employee on a 12-hour shift will be working double time on the 24 hours before their 12-hour rest period before the start of the next shift.

5. **Discipline:** Discipline will be administered in days where one day is equal to 8 hours.

6. **Vacation:** Vacation will be administered in hours. If an employee takes vacation in a 48-hour week, the employee will have the option of using either 40 hours or 48 hours of vacation at their discretion Vacation will only be paid on a straight time basis.

7. **Holidays**: Employees scheduled to work the actual calendar holiday that are excused from work by the Company will receive holiday pay for the regularly scheduled hours they would have worked on the actual calendar holiday. All other employees will receive 8 hours of holiday pay. Employees working on the actual calendar holiday will receive time and one-half pay for the first 12 hours worked on the actual calendar holiday. If employee's overtime pay hours (last 8 hours of a 48-hour week) fall on an actual calendar holiday, the employee shall be paid 12 hours at the time and one half-wage rate for that day.

8. **Death in Family:** A day off for death in the family shall be equal in pay to the hours of pay an employee would have received if you had worked that day.

9. **Meal Monies:** Meal monies shall be paid after 13 contiguous hours worked and again after 15 hours worked. Call-in situations shall follow the current contract guidelines of meal money paid for every five hours of contiguous work.

10. **Shift Differential:** Shift differential will be paid on night shift only (12 hours) at the current contract night shift rate. No shift differential will be paid on the four evening hours of day shift (3PM – 7 PM).

11. **Short-Term Disability**: As per the current Agreement, during the seven consecutive calendar day waiting period, it is intended that no employee will incur a loss of more than forty hours of straight time pay.

Duke Energy

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Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Store Room Bidding

Dear Mr. Feldhaus:

During the 2006 negotiation meetings, the Company and the Union discussed restoring the former combined bidding process for storeroom employees.

As discussed, since 2000, the job posting procedure for storeroom vacancies between the generating stations and the Brecon store room was changed to being administered as two separate bidding areas, but the bumping rights for the incumbent employees was grandfathered for the former combined bidding area for the term of the 2000 – 2006 Agreement.

During the discussion, it was agreed that for the term of the 2006 – 2009 Agreement, the job posting procedure and bumping rights of the employees in storeroom job classifications, whether in power plant store rooms or the Brecon facility, will be reinstated to the former combined administration for both filling job vacancies and for bumping rights.

It is believed that the above accurately describes the restructuring process for bidding among the storeroom work forces.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

Duke Energy

DUKE ENERGY CORPORATION
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Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Eyeglass Pitting

Dear Mr. Feldhaus:

During the 2006 negotiations, the Company and the Union discussed the unique eyeglass pitting problem experienced by welders in the Electric Repair Section of the Substation Maintenance Department and in the Material and Repair Section of T&D Projects.

As agreed, during the term of the 2006 – 2009 Agreement, the Company will furnish standard frames with prescription safety lenses and permanent side shields from its supplier to each welder in those sections who wear corrective lenses that have been substantially affected by this problem. Affected employees may submit their prescription to the department so that the Company can order these glasses. The glasses are to be worn exclusively by these employees when performing welding work for the Company.

During the term of the Agreement, the employees may submit these glasses to the Company for inspection on an annual basis. If the Company determines that a new pair of glasses is warranted due to this pitting problem, the employee will be issued another pair.

Although this is a mutually agreeable method of providing relief to the affected employees, the Company will continue its efforts to completely resolve the problem in the future. At the time the Company finds a solution to this unique problem, the purchase of eyeglasses for welders will be discontinued.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 2, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Project Work – Outside Duke Energy OH/KY Service Area

Dear Mr. Reilly:

When it is necessary for the Company to utilize employees represented by Local Union 1347 to perform non-emergency Project work outside the Duke Energy Ohio/ Duke Energy Kentucky service area ("Travel Project Work"), the Company will request volunteers from the needed job classifications at the various headquarters. It must be understood that due to pre-scheduled or on-going work projects, specific work/skill requirements and other business needs, the Company must reserve the right to be selective when evaluating voluntary requests for Travel Project Work. However, whenever possible, the required number of individuals or crews will be staffed with those employees who volunteer.

If there are more qualified volunteers than needed for a specific Travel Project Work assignment, selection will be made based on classified seniority. If there is not a sufficient number of available qualified volunteers, the Company will assign the junior available individuals in the required job classifications who are qualified to perform the particular work needed. Employee rotation on projects of long duration may occur at the discretion of the Company.

When employees are required to report to the Travel Project Work site each day and the employee is not utilizing a company assigned vehicle, mileage reimbursement will be provided by calculating the difference of miles driven to assigned headquarters and mileage driven to the jobsite reporting location. If mileage to the jobsite reporting location is less than mileage driven to assigned headquarters no mileage reimbursement will be granted when the mileage to the Travel Project Worksite is less than mileage driven to the employee's regular headquarters.
In addition, when employees are required to report to the Travel Project Work site each day, the following will apply:

- For sites 30 miles or less from the employee's regular headquarters, the employees will be provided 1 hour straight time pay per day.
- Where the job site is 31 miles to 45 miles from the employee's regular headquarters, the employees will be entitled to 1.5 hours straight time pay per day.

- Where the job site is 46 miles to 60 miles from the employee's regular headquarters. the employees will be entitled to 2 hours straight time pay per day.

- Where the job site is greater than 60 miles from the employee's regular headquarters, the employee will have the option of choosing a per diem, or being reimbursed by the Company for actual and reasonable expenses based on receipts provided by the employee. The per diem expense shall be based on the amount allowable per the current IRS Publication for the area where the Travel Project Work is being performed.

  The per diem calculation, on the first and last day of the Travel Project Work assignment, will be reduced per the current IRS Publication. Any lodging and meal expenses incurred over and above the stipulated per diem amount for any given trip will be the responsibility of the employee. However, if the assignment is in an area where hotels have increased their rates for "special events" and the employee presents actual receipts, employees will be reimbursed for their actual out-of-pocket lodging and meal expenses, instead of the established per diem amount.

In addition, for Travel Project Work greater than 60 miles from the employee's assigned headquarters, travel to the job site will generally be on Company time on the first day and from the job site on the last day of the project only. Employees will be paid at the appropriate rate of pay in accordance with the Contract.

When commuting is practical based on the close proximity of the Travel Project Work as determined by the Company, employees will report to the job site at their scheduled starting time and work until their scheduled quitting time.

Employees assigned to Travel Project Work will not be eligible for normal call-out overtime during the work week. However, if employees have returned from the project after the last day of their work week, they can then be eligible for call-out and scheduled overtime at their normally assigned headquarters, if they provide appropriate notice to supervision of their availability. Employees are required to bring tools home on their off days to be eligible for call-out or scheduled overtime on those days. In addition, overtime worked by employees on these projects may or may not be charged to the employee on their regular overtime listing back at their normal headquarters, at the discretion of the Union. Additionally, these employees will also be eligible for emergency assistance assignments to foreign utilities.

These guidelines may be modified due to unusual circumstances on a particular project by mutual consent of the parties. It is understood that this letter accurately defines the guidelines to be utilized during the term of the 2014 – 2017 Agreement in the event of employees represented by Local Union 1347 working on Travel Project Work.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy

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August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Undercover Investigators

Dear Mr. Feldhaus:

During the 2006 negotiations, the Company and the Union discussed the use of undercover investigators during the term of the 2006 – 2009 Agreement.

As discussed, the Company will not allow any undercover investigators it employs to join or attempt to join the Union. It was also agreed that the Union would instruct all its members to encourage employees experiencing substance abuse problems to seek help through the Employee Assistance Plan and to elicit the aid of the Union leadership in so encouraging employees. The Union also agreed to periodically print articles in its newsletter and/or web page concerning the problems associated with substance abuse, encouraging its members to take the necessary positive action to fight the effects of substance abuse in the workplace.

It is thought that this agreement between the parties will further the Company's efforts in establishing and maintaining a work environment that is free from the effects of drug abuse.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

Duke Energy®

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139 East Fourth St.
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Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Leadperson – Trainer Role

Dear Mr. Feldhaus:

During the 2006 negotiations, the Company and the Union discussed bargaining unit employees performing the training function for new employees in the T&D Construction and Maintenance and the T&D Projects areas of the Company.

As agreed, a lead person-trainer role will be performed by bargaining unit personnel in the Sr. Lineperson "A" (Job Code #7879), Lineperson "A" – Trouble (Job Code #6838) and Lineperson "A" (Job Code #6834) job classifications. While serving in that capacity, bargaining unit personnel will be responsible for training newly selected employees entering into the Lineperson progression. The type of training that will be performed will involve classroom and hands-on at the Company's training facilities as well as on-the-job training in the field environment.

Compensation for employees performing the lead person-trainer role will be a premium in the amount of $1.25 per hour above the maximum rate of pay of the Senior Lineperson "A" job classification. Effective January 1, 2007, the premium will be increased to $1.50 per hour. In the event that employees must temporarily change headquarters to perform this role, they will receive compensation for travel in accordance with the Agreement. Such a change of headquarters for greater than six months is not in contravention of the 1996 negotiation letter concerning the posting of small crew work projects lasting more than six months.

The criteria management will use to assess candidates' qualifications to perform the lead person-trainer role will include job performance in their current job classifications and a determination if candidates posses adequate competencies for conducting training. Candidates' qualifications will be evaluated by representatives from the Company's staffing function, in conjunction with departmental management representatives. A practical demonstration test, to assess candidates' abilities to effectively train individuals, will also be utilized for this purpose. As a minimum requirement, only employees who have at least three years of experience working in the job classifications of Lineperson "A" or above in the Lineperson progression will be considered for the lead person-trainer role.

It is expected that qualified employees will volunteer for the lead person-trainer role. While the best qualified (based on assessment scoring) will be selected, it is anticipated that many candidates will be fairly close in scoring on their assessments. Where the scores are fairly similar (approximately within 10 points of each other) between qualified candidates, seniority shall prevail. However, business circumstances may prevent the selection process for qualified individuals from being based solely on the assessments and seniority. For example, it may be a business hardship on management to allow two employees from the same headquarters to simultaneously conduct training for the same training class. Therefore, if an employee would have been selected, but due to business hardship is not, he/she will be offered the next opportunity to fill the trainer function at his/her headquarters.

The Company will provide advanced notice to employees about opportunities for the assignment to the lead person-trainer role in anticipation of having qualified individuals to assume that role when needed in the future.

As further agreed, this arrangement will be in effect during the term of the 2006 – 2009 Agreement.

It is believed that the above accurately describes the accord reached between the parties on the establishment of the lead person-trainer role.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 2, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Leadperson

Dear Mr. Reilly:

During the 2006 negotiations, the Company and the Union discussed maintaining a Lead Person role in areas of the Company other than The Energy Commodities Business Unit for the term of the 2006 – 2009 Agreement. While serving in this capacity, personnel in bargaining unit job classifications are responsible for addressing and coordinating all matters relative to their assigned job sites. Persons in that role also instruct the work of other employees in the same and lower job classifications at job sites, in addition to performing their regular duties.

It was further agreed that due to the differences among the various departmental areas in terms of job site location, the complexity of work and other factors, more specific guidelines should be established with the Union pertaining to the Lead Person role in those respective areas. That process has already occurred between the parties where the Lead Person role was previously established with the Union. Those guidelines will remain in place. To establish the utilization of personnel in the Lead Person role in departmental areas where it has not been already established with the Union, union and management representatives from those areas will develop such Departmental Area Guidelines. Those Guidelines will describe, more specifically, the responsibilities of the Lead Person role in those respective areas. The Guidelines will address such specifics as the number of employees that may be directed, the activities that are to be coordinated at a job site, the manner in which employees will be selected to perform the Lead Person role and any other appropriate details.

As discussed, it is expected that employees in senior job classifications will fill the need for the Lead Person role and that seniority and volunteerism will guide the selection process for filling that role, qualifications being sufficient. However, for the lack of a volunteer or because it may not always be possible or efficient to do so, other employees may on occasion be assigned to a Lead Person role.

Compensation for employees performing the Lead Person role, effective May 5, 2014, will be $1.75 per hour above the maximum rate of pay of their job classification. This exception to the rate of pay for the temporary upgrades is limited to this Agreement and does not pertain to any other situations.

Additionally, it was agreed that the use of the Lead Person role and the establishment of the referenced Guidelines could apply to some work groups within a departmental area and, at the same time, not apply to other work groups within the same departmental area.

It was also discussed that the Lead Person role is meant to expand the duties and responsibilities beyond what is currently assigned within the respective job classifications. The Company assured the Union that in establishing the Guidelines for Lead Person responsibilities, the safety of company employees and the public would be given appropriate consideration. It was also discussed that evaluating the work performance of employees and the administering of disciplinary actions would continue to be the responsibility of appropriate management personnel.

The above accurately describes the agreement concerning the Lead Person role in areas represented by the Union during the term of the 2006 – 2009 Agreement.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy

DUKE ENERGY CORPORATION
139 East Fourth St.
PO Box 960
Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Advanced Wages for Union Business

Dear Mr. Feldhaus:

During the 2006 negotiations, the Company and the Union discussed making arrangements for the Company to advance straight-time wages to employees represented by the Union who are off the payroll for non-compensated union business during their normal working hours.

As agreed during these meetings, during the term of the 2006 – 2009 Agreement, such wages will be advanced to employees. It was also agreed that the Union will send to the Labor Relations area of the Company a copy of all letters from the Union to employees requesting that they be off the payroll to attend non-compensated union business. Additionally, at the end of each month, the Union will provide the Labor Relations area a summary report which includes each employee's name, department, department number, dates on which non-compensated union business occurred and the corresponding number of hours each employee spent on non-compensated union business. The Company will then prepare an invoice to bill the Union for reimbursement of the wages advanced to these employees during the month. The Union, in turn, will submit payment to the Company for the invoiced amount within 30-days.

It is believed that this arrangement will prove to be beneficial to the Union and the individual employees who perform non-compensated union business. However, the Company must reserve the right to discontinue this arrangement at anytime.

Sincerely,

Jay R. Alvaro
Managing Director
Labor Relations

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139 East Fourth St.
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August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
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4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Seniority and Interplant Bidding Rights

Dear Mr. Feldhaus:

During the 2006 negotiation meetings, representatives of the Company and the Union discussed the interplant bidding rights for employees of Power Operations.

During these discussions, the parties agreed that during the term of the 2006 – 2009 Agreement, should the Company declare a surplus at one of its electric generating facilities in the Production, Maintenance Services or Material Services Team Member classifications, and the affected employees cannot be absorbed into the work force at that facility, and that would result in a layoff, the corresponding number of employees, lowest in total combined seniority in the Electric Generating Stations will be determined by station(s) as surplused. Those employees will then have bidding rights into the above-mentioned classifications (at least up to 50 total, not from each classification, subject to provisions below) at other electric generating facilities based on total combined seniority in the Electric Generating Stations. This seniority would exclude any breaks in service. Total seniority will include all time at an employees present work location, and any previous location in Electric Production/Energy Commodities, provided there was no break in service. If there is a break in service, the previous seniority will be lost and the employee's seniority date will begin again with the date the employee returns to one of the above-referenced classifications. If there are more than 50 surplus personnel and the Company cannot place those in excess of 50 under this procedure, it was agreed that the parties would meet to determine alternate methods of handling the situation.

However, it was also agreed that in order to maintain efficient operations at the plants, there will be no bumping of the following employees in the above classifications: a specified number of the most senior, trained employees performing the former Control Operator classification job duties at the other electric generating facilities. This number would include 20 employees at the Beckjord Station, 7 at the East Bend Station, 20 at the Miami Fort Station, 12 at the Woodsdale Station and 10 at the Zimmer Station. This number will also include a specified number of the most senior, trained employees

performing the former Scrubber Operator classification duties at the other electric generating stations, or at the Miami Fort Station, the FGD Operator job duties. This number would include 6 at the East Bend Station, 10 at the Zimmer Station and 5 at Miami Fort Station. The 5 FGD Operators at Miami Fort will remain protected for the term of the contract. Entry of an individual into the protected group will not occur until a vacancy becomes available. Management will fill vacancies (Control Operator, Scrubber Operator) using the existing process.

Attached is a document from the Union agreed to during the 2006 negotiations describing the interplant bidding process, and two examples prepared by the Company describing how this process will operate.

As agreed, if the Company transfers its ownership to a station and subsequently a surplus is declared at another station, the number of surplus employees the Company agrees to absorb into the remaining stations will be decreased by the same percentage that the total number of employees were decreased by that transfer of ownership. For example, if there were 500 union members in Power Operations and a Plant's ownership was transferred along with the 100 bargaining unit employees that work there, the 50 number above would be reduced by 20% (or to 40) for any subsequent Company declared surplus.

It must be understood that allowing such bidding rights may cause employees in the Production, Maintenance Services or Material Services Team Member classifications, junior in total combined seniority in the Electric Generating Stations at the receiving plant(s), to be laid off. Employees who do not accept alternate job opportunities provided from the bumping process will voluntarily resign their employment. This understanding in no way limits Management's rights contained in Article V, Section 19.

It is thought that the above adequately describes how seniority rights will apply for employees within the Power Operations Department in the event such actions are necessary, during the term of the 2006 – 2009 Agreement.

Sincerely,

Jay R. Alvaro

Jay R. Alvaro
Managing Director
Labor Relations

Supplemental Explanation to Seniority and Interplant Bidding

In the event it becomes necessary to eliminate jobs in the bargaining unit that would result in a layoff within any, or all, of the five represented electric generating plants currently owned by the Company (East Bend, Beckjord, Zimmer, Miami Fort, and Woodsdale), the following will be the procedure used to insure a result that is as close as possible to "last in – first out," for the Production, Maintenance Services or Material Services classifications:

1. The Company will identify the number of jobs to be eliminated within each of the above classifications, and at each plant.

2. The employees whose jobs are eliminated will then be notified and given the opportunity to use their total combined contiguous (unbroken) seniority in the above referenced electric generating stations to bump the most junior designated employee at each generating station. They are employed in one of the above referenced classifications, and their seniority will reflect all time at their present location, and any previous location in the above listed generating stations, provided there was no break in service (another department outside EPD, or time spent in a job not represented by the Union).

3. The Union will identify the most junior employees (based on their total electric generating station seniority) in all stations equal to the number of jobs designated for elimination.

4. Employees who have been bumped, or had their job eliminated, will then, in order of their above described seniority, bump the identified most junior employees at each station.

5. These most junior employees who cannot bump will then be laid off or surplused as described elsewhere in this agreement.

6. Certain employees are protected from the bumping described herein as detailed in the letter captioned "Seniority and Interplant Bidding Rights."

For example: If it was determined by the Company that two (2) Generating Stations need to layoff or surplus five (5) Production employees at each Station, the "List" would be used to identify the ten (10) least senior employees at all five Plants. These ten (10) would be the first to go on surplus or layoff. Those resulting openings would be filled by the next ten (10) least senior on the List, providing none of these employees were identified as least senior to be surplused. In that case, this employee could not bump, and would be part of the layoff/surplus group. The previously identified employees from two (2) Generating Stations would then use their total combined Generating Station seniority, or the "List" to choose which openings they would fill. The senior employee would choose an opening first, and so forth, until the openings are filled.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Welding Premium

Dear Mr. Kirk:

During the 2017 negotiations, the Company and the Union discussed a premium for employees within Fossil/Hydro Generation possessing certain welding certifications.

It was agreed that if the Company determines the welding being performed is outside the scope of an employee's classification or requires specialized training and certification then a premium in the amount of $1.00 per hour will apply. This premium will be applicable to all hours paid. The Company solely determines the number of employees receiving this premium based on business need. Should an employee's certification lapse for any reason then no premium will be paid. In addition, the Company may discontinue the use of certified welders based on business need at any time.

The first order of selection will be based on the classified seniority of those employees who possess welding certification. The second order of selection will be based on the classified seniority of those employees who have completed the advanced mechanical discipline.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy

DUKE ENERGY CORPORATION
139 East Fourth St.
PO Box 960
Cincinnati, OH 45201-0960

February 6, 2008

Mr. Stephen H. Feldhaus
Business Manager
Local Union No. 1347
International Brotherhood
of Electrical Workers
4100 Colerain Avenue
Cincinnati, Ohio 45223

Dear Mr. Feldhaus:

Per our discussions, the Company instituted a new training program for workers employed at generating facilities. This program, the Employee Development Qualification Program (EDQP), replaces the Skills Qualification Program (SQP). In conjunction with this program, four new job classifications are being developed:

- Control Room Operator
- Production Technician
- Support Technician
- Simple Cycle Technician

The following will apply to the above-referenced classifications:

A) The minimum wage rate for both the Production Technician and the Support Technician job classifications will be $13.00 per hour and the maximum is established at Pay Level 21. As of January 1, 2008, this wage rate is $29.89.

B) The Control Room Operator job classification will not be implemented until the Company and the Union have had the opportunity to meet further and discuss job responsibilities and wage rates. This is expected to occur during the first quarter of 2008. If the parties do not reach an agreement, then the wage rate will either be set at Level 25 (currently $31.09) or evaluated using the established job evaluation process.

C) The Simple Cycle Technician classification will be evaluated.

1. Existing Employees

A) Employees currently in the Production Team Skills Qualification Program, and not at the maximum rate of pay, will remain in the SQP and will have the ability to reach Pay Level 25.

B) Employees may be required to complete portions of the EDQP, as determined by management, to close any identified skill gaps.

C) Existing employees in the Support Team Member or Material Services Team Member classification who are selected for Production Team vacancies during the remainder of the 2006-2009 Collective Bargaining Agreement will enter the Production Team Member classification. They will be required to close any skill gaps as determined by the Company. In addition, the Company will select the discipline based on business needs. If the Operations discipline is selected, these employees will be required to become Control Room qualified.

D) The Control Room Operator will be a bid position within a job progression. Positions will be posted in accordance with Article III, Section 6 and Article III, Section 7 of the 2006-2009 Collective Bargaining Agreement.

2. Advanced Operators/Control Room Operators

A) Each station will determine the number of Control Room Operators required. See ***"Seniority and Interplant Bidding Rights"*** letter dated August 22, 2006. (Attachment)

B) Production Team Members currently in training as Advanced Operators will be allowed to complete their training.

C) After January 1, 2008, any Production Team Member who begins training for Control Room Operations will do so under the training plan established by the Company.

D) For employees in the Production Technician classification, only those in the Operations discipline are eligible to promote to Control Room Operator.

E) There is no automatic progression. In order for an employee to promote, there must be a vacancy as determined by management.

F) Existing Production Team Members may be assigned control room functions within the scope of the existing classification.

3. New Employees/Transferring Employees

A) Effective January 1, 2008, all new employees or employees that are not currently a Support Team/Material Services Team Member entering the Production Team or Support Team will do so as a Production Technician or Support Technician.

B) Management will determine each employee's discipline at the time of hiring or transfer.

C) Employees will be given credit for past experience and education as outlined in the ***"Entry Wage Level Guidelines – IBEW Production Technician/Support Technician"*** document. (Attachment)

D) Employees placed at other than an entry level position will be required to demonstrate proficiency by completing portions of the training program, as required.

E) Employees may request to change disciplines with no impact to pay. Requests will be evaluated based on business needs and are at the discretion of the Company.

4. Pay Progression

A) Employees will be evaluated and eligible for a pay increase every six months as provided for in the ***"Patrick P. Gibson Letter,"*** dated December 29, 2000. (Attachment)

B) The intent is for employees to reach the maximum pay rate in five years, provided qualifications are met.

C) In lieu of the $0.10 increase as provided for in the 2006-2009 Collective Bargaining Agreement, each increase will be determined by taking the difference between the minimum and maximum wage rate and dividing by 10 for employees starting at the minimum wage rate. Based on current wage levels, this increase is approximately $1.69 per hour every six months.

D) For the Control Room Operator, there will be one increase with the employee reaching maximum rate of pay at six months.

E) For employees starting at a wage rate other than the minimum wage rates, all requirements must be met prior to receiving a six month increase. Employees will still be evaluated every six months and other provisions of the ***"Patrick P. Gibson Letter"*** will apply.

F) Eligibility for increase is based on satisfactory performance. Factors to be considered include, but are not limited to, attendance, job performance, progress in the training program, and disciplinary record.

G) If an increase is denied, the employee will not be eligible for an increase until the next scheduled increase. Given that the employee has corrected any deficiencies identified, they will receive the scheduled increase and the increase that had been previously denied.

H) If the employee is denied an increase, or in the event of receiving an unsatisfactory evaluation as outlined in Paragraph E, serious consideration should be given as to whether or not the employee should be demoted, transferred or released. The Union may request a review of such a decision and such review will be conducted in accordance with the ***"Patrick P. Gibson Letter,"*** dated December 29, 2000.

I) Increases are neither granted nor denied solely on the basis of progress within the training program with the exception of movement from phase-to-phase. Employees must complete each phase within the required time frame to be eligible for pay increase. These hard breaks are at 12 months, 36 months, and 60 months from the start of the program. Employees placed at other than entry level position must meet the hard break requirements as outlined above.

J) Employees on a leave of absence will be treated similarly. When an employee's leave of absence is greater than 30 days, eligibility for any merit increase will be delayed by the length of time equal to the absence. This provision will be applied consistent with the Family and Medical Leave Act, and all other applicable laws and Company policies.

I have attached copies of the job descriptions for Production Technician and Control Room Operator. The job descriptions for the Support Technician and Simple Cycle Technician are still being developed. As stated above, during the first quarter of 2008, the Union and the Company will meet to discuss the Control Room Operator classification. I have also attached a copy of the hiring matrix used in determining starting wage rates.

As with other job descriptions, the Company has a right to discontinue at any time. In addition, this agreement does not in any way restrict or change the rights of management, except as specifically stated in this agreement. If you are in agreement with this proposal, please return a signed copy of this letter to me.

If you have any questions, please contact me at (513) 287-5022.

Sincerely,

Michael A. Ciccarella
Labor Relations Consultant

Attachments

For the Union:

Stephen H. Feldhaus, IBEW Local 1347

2/12/08
Date

Attachments:

1. Seniority and Interplant Bidding Rights Letter Dated August 22, 2006
2. Entry Wage Level Guidelines – IBEW Production Technician/Support Technician
3. Patrick P. Gibson Letter Dated December 29, 2000
4. Production Technician Job Description
5. Control Room Operator Job Description

ATTACHMENT 1

DUKE ENERGY CORPORATION
139 East Fourth St.
PO Box 960
Cincinnati, OH 45201-0960

August 22, 2006

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Seniority and Interplant Bidding Rights

Dear Mr. Feldhaus:

During the 2006 negotiation meetings, representatives of the Company and the Union discussed the interplant bidding rights for employees of Power Operations.

During these discussions, the parties agreed that during the term of the 2006 – 2009 Agreement, should the Company declare a surplus at one of its electric generating facilities in the Production, Maintenance Services or Material Services Team Member classifications, and the affected employees cannot be absorbed into the work force at that facility, and that would result in a layoff, the corresponding number of employees, lowest in total combined seniority in the Electric Generating Stations will be determined by station(s) as surplused. Those employees will then have bidding rights into the above-mentioned classifications (at least up to 50 total, not from each classification, subject to provisions below) at other electric generating facilities based on total combined seniority in the Electric Generating Stations. This seniority would exclude any breaks in service. Total seniority will include all time at an employees present work location, and any previous location in Electric Production/Energy Commodities, provided there was no break in service. If there is a break in service, the previous seniority will be lost and the employee's seniority date will begin again with the date the employee returns to one of the above-referenced classifications. If there are more than 50 surplus personnel and the Company cannot place those in excess of 50 under this procedure, it was agreed that the parties would meet to determine alternate methods of handling the situation.

However, it was also agreed that in order to maintain efficient operations at the plants, there will be no bumping of the following employees in the above classifications: a specified number of the most senior, trained employees performing the former Control Operator classification job duties at the other electric generating facilities. This number would include 20 employees at the Beckjord Station, 7 at the East Bend Station, 20 at the Miami Fort Station, 12 at the Woodsdale Station and 10 at the Zimmer Station. This number will also include a specified number of the most senior, trained employees

performing the former Scrubber Operator classification duties at the other electric generating stations, or at the Miami Fort Station, the FGD Operator job duties. This number would include 6 at the East Bend Station, 10 at the Zimmer Station and 5 at Miami Fort Station. The 5 FGD Operators at Miami Fort will remain protected for the term of the contract. Entry of an individual into the protected group will not occur until a vacancy becomes available. Management will fill vacancies (Control Operator, Scrubber Operator) using the existing process.

Attached is a document from the Union agreed to during the 2006 negotiations describing the interplant bidding process, and two examples prepared by the Company describing how this process will operate.

As agreed, if the Company transfers its ownership to a station and subsequently a surplus is declared at another station, the number of surplus employees the Company agrees to absorb into the remaining stations will be decreased by the same percentage that the total number of employees were decreased by that transfer of ownership. For example, if there were 500 union members in Power Operations and a Plant's ownership was transferred along with the 100 bargaining unit employees that work there, the 50 number above would be reduced by 20% (or to 40) for any subsequent Company declared surplus.

It must be understood that allowing such bidding rights may cause employees in the Production, Maintenance Services or Material Services Team Member classifications, junior in total combined seniority in the Electric Generating Stations at the receiving plant(s), to be laid off. Employees who do not accept alternate job opportunities provided from the bumping process will voluntarily resign their employment. This understanding in no way limits Management's rights contained in Article V, Section 19.

It is thought that the above adequately describes how seniority rights will apply for employees within the Power Operations Department in the event such actions are necessary, during the term of the 2006 – 2009 Agreement.

Sincerely,

Jay R. Alvaro

Jay R. Alvaro
Managing Director
Labor Relations

Supplemental Explanation to Seniority and Interplant Bidding

In the event it becomes necessary to eliminate jobs in the bargaining unit that would result in a layoff within any, or all, of the five represented electric generating plants currently owned by the Company (East Bend, Beckjord, Zimmer, Miami Fort, and Woodsdale), the following will be the procedure used to insure a result that is as close as possible to "last in – first out," for the Production, Maintenance Services or Material Services classifications:

1. The Company will identify the number of jobs to be eliminated within each of the above classifications, and at each plant.

2. The employees whose jobs are eliminated will then be notified and given the opportunity to use their total combined contiguous (unbroken) seniority in the above referenced electric generating stations to bump the most junior designated employee at each generating station. They are employed in one of the above referenced classifications, and their seniority will reflect all time at their present location, and any previous location in the above listed generating stations, provided there was no break in service (another department outside EPD, or time spent in a job not represented by the Union).

3. The Union will identify the most junior employees (based on their total electric generating station seniority) in all stations equal to the number of jobs designated for elimination.

4. Employees who have been bumped, or had their job eliminated, will then, in order of their above described seniority, bump the identified most junior employees at each station.

5. These most junior employees who cannot bump will then be laid off or surplused as described elsewhere in this agreement.

6. Certain employees are protected from the bumping described herein as detailed in the letter captioned "Seniority and Interplant Bidding Rights."

For example: If it was determined by the Company that two (2) Generating Stations need to layoff or surplus five (5) Production employees at each Station, the "List" would be used to identify the ten (10) least senior employees at all five Plants. These ten (10) would be the first to go on surplus or layoff. Those resulting openings would be filled by the next ten (10) least senior on the List, providing none of these employees were identified as least senior to be surplused. In that case, this employee could not bump, and would be part of the layoff/surplus group. The previously identified employees from two (2) Generating Stations would then use their total combined Generating Station seniority, or the "List" to choose which openings they would fill. The senior employee would choose an opening first, and so forth, until the openings are filled.

Seniority and Inter-Plant Bidding Examples
Example A: Surplus 8 Production Team Members at East Bend Station
Example B: Surplus 3 Support Team Members at Zimmer Station
1 Bryson, as an example that a person could bump someone at the same plant with less seniority and the person would take a job at another location
2 Jason, as an example that a person could elect to go to another plant as a direct bump or them being bumped to the plant.

ATTACHMENT 2

Slotting Matrix

For NEW HIRES into Production Technician or Support Technician job classifications:

EXPERIENCE → Related work experience EDUCATION ↓	No Experience	> 1 year directly related experience	> 3 years directly related experience	> 5 years directly related experience	> 8 years directly related experience	> 10 years directly related experience
4 yr. degree plus related work experience	Step 2 of Prod / Support Tech $14.69	Step 3 of Prod / Support Tech $16.38	Step 4 of Prod / Support Technician $18.07	Step 5 of Prod / Support Technician $19.76	Step 6 of Prod / Support Technician $21.45	Step 6 of Prod / Support Technician $21.45
2 yr. related school tech degree plus related work experience	Step 2 of Prod / Support Technician $14.69	Step 2 of Prod / Support Technician $14.69	Step 2 of Prod / Support Technician $14.69	Step 3 of Prod / Support Technician $16.38	Step 3 of Prod / Support Technician $16.38	Step 4 of Prod / Support Technician $18.07
Some advanced education (1 year or more), Non-degreed in related courses or degree in non-related course or 1 year trade school degree.	Not Qualified	Step 1 of Prod / Support Technician $13.00	Step 2 of Prod / Support Technician $14.69	Step 2 of Prod / Support Technician $14.69	Step 3 of Prod/ Support Technician $16.38	Step 3 of Prod / Support Technician $16.38
High School Graduate or equivalency (GED, etc.)	Not Qualified	Not Qualified	Step 1 of Prod / Support Technician $13.00	Step 2 of Prod / Support Technician $14.69	Step 2 of Prod / Support Technician $14.69	Step 3 of Prod / Support Technician $16.38
Directly related work experience = experience in Mechanical, Electrical, Instrument & Controls and/or Operations in a Generating Station or other industrial facility requiring similar knowledge and abilities.						

For POWER GENERATION EMPLOYEES selected for Production Technician or Support Technician job classification:

Job offer for the PT or ST job is at the wage rate equal to or at the next higher wage rate of the pay progression. They are eligible for six month progressions until reaching the designated end of a phase at 12, 36, or 60 months. Must complete all phase requirements for increase at this point prior to progressing.

For OTHER COMPANY EMPLOYEES selected for Production Technician or Support Technician Member job classification:

Job offer for the PT or ST job would be based on the above wage guidelines. They are eligible for six month progressions until reaching the designated end of a phase at 12, 36, or 60 months. Must complete all phase requirements for increase at this point prior to progressing.

INTERNAL CORRESPONDENCE **ATTACHMENT 3**

To: Officers, General Managers and Managers

From: Patrick Gibson

Subject: **MANUAL, CLERICAL AND TECHNICAL JOB CLASSIFICATIONS**

Date: December 29, 2000

Reply By:

CINERGY.

The purpose of this letter is to amend and update the Walter C. Beckjord letter of October 1, 1945, which has served as a preamble to the Cincinnati Gas & Electric Company's job classification and evaluation system for Union represented job classifications.

In October 1945, after a careful and comprehensive study of the various kinds of work necessary to conduct the business of the Company in a safe, efficient and otherwise satisfactory manner, and the requirements of each job involved, the Company by agreement with the Unions representing the employees and with the approval of the National War Labor Board (Region V), placed into effect a schedule of job titles and descriptions for *all* manual, clerical and technical employees. Wage rate schedules were established and made effective in accordance with the Union agreements and the approval of the War Labor Board.

The job descriptions and wage rate schedules were designed to provide a fair and equitable means by which all the jobs, within the scope of the plan, being filled by manual, clerical and technical employees could be designated with uniformity and understanding throughout the Company system. The Company and the duly certified exclusive bargaining representatives of the bargaining units agreed to the basis used for defining jobs. It became the duty and responsibility of the supervisory force as the representatives of management to see that it was applied and maintained in a fair and consistent manner. It was also essential that employees clearly understood the duties and requirements of the jobs to which they were assigned. While the job descriptions were not intended to be all-inclusive, they were intended to cover such typical tasks necessary to provide a fair basis for evaluation.

The job classification and evaluation plan provided:

1. A set of job descriptions which prescribe typical duties and qualifications;

2. A set of promotional charts indicating the line of normal promotions in the respective departments;

3. A set of wage schedules containing maximum wage rates for all jobs and steps of progression to arrive at the maximum wage rates;

In September 1998, a new evaluation system (BOGAR) was implemented to evaluate all manual, clerical and technical job classifications represented by the International Brotherhood of Electrical Workers, Local 1347; the United Steelworkers of America, Locals 12049 and 5541-06; and the Independent Utilities Union. A joint union/management committee designed the BOGAR Job Evaluation System. In addition to the items listed above, the BOGAR system requires a Job Evaluation Questionnaire to be completed and approved for each new or revised job classification.

JOB DESCRIPTIONS

Each job description consists of a statement of the nature of work involved in the job classification, in sufficient detail to identify the title and content to those familiar with the organization; also a statement of the minimum qualifications required to enter the job. Each job description is subdivided into two parts, "Duties" and "Qualifications" as follows:

DUTIES

This section is devoted to a description of the essential duties required in the classification itself, considered entirely apart from the individual who may occupy the position. A sufficient number of duties are listed to:

1. Indicate the character and grade of the work;

2. Indicate the variety of duties;

3. Distinguish each job classification from another.

The duties for each job description are those principal duties that are required to properly identify and evaluate each of the specific job classifications. These duties are not to be considered all-inclusive. Employees may be temporarily assigned, within their capabilities, duties of other classifications. When the temporarily assigned duties are those of a higher or lower rated job classification the employees should be paid the appropriate rate of pay in accordance with the Union agreement.

This section also indicates, as a general guide, the degree of supervision under which the employees are expected to be able to perform their work; that is under "Close," "Directive," or "General Directive" supervision. These terms are defined as follows:

1. The term "under close supervision" means that the employees perform only those tasks which they have been instructed to do and are observed and supervised most of the time while performing them.

For example: A helper assisting a mechanic in performing assignments would ordinarily be under the "close" supervision of the mechanic.

2. The term "under directive supervision" means that the employees perform primarily those tasks and duties which they have been directed to do and then carry out such instructions under observation or checking from time to time.

   For example: A mechanic, working under the direction of a supervisor, assigned to a section of the work but observed or contacted periodically during the day, by the supervisor, would be considered as working under "directive" supervision.

3. The term "under general directive supervision" means that the employees under general instructions perform duties independently, but within the limitations of standard practices or procedure.

   For example: A Senior Lineperson operating in the field on scheduled assignments, in accordance with standard practices and procedures but without any supervision while in the field, whose production or performance would be the check on activities and quality of work, would be considered as working under "general directive" supervision.

QUALIFICATIONS

In this section of the job descriptions are listed those minimum qualifications which the individual is expected to bring to the job. Specifically included are such items as basic education, degree of skill, extent of experience, special knowledge, and other required qualifications.

Company Requirements as to General Qualifications

In addition to the duties and qualifications for each job classification as set forth in the job descriptions, each employee must meet the Company's requirements as to general qualifications, which include:

1. The physical and mental abilities to perform the essential functions of the job classification, with or without reasonable accommodations;

2. The willingness to follow instructions and cooperate with other employees;

3. The willingness to respond to calls outside of regular hours, when the need arises and in emergencies, to help in any department or phase of the Company's operations in which they are qualified to help;

4. The willingness to work a shift schedule and irregular hours where the nature of the work requires it;

5. The willingness to direct and instruct or train employees, of a lower job rating, assisting on the same work;

6. If required by assignment to drive automobile or trucks, must hold a valid State Bureau of Motor Vehicles Operators' license;

7. Compliance with the general rules and practices of the Company, with specific rules of the department in which they are employed, and with those of other departments with which their work must be coordinated;

8. Thorough familiarity with and strict observance of the Company's safety rules applicable to their job;

9. Have the characteristics of dependability, trustworthiness, and carefulness, and have a satisfactory previous record in these respects;

10. The willingness to submit to physical examinations by a licensed physician designated by the Company;

11. The willingness to supply the necessary employment records including, but not limited to, birth certificate, social security number, selective service record, military record, character and past employment records.

JOB EVALUATION QUESTIONNAIRE

Each questionnaire consists of questions related to the six factors used to evaluate a job classification under the BOGAR system. One or more employees in a job classification represented by the applicable Union must complete and sign one questionnaire. A departmental management representative must approve the completed questionnaire. The six factors and related sections of the questionnaire are as follows:

Knowledge

Questions related to the amount of formal and informal education, training and experience.

INTERNAL CORRESPONDENCE

Responsibility

Questions related to the amount of responsibility for such things as: Company funds; confidential information; safety, training and/or work direction of others; materials and equipment; etc.

Customer Contact

Questions related to the amount, importance and difficulty of contacts with internal and external customers.

Decision Making and Complexity of Duties

Questions related to the complexity of the work; the freedom employees have to make decisions; and, the impact their decisions may have on the Company.

Physical/Adverse Characteristics

Questions related to the amount, duration and frequency of: physical work (e.g., lifting, climbing and walking); and, work in adverse conditions (e.g., heat, cold, dust and noise).

Hazards

Questions related to the inherent dangers in the job which directly expose the employee to the possibility of accidents which may result in lost time accidents or death.

WAGE SCHEDULE

Starting Rates

When employees are first assigned to a job classification, they receive the starting/minimum rate indicated in the wage schedule for that job, except in cases where an employee is already receiving a rate equal to or in excess of the starting/minimum rate indicated. In such event when the employee is promoting into the job classification, the employee receives an increase as described in the applicable Union Agreement, but in no event in excess of the maximum wage rate for the job to which the employee is assigned.

Progression Steps within a Wage Range

The wage range provides for progression steps leading up to the maximum evaluated rate of the job. Job progression steps are designed for the purpose of

advancing an employee within the wage range. These progression steps are to be used as follows:

At intervals of six months, the supervisor shall make a review of the employee's development and progress on the assigned job. If progress, measured by demonstrated ability and performance, has been satisfactory, the scheduled progression step will be made effective on the first Monday following the expiration of that particular interval, until the employee's wage rate equals the maximum rate specified for the particular job classification.

When the performance review indicates that the employee has not made satisfactory progress in the job and an increase in pay is not warranted the employee is to be personally notified by the immediate supervisor that the progression step increase is being withheld. The notification must take place at least one month in advance of the date for the scheduled progression step. In addition, serious consideration should be given as to whether or not the employee should be demoted, transferred or released. The Union may request a review of such a decision. Such review is to be made by a representative or representatives of the Union and a representative or representatives of the Company.

For new employees the six-month interval will start from the hiring date, and for promoted employees, a new series of six-month intervals will start on the date of promotion.

CONCLUSION

Although this plan is set forth as clearly and explicitly as possible, questions may arise as to the intent or interpretation of some provisions. In such event, the matter should be discussed with a representative in the Labor Relations department.

Very Truly Yours,

Patrick P. Gibson

Patrick P. Gibson

ATTACHMENT 4

CLASSIFICATION: PRODUCTION TECHNICIAN

A. DUTIES:

Under directive supervision, on a rotating shift schedule, this position is responsible for the safe and efficient operations, mechanical, electrical and instrumentation and controls maintenance of the plant generating units, boilers, turbines, and their auxiliary and associated equipment including environmental systems and equipment, such duties, including but not limited to:

1. Ensuring proper startup, operation and maintenance of station boilers.
2. Ensuring proper startup, operation and maintenance of station turbines and generators.
3. Ensuring proper startup, operation and maintenance of all associated systems and environmental equipment including the remote operation of FGD or other systems.
4. Operating and maintaining the balance of plant equipment, station switchyards and electrical distribution systems.
5. Inspecting plant equipment, take operational and equipment status readings.
6. Identify, troubleshot, and correct equipment problems and performing mechanical, electrical and instrumentation maintenance activities.
7. Ensuring proper Lockout Tagout (LOTO) Energy Control procedures are performed as directed.
8. Completing all log entries and all necessary documentation for work assignments. Communicate information as required at shift turnover.
9. Completing all training and testing requirements of the job.
10. Direct, train and/or assist others as assigned.
11. Performing other similar or less skilled work.
12. Performing overtime work assignments.
13. Compliance with all environmental, health, and safety (EHS) regulations.
14. Communicate with others to allow for safe and efficient operation of equipment.

B. QUALIFICATIONS:

1. Must meet the Company's requirements as to GENERAL QUALIFICATIONS; in addition:
2. Must have a High School diploma or equivalent.
3. Must have three years experience in Industrial Maintenance or Operations.
4. Must maintain a valid driver's license if required.
5. Must successfully complete all required job qualification testing.

ATTACHMENT 5

CLASSIFICATION: CONTROL ROOM OPERATOR

A. DUTIES:

Under directive supervision, on a rotating shift schedule, is responsible for the coordination and the safe/efficient operations of generating units; operates boilers, turbines and their auxiliary, and associated equipment, remotely from a central control room, aided by communication with other plant personnel; directs in his duties personnel assigned to the unit; and performs such duties as:

1. Directing and coordinating shift personnel and activities. In the absence of the shift supervisor authorizes work to be performed including but not limited to authorizing clearances, burning permits, etc.

2. Engaging in the mechanical and electrical switching operations necessary to remove station or substation mechanical and electrical equipment from service and return it to service.

3. Ensuring proper Lockout Tagout (LOTO) Energy Control procedures are performed as directed.

4. Inspecting, monitoring, correcting problems, recording critical data and maintaining logs of operational parameters and activities.

5. Participating in training and may be required to direct, train and/or assist others as assigned.

6. Monitoring operating conditions of equipment for continuous compliance with environmental permit limits and design parameters, thus ensuring proper, safe, and economical operation of units, and taking proactive corrective steps when such conditions are abnormal.

7. Performing the necessary tasks to maintain proper operation of steam or gas turbines, including their related turbine auxiliary and associated equipment.

8. Performing the necessary tasks to maintain the desired output of electric generators, transformers, busses, transmission lines, oil and air circuit breakers and associated equipment including synchronizing and switching operations.

9. Performing the necessary tasks to maintain proper operation of boilers for fuel, air, water, and steam flows, pressures, temperatures, during unit start up, shut down, and steady state operation.

10. Performing the necessary tasks to maintain proper operation of environmental equipment (i.e., FGD Systems, Precipitators, Bag houses, SCR's, SNCR's, and any future equipment, including their auxiliary and associated equipment.

11. Performing the necessary tasks to maintain proper operation of balance of plant equipment, including their auxiliary and associated equipment.

12. Answering trouble calls, identifying the source or root cause of equipment failure, incorrect control operations, or other faulty operation of equipment, reporting to the Supervisor on shift of any trouble beyond their scope to rectify.

13. Initiate corrective action as required and coordinate response to abnormal operating conditions.

14. Maintaining control room and area in a clean, orderly condition, continuously observe Company safety rules and practices, unit operating permits, and other related procedures prescribed by the Company.

15. Completing all training and testing requirements of the job.

16. Performing the duties of Production Technician.

17. Performing other similar or less skilled work.

18. Performing overtime work assignments.

19. Compliance with all environmental, health, and safety (EHS) regulations.

B. QUALIFICATIONS:

Must meet the Company's requirements as to GENERAL QUALIFICATIONS; must have all the qualifications of a Production Team Member; and, in addition:

1. Must have at least six (6) years of station operations and/or maintenance experience.

2. Must have successfully completed all Company defined training and testing requirements and demonstrated an aptitude for and ability to successfully perform the duties of a Production Technician.

3. Must be able to demonstrate the ability to perform the duties of this job classification through the successful completion of required promotional exams.

4. Must maintain a valid driver's license if required.

Duke Energy

JIM O'CONNOR
Vice President
Labor Relations

Duke Energy Corporation
EA506 / 139 East Fourth St.
Cincinnati, OH 45202

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513-403-4147 cell
513-419-5313 fax
jim.o'connor@duke-energy.com

June 15, 2009

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Random Drug and Alcohol Testing

Dear Mr. Feldhaus:

During the 2009 negotiation meetings, the Company negotiated the right to implement random drug and alcohol testing for employees not currently covered by DOT regulations.

Although the Company is unsure at the present time when the testing will be implemented in the new groups, it is known that roll out will most likely begin with the Power Generation group. In any case, the Union and employees will be given no less than a 60 calendar day notice prior to the implementation of the random screens in any new work group. Employees will receive training on the process prior to implementation. It is the Company's intent to administer the random testing program in the same manner as it currently is for other areas of the Company.

The Union was assured that the testing pool for the non-DOT covered testing group will be a single pool at an annual test rate of 25%, including all non-DOT covered employees represented by the Union from each of departmental areas where the testing is implemented. The Company also committed to providing the Union with 550 "quick" drug testing kits on a one-time basis after ratification of the new Agreement.

Nothing in this letter is intended to alter or diminish the Company's right to medically evaluate or test employees for cause at any time. It is hoped that the random testing across the Company will provide consistency on this issue and help to maintain a safe work environment that is free from the effects of substance abuse.

Very truly yours,

Jim O'Connor

Jim O'Connor
VP, Employee & Labor Relations

Duke Energy

JIM O'CONNOR
Vice President
Labor Relations

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June 15, 2009

Mr. Steve Feldhaus
Business Manager
Local 1347
International Brotherhood of Electrical Workers, AFL-CIO

RE: Retirement Plan Agreement

Dear Mr. Feldhaus:

During the 2009 contract negotiations, representatives of the Company and Local Union 1347 of the International Brotherhood of Electrical Workers, AFL-CIO (the "Union") discussed the Company's desire for all employees to move to a common benefits program. The following outlines the agreement between the Company and the Union for providing employees with options for participation in the Cinergy Corp. Union Employees' Retirement Income Plan (the "Retirement Plan") and the Duke Energy Retirement Savings Plan for Legacy Cinergy Union Employees (Midwest) (the "Savings Plan").

Traditional Retirement Program Frozen:

Participation in the Traditional Program under the Retirement Plan will be frozen as of January 1, 2014 for certain employees. In this regard, active employees participating in the Traditional Program immediately prior to January 1, 2014 who have a combined age and years of service (i.e., vesting service under the Retirement Plan) ("Points") that totals less than 75 as of December 31, 2013 will automatically begin participating, as of January 1, 2014, in the "New Duke Retirement Program" under the Retirement Plan, which is substantially similar to the cash balance plan formula provided to legacy Duke employees and which is described in more detail in the mandatory conversion section below.

Voluntary Conversion Opportunity:

All active employees in the Traditional Program will be offered a voluntary window in 2009 to either elect to remain in the Traditional Program or to participate beginning January 1, 2010 in the New Duke Retirement Program, as described in the voluntary conversion section below.

Voluntary Conversion to the New Duke Retirement Program: The retirement benefits of those who voluntarily elect to move to the New Duke Retirement Program during the above-mentioned voluntary window will be as follows:

Part A Benefit (Part A): The pension plan benefit that employees will earn under the Traditional Program will be based on their participation service as of the "day before conversion date" and their final average monthly pay (including accrued vacation) at retirement (not the date of conversion). This Part A benefit will also be payable in a single lump sum, following termination of employment which single lump sum will be calculated using actuarial assumptions (i.e., interest rate and mortality table) determined in the sole discretion of the Company from time to time to the extent permitted by applicable law. For informational purposes only, the interest conversion rate currently resets annually on January 1 for distributions commencing in that year, based on the applicable interest rate published by the IRS for the prior August. In accordance with the Pension Protection Act, the interest conversion rate is being transitioned from the 30-year treasury rate to a three-tiered corporate bond rate.

AND

Part B Benefit (Part B): On the "conversion date," employees will start earning an additional pension plan benefit through a new formula that "mirrors" the cash balance benefit offered under the Duke Energy Retirement Cash Balance Plan. For purposes of clarity, such formula does not include "accrued vacation pay" in the definition of earnings.

The formula under the New Duke Retirement Program as of January 1, 2010 will be a pay credit equal to a percentage of earnings, which percentage is based on an employee's points under the following schedule:

Points	Percentage
0-35	4%
35-49	5%
50-64	6%
65+	7%

If an employee's earnings exceeds the Social Security Wage Base for a year, an additional pay credit equal to 4% of earnings above the Social Security Wage Base is made.

For purposes of clarity, years of service under the Retirement Plan (including years of service prior to participation in the New Duke Retirement Program) are taken into account in determining an employee's points under the New Duke Retirement Program.

The Company matching contributions provided under the Savings Plan for those who move to the New Duke Retirement Program will be enhanced to mirror the matching contributions provided under the Duke Energy Retirement Savings Plan. As a result, employees will be eligible to receive higher matching contributions on a broader definition of pay. The higher amount is a dollar-for-

dollar match on the first 6% of eligible pay (this includes base, overtime and annual incentive pay).

Mandatory Conversion to the New Retirement Program:

Mandatory conversion from the Traditional Program to a cash balance feature that mirrors the cash balance benefit offered under the Duke Energy Retirement Cash Balance Plan will be effective January 1, 2014 for employees who do not have 75 Points or more as of December 31, 2013 and have not voluntarily elected to participate in the New Duke Retirement Program. The benefits provided under the mandatory conversion will be substantially similar to those described above for a voluntary conversion with the following differences:

a. The final average monthly pay for Retirement Plan purposes will not include any compensation (including accrued vacation) received after December 31, 2013 (i.e., no pay run up).

b. Employees will not have the ability to choose a lump sum for their Part A benefit; only the current Traditional Program annuity options will be available for the Part A benefit.

c. Employees can still grow in to the 85 points early retirement subsidy for the Part A benefit.

d. Employees will receive the enhanced 401(k) plan matching contribution under the Savings Plan, as described above, once they mandatorily convert.

e. "Accrued vacation pay" will be included in the definition of earnings but only for purposes of determining an employee's benefit under the cash balance formula of the New Duke Retirement Program.

f. The portion of an employee's benefit that is earned under the Traditional Program cannot be distributed before the age of 50.

For purposes of clarity, active employees who have 75 Points or more as of December 31, 2013 and had elected to remain in the Traditional Program in 2009 will remain in the Traditional Program.

Employees Currently in the Cash Balance Plans and New Employees:

Employees who are currently in one of the Cinergy cash balance programs (i.e., Balanced or Investor) under the Retirement Plan will automatically transition to the New Duke Energy Retirement Program effective on January 1, 2010. For this group, the New Duke Retirement Program will include participation in a cash balance pension benefit that mirrors the benefits provided under the Duke Energy Retirement Cash Balance Plan, and an enhanced 401(k) plan matching contribution under the Savings Plan that mirrors the matching contribution provided under the Duke Energy Retirement Savings Plan. Employees who are hired prior to the transition date described

immediately above will participate in an existing cash balance formula under the Retirement Plan (i.e., the Balanced or Investor Program) and transfer to the New Duke Energy Retirement Program at the transition date in the same manner as other current employees. Employees who are hired on or after the transition date described immediately above will participate in the New Duke Retirement Program.

Profit Sharing and Incentive Matching Contributions

Once an employee is covered by the New Duke Retirement Program, he or she will no longer be entitled to profit sharing contributions (if they were previously in the Balanced or Investor Program) or incentive matching contributions (if they were previously in the Traditional Program). If an employee moves to the New Duke Retirement Program other than on the first day of a calendar year, he or she will not be eligible for an incentive matching contribution but will be eligible for a pro-rated profit sharing contribution (if otherwise earned) for that calendar year.

Retirement Plan and Savings Plan

This agreement outlines certain benefits to be provided to employees represented by the Union. This agreement shall not be construed as limiting or restricting the right of the Company as to the manner of providing such benefits, including the right to amend, modify or merge the Retirement Plan and/or Savings Plan.

Very truly yours,

Jim O'Connor

Jim O'Connor
VP, Employee & Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 2, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Amendment to A-61 "Retirement Plan Agreement" Letter

Dear Mr. Reilly:

During the 2014 negotiations, the Company and the Union discussed changes to the Company's retirement programs. This letter sets forth the changes that were agreed to by the Company and the Union.

Retirement Benefits for New Hires

For employees hired or rehired on or after January 1, 2015, the Company will provide an annual contribution to the Duke Energy Retirement Savings Plan ("RSP") in the amount of 4% of the employee's annual compensation (including base, overtime, and incentive compensation) in accordance with the RSP plan documents. Such newly hired or rehired employees also will be eligible for the Company-provided matching contribution equal to 100% of the before-tax (and Roth) contributions made up to 6% of eligible pay in accordance with the RSP plan documents on the same basis as employees hired prior to January 1, 2015. Employees hired or rehired on or after January 1, 2015 will not be eligible to participate in the Cinergy Corp. Union Employees' Retirement Income Plan (the "Pension Plan").

Cash Balance Interest Credit

The cash balance interest credit rate under the Pension Plan for pay credits made on and after January 1, 2015 will be based on a 4% interest rate (0.327% monthly equivalent interest rate). For purposes of clarity, the cash balance interest credit rate applies to cash balance participants and the Part B benefit for participants who have a Part A (traditional) and Part B (cash balance) pension plan benefit. The Part A (traditional) portion of the participant's benefit will not be affected by this change.

Pension Plan Benefit for Long-Term Disability

A participant who starts receiving long-term disability benefits on or after July 1, 2015 will receive interest credits under the Pension Plan's cash balance formula while disabled, but will

not receive pay credits while on LTD, in accordance with the Pension Plan documents. This change will not apply for any individual who starts receiving long-term disability benefits before July 1, 2015, or participates under the traditional formula, or for the Part A benefit for participants who have a Part A (traditional) and Part B (cash balance) pension plan benefit.

The complete provisions of the Company's retirement plans are set forth in the plan documents. In the event of a conflict between any other communication and the plan documents themselves, the plan documents control.

It is thought that this letter accurately describes the agreement reached by the parties regarding amendments to Sidebar Letter A-61 relating to retirement plan agreements.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy.

REVISIONS TO THE SABBATICAL VACATION BANK AND VACATION CREDITS PROGRAMS FOR IBEW 1347 EMPLOYEES

Effective January 1, 2010, the Vacation Bank and Vacation Credit Programs will be phased out over a 4 year period ending on December 31, 2013.

The Changes:

Sabbatical Vacation Program (Employee Banked Time):

- The sabbatical banking program will be eliminated for employees who are younger than 47 years old as of December 31, 2009.
- Employees who are 47 years old or older as of December 31, 2009 will be eligible to continue banking vacation until 12/31/2013, up to the limits described on the schedule below.
- Employees who have already banked more than the maximum amount of vacation based on the schedule below (including any vacation and service credits) cannot bank more after 12/31/2009, but will be grandfathered with the amount they have banked.
- No additional banking will be permitted after 12/31/2013. The last opportunity to bank vacation will be in December 2013.
- Banked vacation will be paid out at the final rate of pay at retirement.

Vacation Credit Program:

- Employees will be eligible to receive one week of vacation credit each year beginning at age 51, up to their annual vacation entitlement. A maximum of 240 hours will be awarded.
- Employees who are at least 51 years old as of 12/31/2013 will continue to receive vacation credits up to the lesser of their annual vacation entitlement or the schedule below.
- The vacation credit program will be modified for employees who are younger than 51 years old as of December 31, 2013. Those employees "only" hired prior to January 1, 1997 will receive their vacation credits up to the amount of vacation time they were eligible for as of January 1, 2005.
- Vacation credits will be paid out at the final rate of pay at retirement.

Service Credit Program:

- Employees will continue to receive one week of "service credit" added to their vacation bank in years 32 and 33 of employment in lieu of time off until December 31, 2013. Effective January 1, 2014, employees will be granted a 6th week of vacation time off during their 32nd and 33rd year of employment in lieu of a week of service credit.
- An employee who has already reached their maximum of vacation bank before January 1, 2014 will receive their 6th week of vacation as "time-off" in lieu of a service credit in years 32 and 33 of employment.
- Service credits will be paid out at the final rate of pay at retirement.

The Schedule:

Age as of 12/31/2009	Maximum Banked Vacation Weeks (including vacation and service credits)
47	10
48	10
49	10
50	12
51	14
52	16
53	18
54	20
55	22
56+	22

Jim O'Connor

Duke Energy.

JIM O'CONNOR
Vice President
Labor Relations

Duke Energy Corporation
EA506 / 139 East Fourth St.
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513-403-4147 cell
513-419-5313 fax
jim.o'connor@duke-energy.com

June 15, 2009

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Short Term Disability Issues

Dear Mr. Feldhaus:

During the 2009 negotiation meetings, the Union expressed concern about delays that have occurred and delayed pay of employees who have attempted to gain approval for Short Term Disability (STD) benefits.

The Union was assured that in situations where employees experience administrative delay in the approval process for initiating or extending STD pay, they may request use of available vacation pay and/or personal days to avoid the temporary loss of pay due to the delay. The requests are subject to management approval, but under normal circumstances they will be granted. When the Company's third party administrator approves STD retroactively, the pay coding for those days will be amended to reflect the payment of STD and the vacation and/or personal day hours will be added back to the employee's total amount of unused days for that calendar year.

It was also agreed that after the conclusion of the 2009 negotiations the Company would make arrangements for the union leadership to meet with company representatives and a representative from the third party administrator of STD, to explore how improved understanding of the process and better communication may help to prevent unnecessary delays to STD approval in future cases.

Very truly yours,

Jim O'Connor

Jim O'Connor
VP, Employee & Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Partial Day Vacations & Vacation Carryover

Dear Mr. Kirk:

During the 2017 negotiation meetings, the committees for the Company and the Union discussed the use of vacation in less than whole day increments and vacation carryover.

The Company agreed that upon ratification of the 2017 Agreement, department managers will review their individual work groups and where it will not disrupt normal operations, at their discretion, permit requests for partial day vacations in increments of one-half the employee's scheduled work day. However, use of the half-days is limited to two whole days (four half-days) per calendar year for use either at the start or end of the work day. It was further agreed that requests for these partial days must be made at least five calendar days prior to the date requested and must be approved by supervision. However, because of extenuating circumstances, a partial day off with less than a five calendar day notification may be approved by an employee's supervisor.

It was also agreed that henceforth employees entitled to a vacation may carryover up to a maximum of 80 hours of vacation into the next year. The amount of carryover vacation available in any calendar year may not exceed the 80 hour maximum. Use of vacation carried over may be taken any time during the following calendar year, subject to approval by supervision and the terms outlined in the Agreement for vacation use.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy.

JIM O'CONNOR
Vice President
Labor Relations

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June 15, 2009

Mr. Steve Feldhaus
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Union Employee Incentive Plan (UEIP)

Dear Mr. Feldhaus:

During the 2009 negotiations, the parties discussed additional incentive pay opportunities for employees represented by IBEW 1347 in conjunction with the transition to the New Retirement Program, and agreed that, during the term of the 2009 through 2014 Agreement, the following shall apply:

1. All employees who volunteer or are mandatorily converted to the New Retirement Program under the Cinergy Corp. Union Employees' Retirement Income Plan (the "RIP") will have an annual incentive opportunity with a 5% maximum (2% minimum, 3% target, 5% maximum) payout level.

2. All employees who participate in the Traditional Program under the RIP will continue to have their current annual incentive opportunity with a 2% maximum (1.0% minimum, 1.5% target, 2% maximum) payout level.

Very truly yours,

Tim O'Connor

Jim O'Connor
VP, Employee & Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
2100 Oak Road
Cincinnati, Ohio 45241

Re: Overtime Guidelines

Dear Mr. Kirk:

During the 2017 negotiation meetings, the committees for the Company and the Union discussed the following process for contacting employees in Distribution Construction & Maintenance (Overhead and Underground, excluding Electric Trouble), Transmission Lines and Brecon Heavy Equipment, for call-out overtime and for evaluating overtime responsiveness.

When the Company determines that a call-out is required, management will contact employees at the appropriate Operation Centers and will document the call and the response. The size of the crew will be the determination of management.

Overtime Lists

The Company will maintain and utilize one overtime list for the purpose of identifying employees for scheduled and unscheduled overtime opportunities. Selection will be based on the lowest amount of overtime hours worked and waived. The Company will discontinue the use of separate lists.

The Company will also maintain an Out of Town list for the purpose of identifying employees who will be contacted for emergency work assignments performed out of town requiring an overnight stay. Employees will be contacted based on the lowest amount of overtime hours worked. Hours accumulated will be carried by each individual from location to location and from classification to classification. New hires will be averaged into the list. Assignments for emergency overtime opportunities involving work for other utilities not owned or operated by Duke Energy, will be made on a voluntary basis based on overtime hours worked.

Hours will be considered waived when the employee fails to respond and/or declines the overtime opportunity. Hours charged as waived will be based on the lowest amount of time worked by the responding crew member(s).

If it is necessary to assign overtime to someone, the employee(s) will be assigned based on the lowest amount of overtime hours worked. Nothing in this letter will preclude an Operations Center from determining qualifications for specific assignments.

Call-out Responsiveness Rate

A call-out is defined as a contact or attempted contact by the Company to an employee who is not currently working for the purpose of performing work. The response rate expectation for the above-referenced work groups shall be reviewed quarterly based on a rolling 12 (twelve) month average. An average response rate of at least 33% must be maintained by each employee. The response rate shall be calculated based on the employee's cumulative responses during the rolling twelve-month period.

Call-out Responsiveness Measures

- Employees will provide the Company with accurate contact information and keep contact information up to date.
- Employees will be contacted, via contact information they provide, to report for job assignments.
- If Management determines the need for a "preferred volunteer" crew at an Operations Center, employees will be able to volunteer for the "preferred volunteer" crew and that crew(s) will be contacted before utilizing the overtime list.
- After contacting the preferred volunteer crew at an Operations Center, if additional resources are needed, employees will be contacted in order based on low overtime hours (worked and waived).
- If an Operations Center does not have a preferred volunteer crew, employees will be contacted in order based on low overtime hours (worked and waived).
- Employees that accept or decline an unscheduled overtime work assignment or an out of town work assignment (at any facility or location owned and/or operated by the Company) will be credited a "response" or a "non-response" as appropriate.
- Employees that accept or decline an unscheduled overtime work assignment for a utility not owned or operated by the Company, will not be credited with a "response" or a "non-response".
- Employees held at the end of a regularly scheduled work day for overtime assignments, will not be charged with a "non-response" if after being released from that overtime assignment, they are subsequently called for an overtime assignment and are unable to respond.
- Employees held over by the Trouble Desk for additional work following a scheduled overtime assignment, will be credited a "response" or a "non-response" as appropriate.
- During emergency work assignments, an employee will receive a maximum of one response or non-response as appropriate, for the duration of the event.
- The response rate will be calculated on actual call-outs and responses to those call-outs based on the above criteria. A minimum of eight call-outs are required for the calculation of the response rate.

- Employee(s) who have been unavailable for call-out due to time off work protected by applicable law or Company policy and who do not have the minimum eight call-outs and 9 months of full duty will not have response rate calculations until they meet both requirements. The 9 months of full duty availability do not have to be consecutive months.
- Employees will be eligible to receive an incentive award based on a call-out response rate to be determined.

Employees failing to maintain at least a 33% response rate will be subject to progressive corrective action beginning with an oral warning. Any particular corrective action will remain in effect and subject to further corrective action, until the employee has met the call-out responsiveness rate expectations in four consecutive quarterly reviews after that action. In addition, he/she may not be permitted to travel out of the Ohio/Kentucky service territory on emergency work assignments unless approved or designated by the Supervisor.

Employees who were under the 33% response rate in the previous review period, will not be subject to corrective action again if they remain under the required response rate at the subsequent review because they were not contacted for the minimum number of overtime opportunities.

If the Customer Average Interruption Duration Index (CAIDI) has not improved by July 1, 2019, the Company reserves the right to initiate a one-time reopener with the Union solely concerning these overtime guidelines, during the term of the Agreement.

Based on the foregoing, this letter supersedes any prior letters or agreements among the parties relating to this matter. It is thought that the above adequately describes the parties agreement on this matter.

Sincerely,

Jay Alvaro
Director, Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 2, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Temporary Assignments at Other Locations

Dear Mr. Reilly:

During the 2014 negotiations, the parties discussed temporary assignments by maintenance employees within Midwest Commercial Generation and Regulated Generation.

When it is necessary to temporarily assign a Hoist Operator, Material Services Team Member, Maintenance Services Team Member, a Maintenance Technician, a Maintenance Journeyman, or a Maintenance Apprentice to a generating facility other than their regular headquarters, the Company will make the assignment in accordance with Article V, Section 9 of the Collective Bargaining Agreement. For employees in the above mentioned classifications who receive less than a twenty-four hour notice of a temporary change in location, the Company will provide premium pay for all straight time hours the employee actually works at the new location, up to twenty-four hours after the notice was provided. To prevent stacking of benefits, such premium pay will not be provided when employees already are receiving overtime compensation for hours worked at the new location. No notice is required when the above referenced employees are returning to their regular headquarters.

The administration of this provision in no manner restricts the right of the Company to have an employee report to another location or facility temporarily once they have reported to work at their regular headquarters. In this case, no premium will be paid when the employee begins and ends their regularly scheduled shift at their assigned headquarters

It is thought that this letter accurately describes the parties' agreement relating to a temporary change in reporting location.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 2, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Retirement Savings Plan Changes for Traditional Pension Plan Participants

Dear Mr. Reilly:

During the 2014 negotiations, the Company and the Union discussed the benefits provided to traditional plan participants under the Duke Energy Retirement Savings Plan ("RSP"). This letter sets forth the related changes that were agreed to by the Company and the Union during the 2014 negotiations.

Matching Contribution

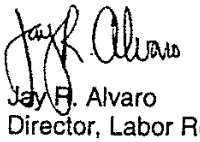
The Company agreed that, effective January 1, 2015, the matching contribution formula applicable under the RSP for traditional pension plan participants will change to the following: Each pay period, the Company will match 100% of each eligible traditional plan participant's before-tax and/or Roth contributions (excluding "catch-up" contributions) contributed to the RSP for the pay period for up to 4% of his/her eligible pay, plus 50% of the eligible traditional plan participant's before-tax and/or Roth contributions (excluding "catch-up" contributions) contributed to the RSP for the pay period for up to the next 1% of his/her eligible pay. For purposes of clarity, traditional plan participants will not be eligible to receive incentive matching contributions for periods after the 2014 plan year.

Compensation

The Company agreed that, effective January 1, 2015, the definition of eligible pay for purposes of determining the amount of traditional plan participants' before-tax, after-tax and/or Roth contributions (including "catch-up contributions) under the RSP will be expanded to include incentive pay, as well as base pay, unused vacation pay (when paid) and overtime pay, which are currently included in eligible pay. For purposes of clarity, there will be no change to the definition of eligible pay used to determine the amount of Company matching contributions made on behalf of the traditional plan participants under the RSP, which definition only includes base pay and unused vacation pay (when paid).

It is thought that this letter accurately describes the agreement reached by the parties regarding the RSP.

Sincerely,



Jay R. Alvaro
Director, Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 2, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Safety Shoe Policy

Mr. Reilly:

During the 2014 negotiations, the Company and the Union discussed the new Safety Shoe Policy describing appropriate footwear to be worn by employees in certain departments as referenced in this letter.

To facilitate compliance, the Company will provide an initial reimbursement for existing employees and subsequent new hires as described below for employees to purchase two (2) pairs of boots that meet the requirements for their position.

1. The Company will reimburse employees in Transmission C&M and Distribution C&M for reasonable expenses associated with the initial purchase of two pairs of boots.

2. The Company will provide reimbursement not to exceed $300 for the initial boot purchase for employees in Fleet Services, Supply Chain, and Metering Services.

3. Employees will not be eligible for this initial reimbursement if they were previously provided reimbursement by the Company for two pairs of compliant boots to ensure that there is no duplication or stacking of benefits for this purpose.

Going forward, employees in the above referenced groups, will be eligible to receive reimbursement not to exceed $300 every two years for the purpose of replacing worn boots. Employees are expected to manage their boot allowance as they deem best, provided that reimbursement will not exceed $300 every two years.

Employees are expected to purchase footwear from a vendor of their choosing that meets the requirements for the type of work they are required to perform in compliance with departmental requirements. Employees are required to wear compliant footwear at all times when they are working. Individual business units may choose to implement variations of the policy with respect to specific shoe requirements based on the work environment in that department and reimbursement approach.

Prior to any reimbursement, employees are required to provide a copy of the receipt and also proof that the boots meet the departmental standards. It is the Company's expectation that this reimbursement will be sufficient for employees to maintain protective footwear for work purposes. Employees who experience legitimate damage to their boots related to work activities, as determined by Management, should contact their supervisor to make arrangements for replacement.

It is expected that impacted employees will be in compliance with the Company's new Safety Shoe Policy by July 1, 2014.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
International Brotherhood of
Electrical Workers, Local Union No. 1347
2100 Oak Road
Cincinnati, Ohio 45241

Dear Mr. Kirk:

During the 2017 negotiations, the Company and the Union discussed the Safety Shoe Policy describing appropriate footwear to be worn by employees in certain departments as referenced in this letter, and the reimbursement process. The reimbursement amount specified in this letter, replaces the $150 reimbursement outlined in Sidebar Letter A-76 (Generation Foot Protection Policy). All other provisions of Sidebar Letter A-76 remain in effect.

To facilitate compliance, the Company will provide an initial reimbursement, not to exceed $200, for new hires within the Field Services Division (Telecommunications) and Fossil Hydro Operations (FHO) for one (1) pair of boots that meet the requirements for their position.

Existing employees, in the above referenced groups, will be eligible to receive reimbursement not to exceed $200 when they are next eligible to receive reimbursement by the Company, for the purpose of replacing worn boots.

Going forward, employees in the above referenced groups, will be eligible to receive reimbursement not to exceed $200 every two years, for the purpose of replacing worn boots. Employees are expected to manage their boot allowance as they deem best, provided that reimbursement will not exceed $200 every two years.

Employees are expected to purchase footwear from a vendor of their choosing that meets the requirements for the type of work they are required to perform in compliance with departmental requirements. Employees are required to wear compliant footwear at all times when they are working.

Prior to any reimbursement, employees are required to provide a copy of the receipt and also proof that the boots meet the departmental standards. It is the Company's expectation that this reimbursement will be sufficient for employees to maintain protective footwear for work purposes. Employees who experience legitimate damage to their boots related to work activities, as determined by Management, should contact their supervisor to make arrangements for replacement.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

A-76

DUKE ENERGY.

Duke Energy
139 East Fourth St.
Cincinnati, OH 45202

June 20, 2013

Mr. Donald Reilly
Business Manager
Local Union No. 1347
International Brotherhood
of Electrical Workers
4100 Colerain Avenue
Cincinnati, Ohio 45223

RE: ***Transportation Senior Servicer Wage Rate***

Dear Mr. Reilly:

Reference is made to our recent conversation regarding the starting wage rate and wage progression for the Transportation Senior Servicer job classification. This is an entry level position with a starting wage of $12.50 per hour. Per our discussion, the Company is adjusting the minimum wage rate to $17.00 per hour. As with other entry level positions, the Company reserves the right to increase or decrease the minimum wage rate based on market conditions.

In addition, we discussed that after the successful completion of their probationary period, employees in this classification will receive an increase to $0.65 below the maximum wage rate for this classification. At this point, the wage progression will be as outlined in the Collective Bargaining Agreement and the Patrick P. Gibson Letter.

I believe that this letter accurately describes our conversation regarding this issue. If you are in agreement, please sign and return this letter to me.

Very truly yours,

Michael A. Ciccarella
Labor Relations Consultant

For the Union:

Donald J. Reilly
Don Reilly
Business Manager, Local 1347, IBEW

6/24/13
Date

www.duke-energy.com

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

January 15, 2014

Mr. Donald Reilly
Business Manager
Local Union No. 1347
International Brotherhood
of Electrical Workers
4100 Colerain Avenue
Cincinnati, Ohio 45223

RE: *Revised Material Services Team Member Job Description - EBS*

Dear Mr. Reilly:

Reference is made to our meeting held on January 10, 2014 to discuss the Company's intent to revise the East Bend Material Services Team Member job description. Originally established in 1997, this position encompassed the Coal Yard Helper, Conveyor Operator, Mobile Equipment Operator, and Assistant Fleet Operator. The duties of the Assistant Fleet Operator, of which the wage rate of the MSTM is equal to, are no longer being performed.

The minimum wage rate for the revised MSTM will be $14.49 (currently $12.23) per hour, and the maximum rate will equal the maximum hourly rate for Wage Level 15 which is currently $29.94. The minimum wage rate is not subject to the annual wage increase, and the Company reserves the right to raise minimum rate at its discretion. Employees may be placed at a higher wage rate based on education and experience as follows;

	Years of Directly Related Experience					
Education	*None*	*>1 Year*	*>3 Years*	*>5 Years*	*>8 Years*	*>10 Years*
Two year technical degree plus related work experience.	$ 14.49	$ 16.04	$ 17.58	$ 19.13	$ 20.67	$ 20.67
Some advanced education (>1 year) non-degreed in related courses or degree in non-related course or 1 year trade degree	NQ	$ 14.49	$ 16.04	$ 17.58	$ 19.13	$ 20.67
High School Graduate or equivalency.	NQ	NQ	$ 14.49	$ 16.04	$ 17.58	$ 19.13

Directly related work experience = experience in Heavy Equipment Operations, Material Handling Operations, Landfill Activities including Surveying Skills, and Basic Maintenance Skills in a Generating Station or other industrial facility requiring similar knowledge and abilities.

Article III, Section 7 (f) of the Collective Bargaining Agreement will not apply to this position in regard to establishing an employee's wage rate. Existing employees accepting this position will have their hourly rate established according to the table above based on experience and education. All other provisions of Article III, Section 7 (f) apply.

Current pay structure, which is associated with the Skills Qualification Plan, is no longer supported. Going forward, pay progression will be as follows;

A) Employees will be evaluated and given a pay increase every six months as provided for in the "Patrick P. Gibson Letter" dated December 29, 2000.

B) Intent is for employees starting at the minimum rate of pay to reach maximum pay in five years.

C) In lieu of the $0.10 increase as provided for in the Collective Bargaining Agreement each increase will be determined by taking the difference between the entry and maximum wage rate and dividing by ten. The merit increase amount will be adjusted annually in conjunction with the General Wage Increase.

D) Increase is to be based on satisfactory performance. Factors to be considered are attendance, job performance, completion of required training, and disciplinary record.

E) If a merit increase is denied, the employee will not be eligible for an increase until the next scheduled increase.

F) Employees on short term disability, military leave, or leave of absence greater than thirty days may have the merit increase delayed by the length of time equal to the absence. This provision will be applied consistent with the Family & Medical Leave Act, and all other applicable laws and company policies.

This agreement in no manner restricts the Company from revising this this job description in the future. If the job description is modified at a future date, all applicable provisions of the Collective Bargaining Agreement will apply.

I believe that this letter accurately describes our conversations regarding this issue. If you are in agreement, please sign and return this letter to me.

Very truly yours,

Michael Ciccarella

Michael A. Ciccarella
Labor Relations Consultant

For the Union:

Donald J. Reilly

Don Reilly
Business Manager, Local 1347, IBEW

1-20-14
Date

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

August 27, 2013

Mr. Donald Reilly
Business Manager
Local Union No. 1347
International Brotherhood
of Electrical Workers
4100 Colerain Avenue
Cincinnati, Ohio 45223

RE: *Repair Specialist and Sr. Repair Mechanic Job Classifications*

Dear Mr. Reilly:

Per our recent discussions the Company is modifying the Senior Repair Mechanic (#67567) job description. We agreed that the modifications are not significant enough to warrant a re-evaluation of this position and the wage rate will remain as established. Currently, this is Level 20 with a maximum rate of $34.62 per hour.

We also discussed the re-classification of the sole remaining Repair Specialist. This employee, Michael Dieckmann, will be reclassified as a Senior Repair Mechanic (at the maximum rate of pay) on the first pay period after the Company receives a signed copy of this agreement. In accordance with the Collective Bargaining Agreement, this date will also be Mr. Dieckmann's classified seniority date.

I would like to emphasize that the Repair Specialist position is not being discontinued at this time and the Company reserves the right to fill future vacancies in this classification as business needs dictate. Furthermore, this agreement in no manner waives the Company's right under the Collective Bargaining Agreement to revise either job description at a future date.

I believe that this letter accurately describes our conversations regarding this issue. If you are in agreement, please sign and return this letter to me.

Very truly yours,

Michael Ciccarella

Michael A. Ciccarella
Labor Relations Consultant

For the Union:

Donald J Reilly

Don Reilly
Business Manager, Local 1347, IBEW

8/27/13
Date

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

March 20, 2014

Mr. Don Reilly
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Mr. Steve Bowermaster
President
Local 5541-06
United Steelworkers
Todhunter Headquarters

Mr. John Waits
President
Local 12049
United Steelworkers
Valley View Headquarters

Re: Separation of Gas and Electric Customer Premise Work

Gentlemen:

In late 2013, the Company and the Unions resumed discussions concerning the separation of the workforce that performs combination gas and electric duties on customer premises.

As soon as practical and except as provided below, Service Delivery employees represented by IBEW Local 1347 will not be assigned to perform gas customer premise work, including but not limited to, disconnection of gas service for failure to pay. Further, Gas Operations employees represented by USW Locals 12049 and 5541-06 will not perform electric customer premise work, including but not limited to, disconnection of electric service for failure to pay. While the Company will determine the effective date of this agreement, separation will occur simultaneously for Gas and Electric employees.

However, the Company reserves the right to assign gas and electric customer premise work to the first responder who is qualified to safely perform the work, regardless of the

department or union affiliation of the first responder, when such work is necessary to protect life, property or continuity of service.

The separation of the gas and electric customer premise work will not cause wage levels to be re-evaluated at this time for employees assigned to perform gas or electric customer premise work. Employees will continue to be expected to comply with regulations and department work rules as determined by management, including but not limited to, home site reporting expectations.

Based on the foregoing, this letter supersedes any prior letters or agreements among the parties relating to this matter. It is thought that the above adequately describes the parties' agreement on this matter.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

AGREED TO BY:

IBEW Local 1347, by:

Don Reilly, Business Manager

USW Local 5541-06, by:

Steve Bowermaster, President

USW Local 12049, by:

John Waits, President

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
International Brotherhood of
Electrical Workers, Local 1347
2100 Oak Road
Cincinnati, Ohio 45241

Re: Lineperson Program

Dear Mr. Kirk:

Reference is made to the parties efforts and discussions related to the hiring of Linepersons. This correspondence will supersede all previous correspondence pertaining to this subject.

Employees hired into the Groundperson or Lineperson C classification will be provided training and required to progress satisfactorily through the Lineperson sequence to the Lineperson "A" job classification in accordance with timeframes provided below, excepting legally protected time off that may delay progression.

Groundperson	3-6 months
Lineperson C	15-18 months
Lineperson B	24-27 months
Total apprenticeship time	42-51 months

New employees with prior line experience hired into the Lineperson Program from outside of the Company or transferred from within the Company will be employed with the understanding that the promotional principle of the Lineperson Program will be the controlling condition from the time they enter the Lineperson sequence until they become a Lineperson "A".

Employees are required to successfully progress to remain employed in the Lineperson Program. Inability to successfully progress means that two successive written examinations, or two successive practical demonstrations were not passed as determined by the Company. The employment of an individual who does not progress satisfactorily will be terminated.

Commercial driver's license (CDL) Driver's Training will be given to employees entering the Program. If an employee does not pass the driving CDL test, consideration will be given to retesting the employee based on the existing circumstances and the trainer's evaluation of the employee's driving aptitude and potential. Employees are expected to successfully acquire a CDL license within their first 6 months of employment.

Employees in the Lineperson Program will be required to successfully demonstrate pole climbing aptitude throughout their training and progression. Any individual who does not exhibit climbing aptitude satisfactory to supervision will be subject to immediate termination.

Employees in the Lineperson Program will be assigned to an Operations Center based on the Company's staffing requirements, the employee's seniority status, and the employee's headquarter preference.

Employees will not be permitted to bid to other headquarters until they have successfully completed all the necessary skills and training and the Company has certified that the employee is qualified for promotion to Lineperson B. In order to effectively implement the required promotional principle, all employees in the Lineperson Program should submit a bid sheet to Labor Relations at least once a year for all locations and positions. In order for this program to work effectively, the Company will assign the senior qualified employee to an available opening, if such employee has not submitted a bid for consideration on all possible openings and locations for the posting being processed. This procedure is contrary to the established practice that the junior qualified employee is assigned to a position when no eligible employees have submitted bids for a particular job.

An employee in the Lineperson job sequence will be permitted to cross bid from one location to another except when such employee is a probationary employee, a Groundperson or a Lineperson "C". Employees generally will not be upgraded during their training, absent business necessity as determined by management in accordance with Article V, section 20 (a).

To the extent that this letter is inconsistent with the job descriptions and program procedures, the provisions of the letter shall prevail.

Sincerely,

Lisa A. Gregory

Lisa A. Gregory
Human Resources Principal

cc: J. Sochacki
V. Huffaker
J. Wical

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
International Brotherhood of
Electrical Workers, Local Union No. 1347
2100 Oak Road
Cincinnati, Ohio 45241

Dear Mr. Kirk:

This letter is to follow up on recent conversations held between the Union and management regarding concerns with potential conflicts of interest relating to the employment of relatives within 1 Distribution Force-Midwest (1DF-MW) and the Transmission organization.

As we discussed, the Company has an Employment Policy that prohibits conflicts of interest resulting from the employment of relatives. The "Employment of Relatives" section of the Employment Policy states in relevant part:

> For purposes 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. Each situation will be evaluated on an individual basis.
>
> A supervisor 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.

Effective after ratification of the 2017 Agreement, if a conflict arises or if the results of a bid identify the potential for a conflict of interest as described above, the Company will contact Union leadership to discuss possible solutions to resolve the conflict. Examples of solutions could include, but are not limited to, processing the bids as normal, processing the bids as normal and then allowing the employee to promote in place at their current work location, move the employee to one of their subsequent bid choices, etc. If the resolution results in creating a position, bids will be reevaluated to account for the newly created position. If the Company and the Union cannot mutually agree on a solution, within a reasonable amount of time, the Company reserves the right to move the employee to a location that does not create a conflict as described above.

Sincerely,

Lisa A. Gregory

Lisa A. Gregory
HR Principal

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
4100 Colerain Avenue
Cincinnati, Ohio 45223

Re: Production Technicians

Mr. Kirk:

During the 2017 negotiations, the Company and the Union discussed the Production Technician job progression within the Fossil Hydro Organization (FHO) and the application of Article III, Section 7 (f) of the Collective Bargaining Agreement.

The skills required for the Production Technician are station specific, and given the five year training program, the Company has concerns with retention within this classification. As such, any employee entering this job classification after the ratification of the 2017 – xxxx Agreement, will not be permitted to apply for Duke Energy positions outside of the Production Group for a period of three years.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
2100 Oak Road
Cincinnati, Ohio 45241

Re: Union Employees' Incentive Plan (UEIP) – Joint Committee

Dear Mr. Kirk:

During the 2017 negotiation meetings, the committees for the Company and the Union discussed the goals associated with the Union Employees' Incentive Plan (UEIP).

The parties have agreed that, following the 2017 negotiations, a joint committee will be established to discuss the goals to be implemented in 2018 for represented employees working in the non-Generation areas of the business.

It is further agreed that the joint committee is not limited to consideration of goals relating only to safety. The joint committee discussions may result in goals being established by the Company for purposes of the UEIP, relating to safety and/or non-safety measures. Any goals resulting from such joint committee discussions will be established no later than March 1, 2018, and in any event will not be effective for the 2017 performance period. If the goals are not modified as a result of these discussions, the goals will continue to be based on safety.

This letter does not impact Sidebar Letter A-67 regarding the level of UEIP opportunities, which remains in effect.

Sincerely,

Jay Alvaro
Director, Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

April 01, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
2100 Oak Road
Cincinnati, Ohio 45241

Re: Leadperson – Senior Maintenance Electrician

Dear Mr. Kirk:

During the 2017 negotiation meetings, the committees for the Company and the Union discussed the application of "Leadperson" within Substation for employees in the Senior Maintenance Electrician job classification.

The parties have agreed that following the 2017 negotiations, a joint committee will be established to meet and discuss the roles and responsibilities of employees within Substation Maintenance in the Senior Maintenance Electrician job classification. The committee will determine when the lead person premium is applicable and establish guidelines for the application of the Leadperson premium going forward. As stated in Sidebar Letter A52, the Leadperson role will encompass duties and responsibilities beyond those contained within Senior Maintenance Electrician job description.

It is further agreed that these guidelines will be established by no later than September 30, 2017.

Sincerely,

Jay Alvaro
Director, Labor Relations

cc: Donald Broadhurst
John Froehle

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

October 31, 2017

Mr. Andrew Kirk
Business Manager
Local Union 1347
International Brotherhood of
Electrical Workers, AFL-CIO
2100 Oak Road
Cincinnati, Ohio 45241

Re: Union Employees' Incentive Plan (UEIP) Goals

Mr. Kirk:

During the 2017 negotiations, the Company and the Union agreed to meet following negotiations to discuss the goals associated with the Union Employees' Incentive Plan for IBEW 1347 represented employees working in the non-Generation areas of the business.

As was agreed to, beginning with the 2018 performance period, the goals for those IBEW 1347 represented employees working in the non-Generation areas of the business, will be the applicable corporate goals (i.e. earnings per share ("EPS"), operational excellence and customer satisfaction) and organizational team goals, as determined, in its sole discretion, by the Company.

1. Eligible employees with a cash balance component in their Duke Energy Cash Balance Plan benefit or those employees with a Retirement Savings Plan benefit only, will be eligible for an annual incentive opportunity with a 5% maximum (2% minimum, 3% target, and 5% maximum) payout level based on corporate and team goals which may include safety, reliability, customer satisfaction or financial goals as established by the Company.

2. Eligible employees without a cash balance component in their Duke Energy Cash Balance Plan benefit will be eligible for an annual incentive opportunity with a 2% maximum (1% minimum, 1.5% target, and 2% maximum) payout level based on corporate and team goals which may include safety, reliability, customer satisfaction or financial goals as established by the Company.

It is thought that this letter accurately describes the parties' agreement relating to incentive opportunities.

Sincerely,

Lisa A. Gregory

Lisa A. Gregory
Human Resources Principal

OUR VISION

DUKE ENERGY

SAFETYFirst

DUKE ENERGY HEALTH AND SAFETY VISION

Our health and safety vision is aimed at cultivating:
A healthy and injury-free workplace, sustained by behaviors that consistently demonstrate our commitment to the welfare of each other, our contractors and to the communities we serve.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-038

REQUEST:

Provide the information requested in Schedule J for budgeted and actual numbers of full- and part-time employees, regular wages, overtime wages, and total wages by employee group, by month, for the three most recent calendar years, the base period, and the forecasted test period. Explain any variance exceeding 5 percent.

RESPONSE:

Please see Schedule J in STAFF-DR-01-038 Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell
Grady "Tripp" S. Carpenter

Duke Energy Kentucky - Electric
Case No. 2024-00354
Monthly Payroll Variance Analysis

Note: Payroll dollars are provided as all labor charged to Kentucky Electric, regardless of account (Capital and O&M) or payroll company. Does not include loaders (benefits, incentives, taxes).

YTD 2023 had a variance slightly over 5% at 6.2%, mainly due to lower Grid work and lower project O&M.

Employee counts are for Duke Energy Kentucky payroll company only. We do not budget number of employees; therefore, only actual employee counts are provided.

		Number of Full-Time Employees		Number of Part-Time Employees		Monthly Budget			Monthly Actual			Variance Percent		
Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jan-21	Union					894,510	156,553	1,051,062	1,000,450	161,307	1,161,757			
Jan-21	Non-Union					1,986,879	9,244	1,996,123	1,940,666	3,803	1,944,469			
		162		0		2,881,389	165,796	3,047,185	2,941,116	165,110	3,106,226	2.1%	-0.4%	1.9%
Feb-21	Union					894,398	156,062	1,050,460	981,853	213,360	1,195,214			
Feb-21	Non-Union					2,105,350	16,779	2,122,128	1,985,733	4,519	1,990,252			
		166		0		2,999,748	172,841	3,172,589	2,967,587	217,879	3,185,466	-1.1%	26.1%	0.4%
Mar-21	Union					874,172	156,031	1,030,203	1,090,395	248,766	1,339,162			
Mar-21	Non-Union					2,422,886	15,498	2,438,385	1,928,029	4,789	1,932,818			
		166		0		3,297,058	171,530	3,468,588	3,018,424	253,555	3,271,979	-8.5%	47.8%	-5.7%
Apr-21	Union					891,165	157,964	1,049,129	1,092,170	205,064	1,297,235			
Apr-21	Non-Union					2,141,551	14,910	2,156,461	1,891,854	4,767	1,896,621			
		162		0		3,032,716	172,874	3,205,590	2,984,024	209,831	3,193,856	-1.6%	21.4%	-0.4%
May-21	Union					895,180	158,518	1,053,698	1,119,949	252,971	1,372,920			
May-21	Non-Union					2,364,841	11,715	2,376,556	1,933,849	3,491	1,937,340			
		160		0		3,260,021	170,233	3,430,254	3,053,797	256,463	3,310,260	-6.3%	50.7%	-3.5%
Jun-21	Union					872,110	158,078	1,030,189	1,007,503	207,418	1,214,922			
Jun-21	Non-Union					2,105,030	9,984	2,115,014	2,014,951	6,198	2,021,149			
		162		0		2,977,140	168,062	3,145,202	3,022,454	213,616	3,236,070	1.5%	27.1%	2.9%
Jul-21	Union					1,308,136	229,205	1,537,341	1,503,114	379,929	1,883,043			
Jul-21	Non-Union					2,133,316	9,011	2,142,327	1,925,154	15,620	1,940,774			
		160		0		3,441,452	238,216	3,679,668	3,428,268	395,549	3,823,818	-0.4%	66.0%	3.9%

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

PUBLIC STAFF-DR-01-039
(As to Attachments only)

REQUEST:

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

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachments only)

Non-Union Employees:

For non-union employees, market data is reviewed and used to determine annual wage increase recommendations. Each year, these increases are effective the first day of the pay period that contains March 1. The chart below depicts the annual market adjustments reported in two surveys utilized by Duke Energy as compared to Duke Energy's historical overall wage increase budgets for the corresponding years.

Salary Increase History								
	All Groups		Executive		Exempt		Non-Exempt	
Year	Industry*	Duke Energy	Industry*	Duke Energy	Industry*	Duke Energy	Industry*	Duke Energy
2022	4.0%	3.5%	3.5%	3.5%	4.0%	3.5%	4.0%	3.5%
2023	4.0%	3.5%	4.0%	3.5%	4.0%	3.5%	4.0%	3.5%
2024	4.0%	3.5%	4.0%	3.5%	4.0%	3.5%	4.0%	3.5%
*WorldatWork Salary Budget Survey, U.S. Salary Increase Budget								

The full 2023/2024 World at Work Salary Budget Survey Results and The Conference Board's U.S. Salary Increase Budgets Survey Results can be found in STAFF-DR-01-039 Confidential Attachments 1 and 2. It should be noted that employees' individual increases may vary relative to the budget to allow for individual differentiators based on performance

and current pay levels relative to the market. The increase awarded to each employee, if any, is based on a combination of factors, including his/her individual performance rating, his/her performance relative to his/her peers, the position of his/her salary within the salary range for his/her job and the size of the merit budget.

The forecasted test period assumes labor increases for exempt and non-exempt non-union employees of 3.5 percent which includes merit increases of 3.0 percent and an allowance for promotions of 0.5 percent.

Union Employees:

The general wage increases awarded to union employees may be referenced in the labor union contracts in Attachments SAC-2(a) and (b) of Shannon A. Caldwell's direct testimony and in STAFF-DR-01-037 Attachments 1 and 2.

Duke Energy Kentucky and the Utility Workers Union of America (UWUA) Local No. 600 entered into a collective bargaining agreement (CBA) effective on April 1, 2023, that expires on March 31, 2027. The chart below reflects the wage increases for the past two calendar years and the base period. Each wage increase is effective at the beginning of the pay period that includes April 1.

Wage Increase Schedule	
Year	UWUA
2023	3.0%
2024	3.0%
2025	3.0%
2026	3.0%

Duke Energy Kentucky and the International Brotherhood of Electrical Workers Local No. 1347 entered into a CBA effective on April 1, 2022, that expires on March 31, 2026. The chart below reflects the wage increases for the past two calendar years, the base period, and the forecasted test period. Each wage increase is effective on April 1. The

wage increase that impacts the forecasted test period will be determined with the next contract:

Wage Increase Schedule	
Year	IBEW 1347
2022	3.5%
2023	3.5%
2024	3.0%
2025	3.0%

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky - Electric
Case No. 2024-00354
Monthly Payroll Variance Analysis

Note: Payroll dollars are provided as all labor charged to Kentucky Electric, regardless of account (Capital and O&M) or payroll company. Does not include loaders (benefits, incentives, taxes).

YTD 2023 had a variance slightly over 5% at 6.2%, mainly due to lower Grid work and lower project O&M.

Employee counts are for Duke Energy Kentucky payroll company only. We do not budget number of employees; therefore, only actual employee counts are provided.

		Number of Full-Time Employees		Number of Part-Time Employees		Monthly Budget			Monthly Actual			Variance Percent		
Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Aug-21	Union					877,287	158,005	1,035,292	1,022,919	222,358	1,245,277			
Aug-21	Non-Union					2,048,601	8,255	2,056,856	1,938,133	8,631	1,946,764			
		156		0		2,925,888	166,260	3,092,148	2,961,052	230,989	3,192,041	1.2%	38.9%	3.2%
Sep-21	Union					853,511	157,863	1,011,374	971,847	319,734	1,291,581			
Sep-21	Non-Union					2,054,192	11,178	2,065,370	1,975,494	7,221	1,982,715			
		152		0		2,907,703	169,041	3,076,744	2,947,341	326,955	3,274,296	1.4%	93.4%	6.4%
Oct-21	Union					879,539	157,844	1,037,383	1,007,583	257,095	1,264,679			
Oct-21	Non-Union					2,175,460	9,143	2,184,603	1,992,661	8,064	2,000,725			
		155		0		3,054,999	166,987	3,221,986	3,000,244	265,159	3,265,403	-1.8%	58.8%	1.3%
Nov-21	Union					894,788	157,802	1,052,589	1,404,556	238,061	1,642,617			
Nov-21	Non-Union					2,071,267	10,073	2,081,340	1,894,922	8,659	1,903,581			
		158		0		2,966,054	167,875	3,133,930	3,299,478	246,720	3,546,198	11.2%	47.0%	13.2%
Dec-21	Union					1,269,323	228,753	1,498,076	1,597,649	388,251	1,985,900			
Dec-21	Non-Union					2,101,051	8,285	2,109,336	1,892,144	34,532	1,926,676			
		163		0		3,370,375	237,038	3,607,413	3,489,793	422,782	3,912,575	3.5%	78.4%	8.5%
YTD - 21	Union					11,404,119	2,032,677	13,436,797	13,799,989	3,094,316	16,894,305			
YTD - 21	Non-Union					25,710,424	134,075	25,844,499	23,313,589	110,294	23,423,882			
						37,114,544	2,166,752	39,281,296	37,113,578	3,204,609	40,318,187	0.0%	47.9%	2.6%

Duke Energy Kentucky - Electric
Case No. 2024-00354
Monthly Payroll Variance Analysis

Note: Payroll dollars are provided as all labor charged to Kentucky Electric, regardless of account (Capital and O&M) or payroll company. Does not include loaders (benefits, incentives, taxes).

YTD 2023 had a variance slightly over 5% at 6.2%, mainly due to lower Grid work and lower project O&M.

Employee counts are for Duke Energy Kentucky payroll company only. We do not budget number of employees; therefore, only actual employee counts are provided.

		Number of Full-Time Employees		Number of Part-Time Employees		Monthly Budget			Monthly Actual			Variance Percent		
Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jan-22	Union					870,480	157,844	1,028,324	883,369	183,588	1,066,957			
Jan-22	Non-Union					2,006,513	7,181	2,013,694	1,906,507	10,939	1,917,447			
			165		0	2,876,994	165,025	3,042,019	2,789,877	194,527	2,984,403	-3.0%	17.9%	-1.9%
Feb-22	Union					872,241	157,340	1,029,581	1,045,477	256,421	1,301,899			
Feb-22	Non-Union					2,120,899	7,175	2,128,074	1,993,711	4,398	1,998,109			
			165		0	2,993,140	164,515	3,157,655	3,039,188	260,820	3,300,007	1.5%	58.5%	4.5%
Mar-22	Union					864,773	161,095	1,025,868	1,050,903	221,186	1,272,089			
Mar-22	Non-Union					2,154,428	7,479	2,161,907	2,114,001	8,615	2,122,616			
		160		0		3,019,201	168,574	3,187,774	3,164,904	229,801	3,394,705	4.8%	36.3%	6.5%
Apr-22	Union					901,848	161,011	1,062,860	1,025,579	184,740	1,210,318			
Apr-22	Non-Union					2,155,124	7,255	2,162,379	2,044,893	11,090	2,055,984			
		157		0		3,056,973	168,266	3,225,239	3,070,472	195,830	3,266,302	0.4%	16.4%	1.3%
May-22	Union					927,361	161,776	1,089,137	1,025,537	206,437	1,231,974			
May-22	Non-Union					2,121,352	7,256	2,128,608	2,031,743	8,885	2,040,628			
		157		0		3,048,713	169,033	3,217,745	3,057,280	215,322	3,272,602	0.3%	27.4%	1.7%
Jun-22	Union					900,080	161,739	1,061,819	988,310	259,636	1,247,946			
Jun-22	Non-Union					2,081,591	8,042	2,089,633	2,057,260	7,137	2,064,397			
		157		0		2,981,672	169,781	3,151,452	3,045,570	266,773	3,312,343	2.1%	57.1%	5.1%
Jul-22	Union					1,307,715	238,225	1,545,940	1,471,768	517,261	1,989,029			
Jul-22	Non-Union					2,019,445	7,456	2,026,901	1,978,446	29,268	2,007,714			
		154		0		3,327,160	245,681	3,572,841	3,450,214	546,529	3,996,743	3.7%	122.5%	11.9%

Duke Energy Kentucky - Electric
Case No. 2024-00354
Monthly Payroll Variance Analysis

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		Number of Full-Time Employees		Number of Part-Time Employees		Monthly Budget			Monthly Actual			Variance Percent		
Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Aug-22	Union					916,228	161,445	1,077,673	1,079,192	194,023	1,273,215			
Aug-22	Non-Union					1,985,117	7,399	1,992,516	2,028,389	6,932	2,035,321			
		158		0		2,901,345	168,844	3,070,189	3,107,581	200,955	3,308,536	7.1%	19.0%	7.8%
Sep-22	Union					910,963	163,064	1,074,027	1,083,204	155,718	1,238,922			
Sep-22	Non-Union					1,987,164	7,976	1,995,140	2,021,630	6,251	2,027,881			
		160		0		2,898,127	171,040	3,069,167	3,104,834	161,969	3,266,803	7.1%	-5.3%	6.4%
Oct-22	Union					932,648	163,669	1,096,318	970,882	220,830	1,191,712			
Oct-22	Non-Union					1,990,348	7,706	1,998,054	1,597,135	3,327	1,600,462			
		159		0		2,922,996	171,376	3,094,372	2,568,016	224,158	2,792,174	-12.1%	30.8%	-9.8%
Nov-22	Union					916,100	162,570	1,078,671	1,008,878	237,642	1,246,520			
Nov-22	Non-Union					1,989,915	7,768	1,997,683	1,935,350	6,671	1,942,021			
		161		0		2,906,016	170,338	3,076,354	2,944,229	244,313	3,188,542	1.3%	43.4%	3.6%
Dec-22	Union					1,265,032	237,027	1,502,059	1,196,375	413,715	1,610,090			
Dec-22	Non-Union					2,022,161	8,111	2,030,272	1,759,287	11,004	1,770,290			
		159		0		3,287,192	245,138	3,532,331	2,955,662	424,719	3,380,380	-10.1%	73.3%	-4.3%
YTD - 22	Union					11,585,470	2,086,806	13,672,276	12,829,474	3,051,197	15,880,671			
YTD - 22	Non-Union					24,634,057	90,805	24,724,861	23,468,350	114,518	23,582,869			
						36,219,527	2,177,611	38,397,138	36,297,825	3,165,715	39,463,540	0.2%	45.4%	2.8%

Duke Energy Kentucky - Electric
Case No. 2024-00354
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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jan-23	Union					1,214,601	183,430	1,398,031	947,336	213,285	1,160,621			
Jan-23	Non-Union					2,045,367	8,122	2,053,489	1,909,456	8,202	1,917,658			
			157		0	3,259,968	191,553	3,451,521	2,856,793	221,487	3,078,280	-12.4%	15.6%	-10.8%
Feb-23	Union					1,103,139	182,359	1,285,498	1,052,680	205,036	1,257,716			
Feb-23	Non-Union					2,012,883	8,085	2,020,968	2,008,862	8,145	2,017,007			
			156		0	3,116,023	190,444	3,306,466	3,061,542	213,180	3,274,722	-1.7%	11.9%	-1.0%
Mar-23	Union					1,116,939	192,883	1,309,822	1,050,132	309,624	1,359,755			
Mar-23	Non-Union					2,081,041	8,169	2,089,210	2,055,346	15,901	2,071,246			
			151		0	3,197,981	201,051	3,399,032	3,105,477	325,524	3,431,002	-2.9%	61.9%	0.9%
Apr-23	Union					1,139,310	191,845	1,331,155	1,024,832	239,613	1,264,445			
Apr-23	Non-Union					2,084,348	8,091	2,092,439	1,983,334	12,394	1,995,728			
			149		0	3,223,658	199,936	3,423,594	3,008,166	252,007	3,260,173	-6.7%	26.0%	-4.8%
May-23	Union					1,171,205	190,897	1,362,102	1,100,522	267,910	1,368,432			
May-23	Non-Union					2,100,956	8,082	2,109,038	1,998,757	9,284	2,008,041			
			151		0	3,272,162	198,979	3,471,141	3,099,279	277,194	3,376,473	-5.3%	39.3%	-2.7%
Jun-23	Union					1,541,700	245,511	1,787,211	1,660,191	335,179	1,995,370			
Jun-23	Non-Union					2,113,549	8,127	2,121,676	2,116,104	10,724	2,126,828			
			150		0	3,655,249	253,638	3,908,887	3,776,296	345,903	4,122,198	3.3%	36.4%	5.5%
Jul-23	Union					1,417,296	223,659	1,640,955	994,638	203,914	1,198,552			
Jul-23	Non-Union					2,061,682	8,118	2,069,800	2,040,206	8,786	2,048,991			
			149		0	3,478,978	231,777	3,710,755	3,034,844	212,700	3,247,544	-12.8%	-8.2%	-12.5%

Duke Energy Kentucky - Electric
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		Number of Full-Time Employees		Number of Part-Time Employees		Monthly Budget			Monthly Actual			Variance Percent		
Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Aug-23	Union					1,211,016	194,636	1,405,652	1,059,681	216,589	1,276,271			
Aug-23	Non-Union					2,073,524	8,262	2,081,786	2,119,055	8,364	2,127,419			
			151		0	3,284,540	202,898	3,487,438	3,178,737	224,953	3,403,690	-3.2%	10.9%	-2.4%
Sep-23	Union					1,225,729	198,421	1,424,150	1,003,110	237,112	1,240,222			
Sep-23	Non-Union					2,082,952	8,012	2,090,963	1,987,788	7,471	1,995,259			
			151		0	3,308,680	206,433	3,515,114	2,990,898	244,583	3,235,480	-9.6%	18.5%	-8.0%
Oct-23	Union					1,263,853	225,770	1,489,623	1,113,793	290,380	1,404,173			
Oct-23	Non-Union					2,148,970	8,117	2,157,087	2,081,862	11,614	2,093,476			
			149		0	3,412,823	233,887	3,646,710	3,195,655	301,994	3,497,649	-6.4%	29.1%	-4.1%
Nov-23	Union					1,374,991	190,767	1,565,758	1,013,520	283,622	1,297,142			
Nov-23	Non-Union					2,147,362	8,011	2,155,372	1,908,293	9,121	1,917,413			
			147		0	3,522,352	198,777	3,721,130	2,921,813	292,743	3,214,556	-17.0%	47.3%	-13.6%
Dec-23	Union					1,942,437	285,579	2,228,016	1,367,771	307,187	1,674,959			
Dec-23	Non-Union					2,140,289	8,116	2,148,405	1,872,800	15,379	1,888,179			
			150		0	4,082,726	293,695	4,376,421	3,240,571	322,566	3,563,138	-20.6%	9.8%	-18.6%
YTD - 23	Union					15,722,216	2,505,757	18,227,973	13,388,207	3,109,450	16,497,658			
YTD - 23	Non-Union					25,092,923	97,311	25,190,235	24,081,862	125,384	24,207,246			
						40,815,139	2,603,068	43,418,208	37,470,070	3,234,834	40,704,904	-8.2%	24.3%	-6.2%

Duke Energy Kentucky - Electric
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		Number of Full-Time Employees		Number of Part-Time Employees		Monthly Budget			Monthly Actual			Variance Percent		
Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Base Period														
Mar-24	Union					1,086,365	192,230	1,278,596	1,233,082	218,325	1,451,408			
Mar-24	Non-Union					2,256,930	17,510	2,274,441	2,039,355	5,451	2,044,807			
			150		0	3,343,296	209,740	3,553,036	3,272,437	223,777	3,496,214	-2.1%	6.7%	-1.6%
Apr-24	Union					1,113,501	177,015	1,290,516	1,085,946	254,861	1,340,807			
Apr-24	Non-Union					2,372,365	17,586	2,389,951	2,000,276	10,678	2,010,955			
			153		0	3,485,865	194,601	3,680,466	3,086,223	265,539	3,351,762	-11.5%	36.5%	-8.9%
May-24	Union					1,556,893	209,515	1,766,408	1,764,290	407,381	2,171,671			
May-24	Non-Union					2,287,800	17,676	2,305,476	2,124,076	9,581	2,133,657			
			146		0	3,844,693	227,191	4,071,885	3,888,366	416,962	4,305,328	1.1%	83.5%	5.7%
Jun-24	Union					1,145,227	172,377	1,317,604	1,133,656	249,970	1,383,627			
Jun-24	Non-Union					2,247,072	17,611	2,264,683	2,005,351	8,469	2,013,820			
			139		0	3,392,299	189,989	3,582,288	3,139,007	258,439	3,397,447	-7.5%	36.0%	-5.2%
Jul-24	Union					1,055,433	161,640	1,217,072	1,038,643	268,881	1,307,524			
Jul-24	Non-Union					2,255,919	17,626	2,273,545	1,944,773	8,494	1,953,266			
			141		0	3,311,351	179,266	3,490,617	2,983,416	277,374	3,260,790	-9.9%	54.7%	-6.6%
Aug-24	Union					1,039,375	160,949	1,200,324	1,107,936	242,228	1,350,164			
Aug-24	Non-Union					2,274,108	17,642	2,291,750	2,069,706	7,457	2,077,163			
			142		0	3,313,483	178,591	3,492,074	3,177,642	249,685	3,427,327	-4.1%	39.8%	-1.9%
Sep-24	Union					1,158,845	144,832	1,303,677						
Sep-24	Non-Union					2,258,310	17,675	2,275,985						
						3,417,155	162,507	3,579,662						

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Oct-24	Union					1,081,549	156,294	1,237,843						
Oct-24	Non-Union					2,252,669	17,707	2,270,376						
						3,334,218	174,001	3,508,219						
Nov-24	Union					1,551,209	229,419	1,780,628						
Nov-24	Non-Union					2,286,055	17,819	2,303,874						
						3,837,264	247,238	4,084,503						
Dec-24	Union					1,053,588	179,739	1,233,327						
Dec-24	Non-Union					2,237,162	17,656	2,254,819						
						3,290,751	197,395	3,488,146						
Jan-25	Union					1,057,137	179,739	1,236,876						
Jan-25	Non-Union					2,235,934	17,656	2,253,591						
						3,293,072	197,395	3,490,467						
Feb-25	Union					1,055,781	179,739	1,235,520						
Feb-25	Non-Union					2,236,331	17,656	2,253,987						
						3,292,112	197,395	3,489,507						
Base Period	Union					13,954,905	2,143,487	16,098,392						
Base Period	Non-Union					27,200,655	211,822	27,412,477						
						41,155,560	2,355,309	43,510,869						

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Forecast Period														
Jul-25	Union					1,091,105	186,029	1,277,134						
Jul-25	Non-Union					2,314,747	18,274	2,333,022						
						3,405,852	204,304	3,610,156						
Aug-25	Union					1,090,139	186,029	1,276,169						
Aug-25	Non-Union					2,315,088	18,274	2,333,363						
						3,405,228	204,304	3,609,532						
Sep-25	Union					1,091,315	186,029	1,277,345						
Sep-25	Non-Union					2,314,876	18,274	2,333,150						
						3,406,191	204,304	3,610,495						
Oct-25	Union					1,606,939	237,449	1,844,388						
Oct-25	Non-Union					2,365,118	18,443	2,383,561						
						3,972,057	255,892	4,227,948						
Nov-25	Union					1,091,948	186,029	1,277,978						
Nov-25	Non-Union					2,314,652	18,274	2,332,926						
						3,406,600	204,304	3,610,904						
Dec-25	Union					1,090,415	186,029	1,276,445						
Dec-25	Non-Union					2,314,386	18,274	2,332,661						
						3,404,801	204,304	3,609,105						
Jan-26	Union					1,093,964	186,029	1,279,993						
Jan-26	Non-Union					2,314,638	18,274	2,332,913						
						3,408,602	204,304	3,612,906						

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Feb-26	Union					1,092,608	186,029	1,278,637						
Feb-26	Non-Union					2,315,035	18,274	2,333,309						
						3,407,643	204,304	3,611,946						
Mar-26	Union					1,130,628	192,540	1,323,169						
Mar-26	Non-Union					2,396,695	18,914	2,415,609						
						3,527,323	211,454	3,738,778						
Apr-26	Union					1,130,943	192,540	1,323,483						
Apr-26	Non-Union					2,396,417	18,914	2,415,331						
						3,527,360	211,454	3,738,814						
May-26	Union					1,661,443	245,759	1,907,202						
May-26	Non-Union					2,448,541	19,088	2,467,630						
						4,109,984	264,848	4,374,832						
Jun-26	Union					1,130,709	192,540	1,323,250						
Jun-26	Non-Union					2,396,235	18,914	2,415,149						
						3,526,944	211,454	3,738,398						
Forecast Period	Union					14,302,157	2,363,035	16,665,193						
Forecast Period	Non-Union					28,206,428	222,195	28,428,622						
						42,508,585	2,585,230	45,093,815						

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-039
CONFIDENTIAL ATTACHMENT 1

FILED UNDER SEAL

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-039
CONFIDENTIAL ATTACHMENT 2

FILED UNDER SEAL

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

PUBLIC STAFF-DR-01-040
(As to Attachments 1 and 3 only)

REQUEST:

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

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET
(As to Attachments 1 and 3 only)

Please see STAFF-DR-01-040 Confidential Attachment 1 for schedules showing salary information and employee counts for current executives.

Please see STAFF-DR-01-040 Attachment 2 for responsibilities by executive officer.

Please see STAFF-DR-01-040 Confidential Attachment 3 for prior executive officers and salaries.

PERSON RESPONSIBLE: Shannon A. Caldwell

CONFIDENTIAL PROPRIETARY TRADE SECRET

Executive Officer Job History

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
3/1/2024	[redacted]	8.00%	$756,000	100%	350%	1,150	Good, Lynn J
1/1/2024			$700,000	100%	350%	1,169	Good, Lynn J
3/1/2023		4.01%	$700,000	100%	325%	451	Good, Lynn J
1/1/2023			$673,002	100%	325%	450	Good, Lynn J
9/1/2022		3.00%	$673,002	90%	300%	467	Good, Lynn J
3/1/2022		8.00%	$653,400	90%	300%	193	Good, Lynn J
1/1/2022			$605,000	90%	300%	190	Good, Lynn J
3/1/2021		10.00%	$605,000	80%	275%	192	Good, Lynn J
1/1/2021			$550,000	80%	275%	192	Good, Lynn J

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2024	[redacted]		$772,967	95%	275%	7,745	Sideris, Harry K
3/1/2024		5.00%	$772,967	95%	275%	7,730	Good, Lynn J
1/1/2024			$736,159	95%	275%	7,674	Good, Lynn J
3/1/2023		3.00%	$736,159	85%	225%	7,755	Good, Lynn J
1/1/2023			$714,718	85%	225%	7,775	Good, Lynn J
9/1/2022			$714,718	75%	190%	7,410	Good, Lynn J
3/1/2022		4.50%	$714,718	75%	190%	7,511	Good, Lynn J
1/1/2022			$683,941	75%	190%	7,552	Jamil, Dhiaa M
9/30/2021			$683,941	75%	190%	7,635	Jamil, Dhiaa M
3/1/2021		2.00%	$683,941	75%	190%	7,760	Jamil, Dhiaa M
1/1/2021			$670,530	75%	190%	7,813	Jamil, Dhiaa M

CONFIDENTIAL PROPRIETARY TRADE SECRET

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Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2024	[redacted]		$562,913	85%	300%	121	Sideris, Harry K
3/1/2024		4.00%	$562,913	85%	300%	124	Good, Lynn J
1/1/2024			$541,263	85%	300%	196	Good, Lynn J
3/1/2023		6.00%	$541,263	80%	250%	193	Good, Lynn J
1/1/2023			$510,625	80%	250%	179	Good, Lynn J
9/1/2022			$510,625	75%	200%	283	Good, Lynn J
3/1/2022		7.50%	$510,625	75%	200%	145	Good, Lynn J
1/1/2022			$475,000	75%	200%	141	Good, Lynn J
5/1/2021		14.35%	$475,000	70%	175%	128	Good, Lynn J
3/1/2021		2.00%	$415,395	50%	95%	25	Ghartey-Tagoe,Kodwo
1/1/2021			$407,250	50%	95%	26	Ghartey-Tagoe,Kodwo

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2024	[redacted]		$1,500,000	200%	1067%	27,556	
1/1/2024			$1,500,000	200%	1067%	27,596	
3/1/2022		7.87%	$1,500,000	175%	1050%	28,280	
1/1/2022			$1,390,500	175%	1050%	28,045	
1/1/2021			$1,390,500	165%	800%	27,847	

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2024	[redacted]		$900,000	115%	350%	2,120	Sideris, Harry K
3/1/2024		12.45%	$900,000	115%	350%	107	Good, Lynn J
1/1/2024			$800,337	115%	350%	103	Good, Lynn J
3/1/2023			$800,337	100%	350%	104	Good, Lynn J
1/1/2023			$800,337	100%	350%	99	Good, Lynn J
9/1/2022		3.00%	$800,337	100%	350%	89	Good, Lynn J
3/1/2022		3.50%	$777,026	100%	325%	85	Good, Lynn J
1/1/2022			$750,750	100%	325%	80	Good, Lynn J
5/1/2021			$750,750	90%	300%	77	Good, Lynn J
1/1/2021			$750,750	90%	300%	257	Good, Lynn J

CONFIDENTIAL PROPRIETARY TRADE SECRET

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Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
3/1/2024	[redacted]	2.75%	$346,913	50%	90%	89	Savoy, Brian D
1/1/2024			$337,629	50%	90%	90	Savoy, Brian D
3/1/2023		5.57%	$337,629	50%	90%	195	Savoy, Brian D
1/1/2023			$319,815	50%	90%	193	Savoy, Brian D
9/1/2022			$319,815	50%	75%	203	Savoy, Brian D
3/1/2022		6.61%	$319,815	50%	75%	201	Young,Steven K
1/1/2022			$300,000	50%	75%	200	Young,Steven K
5/16/2021		53.61%	$300,000	45%	75%	198	Young,Steven K
3/1/2021		2.00%	$195,305	30%	30%	1	Sullivan III,John L
1/1/2021			$191,476	30%	30%	1	Sullivan III,John L

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
3/1/2024	[redacted]	2.25%	$565,489	61%	100%	20	Savoy, Brian D
1/1/2024			$553,045	61%	100%	21	Savoy, Brian D
3/1/2023		2.50%	$553,045	61%	100%	21	Savoy, Brian D
1/1/2023			$539,556	61%	100%	22	Savoy, Brian D
9/1/2022			$539,556	61%	100%	23	Savoy, Brian D
3/1/2022		3.00%	$539,556	61%	100%	22	Young,Steven K
3/1/2021		2.00%	$523,841	61%	100%	24	Young,Steven K
1/1/2021			$513,570	61%	100%	24	Young,Steven K

CONFIDENTIAL PROPRIETARY TRADE SECRET

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Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
3/1/2024	[redacted]	7.00%	$579,726	95%	325%	113	Good, Lynn J
1/1/2024			$541,800	95%	325%	131	Good, Lynn J
3/1/2023		12.00%	$541,800	85%	275%	137	Good, Lynn J
1/1/2023			$483,750	85%	275%	137	Good, Lynn J
9/1/2022			$483,750	75%	200%	152	Good, Lynn J
3/1/2022		7.50%	$483,750	75%	200%	148	Good, Lynn J
1/1/2022			$450,000	75%	200%	140	Good, Lynn J
5/1/2021		12.58%	$450,000	70%	150%	145	Good, Lynn J
3/1/2021		2.00%	$399,713	50%	95%	40	Janson,Julie
1/1/2021			$391,875	50%	95%	39	Janson,Julie

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
3/1/2024	[redacted]	7.00%	$696,613	100%	350%	397	Good, Lynn J
1/1/2024			$651,040	100%	350%	452	Good, Lynn J
3/1/2023		4.00%	$651,040	100%	325%	570	Good, Lynn J
1/1/2023			$626,000	100%	325%	579	Good, Lynn J
9/1/2022		8.00%	$626,000	90%	300%	653	Good, Lynn J
3/1/2022		8.00%	$579,630	90%	300%	3,134	Good, Lynn J
1/1/2022			$536,694	90%	300%	3,106	Good, Lynn J
5/1/2021		5.00%	$536,694	80%	250%	3,017	Good, Lynn J
3/1/2021		2.00%	$511,137	80%	250%	3,105	Good, Lynn J
1/1/2021			$501,115	80%	250%	2,881	Good, Lynn J

CONFIDENTIAL PROPRIETARY TRADE SECRET

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Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2024	[redacted]	41.15%	$900,000	115%	475%	22,893	Good, Lynn J
3/1/2024			$637,620	95%	325%	13,832	Good, Lynn J
1/1/2024			$637,620	95%	325%	13,598	Good, Lynn J
3/1/2023		5.00%	$637,620	95%	325%	13,353	Good, Lynn J
1/1/2023			$607,257	95%	325%	13,333	Good, Lynn J
9/1/2022		5.00%	$607,257	90%	300%	10,246	Good, Lynn J
3/1/2022		8.00%	$578,340	90%	300%	9,253	Good, Lynn J
1/1/2022			$535,500	90%	300%	9,123	Good, Lynn J
5/1/2021		5.00%	$535,500	80%	250%	9,097	Good, Lynn J
3/1/2021		2.00%	$510,000	80%	250%	8,635	Good, Lynn J
1/1/2021			$500,000	80%	250%	8,576	Good, Lynn J

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
3/1/2024	[redacted]	3.00%	$343,218	45%	75%	31	Glenn, Alex Robert
1/1/2024			$333,221	45%	75%	32	Glenn, Alex Robert
3/1/2023		3.00%	$333,221	45%	75%	29	Glenn, Alex Robert
1/1/2023			$323,516	45%	75%	27	Glenn, Alex Robert
9/1/2022			$323,516	45%	75%	26	Glenn, Alex Robert
3/1/2022		11.81%	$323,516	45%	75%	26	Glenn, Alex Robert
5/1/2021			$289,331	45%	75%	24	Glenn, Alex Robert
3/1/2021		2.00%	$289,331	45%	75%	24	Esamann,Douglas F
1/1/2021			$283,658	45%	75%	24	Esamann,Douglas F

CONFIDENTIAL PROPRIETARY TRADE SECRET

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Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2024	[redacted]		$323,729	50%	95%	2,013	Janson, Julie
3/1/2024		3.25%	$323,729	40%	60%	1,619	Weintraub, Sasha
1/1/2024			$313,539	40%	60%	1,634	Weintraub, Sasha
3/1/2023		4.00%	$313,539	40%	60%	1,583	Weintraub, Sasha
1/1/2023			$301,479	40%	60%	1,598	Weintraub, Sasha
3/1/2022		5.56%	$301,479	40%	60%	1,687	Weintraub, Sasha
1/1/2022			$285,600	40%	60%	1,679	Weintraub, Sasha
3/1/2021		2.00%	$285,600	40%	60%	1,260	Weintraub, Sasha
1/1/2021			$280,000	40%	60%	1,264	Weintraub, Sasha

Kodwo Ghartey-Tagoe serves as executive vice president, chief legal officer and corporate secretary for Duke Energy. He is the primary legal advisor to Duke Energy's board of directors and senior management, and he leads the Office of the General Counsel, which includes the company's legal, corporate governance, internal audit, and ethics and compliance functions. Additionally, he is responsible for the administrative services function, which includes the real estate, land services, aviation and support services organizations.

Prior to being named chief legal officer in October 2019 and corporate secretary in May 2020, Ghartey-Tagoe served as president of Duke Energy's utility operations in South Carolina, which serves approximately 800,000 electric retail customers and 157,000 natural gas customers. He was responsible for the financial performance of Duke Energy's regulated electric utilities in South Carolina and managing state and local regulatory and government relations, and community affairs. He also had responsibility for advancing the company's legislative and regulatory initiatives related to its electric operations.

Joining the company in 2002 as chief regulatory counsel for Duke Power, Ghartey-Tagoe has held numerous leadership positions in the legal department covering several areas of legal services to Duke Energy. He served as Duke Energy's senior vice president of state and federal regulatory legal support; general counsel for litigation; and vice president, legal, for Duke Energy's Commercial Businesses organization. He also served as vice president, legal-state regulation for Duke Energy's franchised electric and gas business. Before joining the company, Ghartey-Tagoe was a partner with McGuireWoods LLP in Richmond, Va.

Ghartey-Tagoe serves on the board of directors of Energy Insurance Mutual, Ltd., the board of visitors of Duke University Law School and on the President's Advisory Board of Clemson University. He is also on the boards of TreesCharlotte and Charlotte Center City Partners. In 2000, Ghartey-Tagoe was appointed by Gov. Gilmore of Virginia to serve on the board of visitors of Virginia State University, one of the nation's most venerated historically black institutions of higher learning. He served on that board for three years.

In 2013, Ghartey-Tagoe received the Diversity Champion Award from the Charlotte Business Journal, and the Thurgood Marshall College Fund honored him with an Award of Excellence for his outstanding achievements in the legal profession and his dedication to diversity in the workplace.

A native of Ghana, Ghartey-Tagoe earned a Juris Doctor from Duke University and a Bachelor of Arts degree, with joint honors in economics and finance, from McGill University in Montreal, Quebec. He also completed the Advanced Management Program at the Wharton School of Business. In 2017, Ghartey-Tagoe was conferred an honorary Doctor of Humanities degree by Francis Marion University. Ghartey-Tagoe and his wife, Phyllis, have three daughters.

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Preston Gillespie serves as executive vice president, chief generation officer and enterprise operational excellence for Duke Energy. He is responsible for the safe, reliable and efficient operations of Duke Energy's fleet of nuclear, natural gas, hydro, solar and coal units with a generating capacity of over 50,000 megawatts. He is also responsible for generation transition and system optimization, operational excellence, project management and environmental, health and safety.

Gillespie has more than 35 years of experience in the energy field. He previously served as Duke Energy's chief nuclear officer. In this role, he was responsible for the safe and efficient operation of the nation's largest regulated nuclear generating fleet. Other leadership roles across the company's nuclear fleet include senior vice president of nuclear operations, site vice president and plant manager of Oconee Nuclear Station, and site operations manager of Catawba Nuclear Station. In these roles, he directed station and facilities management, operations, maintenance, chemistry, radiation protection, engineering, nuclear and industrial safety, and business operations. He joined the company in 1986 as an assistant engineer at Oconee Nuclear Station, where he earned his senior reactor operator license and held positions in a variety of roles in engineering and operations.

Gillespie currently serves on the boards of directors for Nuclear Electric Insurance Limited and Charlotte Sports Foundation, and on the advisory board for Clemson University's College of Engineering, Computing and Applied Sciences. He is also a member of the National Nuclear Accrediting Board for the Institute of Nuclear Power Operations.

A native of Charleston, S.C., Gillespie earned a Bachelor of Science degree in mechanical engineering from Clemson University. He is a registered professional engineer in South Carolina and a graduate of Wharton's Advanced Management Program. Gillespie is also a past recipient of the company's Robinson Award, which recognized employees for their outstanding contributions to the company's operations.

Gillespie and his wife, Donna, have a son.

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Alex Glenn is executive vice president and chief executive officer for Duke Energy Florida and Midwest. He has responsibility for regulatory and legislative affairs – and for the long-term strategic direction, growth and overall financial performance of Duke Energy's regulated utilities in Florida, Indiana, Ohio and Kentucky.

Before assuming his current position in May 2021, Glenn served as senior vice president of state and federal regulatory legal support for Duke Energy. Partnering with the company's corporate and regulatory strategy team and state presidents, he was responsible for advancing rate and regulatory initiatives throughout the enterprise and updating regulatory models. In addition, his team provided legal advice on state and federal regulatory matters.

Glenn has been with Duke Energy (and predecessor companies Progress Energy and Florida Power Corp.) since 1996, and served in various leadership positions. He served as state president of Duke Energy's utility operations in Florida, serving approximately 1.7 million electric retail customers in central Florida, including metropolitan St. Petersburg, Clearwater and the Greater Orlando area. In a previous role as general counsel for the Florida utility operations, Glenn oversaw all regulatory matters affecting the Florida utility. He also served as a key advisor to the Florida state president, as well as other company executive management and the board of directors.

Before joining the company, Glenn practiced energy law at the international law firm of Morgan, Lewis & Bockius LLP in Washington, D.C.

Glenn earned a bachelor's degree, magna cum laude and Phi Beta Kappa, and law degree, with honors, from the University of Connecticut. He is a member of the Connecticut, Washington, D.C., and Florida bars.

He has served on the boards of the North Carolina Museum of Art, Florida Chamber of Commerce, Enterprise Florida, St. Petersburg Chamber of Commerce, the Boys and Girls Club of the Suncoast and the Pinellas Education Foundation and was a resident member of the Florida Council of 100. He is a 2011 graduate of the Leadership Florida Class XXIX.

Glenn and his wife, Robin, have three sons.

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Lynn Good is chair and chief executive officer of Duke Energy, one of America's largest energy holding companies. Under her leadership, Duke Energy is delivering one of the nation's largest clean energy transitions while maintaining the reliability and affordability customers depend on.

Good is focused on Duke Energy executing an aggressive clean energy strategy to achieve its ambitious climate goals – at least a 50% carbon reduction by 2030, 80% by 2040 and net-zero by 2050 for electricity generation. The company expanded its net-zero emissions goal to include Scope 2 and certain Scope 3 emissions. Since 2005, the company has reduced carbon emissions by 44%.

The company is accelerating the transition to cleaner energy by adding significant amounts of renewables and energy storage to its portfolio, extending the life of its nuclear plants, modernizing the energy grid, advocating for new dispatchable clean energy technologies, and collaborating with stakeholders and policymakers to advance supportive energy policy. This transformation will deliver value for the company's customers, communities and shareholders.

Fortune magazine lists Good among the "Most Powerful Women in Business," and Forbes magazine calls her one of "The World's 100 Most Powerful Women."

Duke Energy has paid a quarterly cash dividend on its common stock for 98 consecutive years. The company has also been named to the Forbes list of "America's Best Employers" and recognized by Fortune as one of the "World's Most Admired Companies" in the electric and gas utilities industry.

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

Good currently serves on the boards of directors for Boeing, the Business Roundtable, the Edison Electric Institute, Foundation For The Carolinas, the Institute of Nuclear Power Operations, the World Association of Nuclear Operators, myFutureNC, and New York City Ballet. She also serves on the Department of Homeland Security Advisory Council, the Charlotte Executive Leadership Council, and Bechtler Museum of Modern Art Advisory Council. Good holds Bachelor of Science degrees in systems analysis and accounting from Miami University in Oxford, Ohio. She and her husband, Brian, live in Charlotte.

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Julie Janson is executive vice president and chief executive officer for Duke Energy Carolinas. She has responsibility for regulatory and legislative affairs – and for the long-term strategic direction, growth and overall financial performance of Duke Energy's regulated utilities in North Carolina and South Carolina.

Previously, Janson served as executive vice president of external affairs and president of Duke Energy's Carolinas region. In this role, she oversaw the corporate communications, federal government affairs, strategic policy and sustainability functions, stakeholder strategy and the Duke Energy Foundation. In addition, she had responsibility for the performance of the company's regulated utilities in North Carolina and South Carolina.

Janson's extensive experience in the energy and legal industries includes serving as Duke Energy's chief legal officer, where she was the primary legal advisor to Duke Energy's board of directors and senior management. She led the Office of the General Counsel, which includes the company's legal, corporate governance, ethics and compliance, and corporate audit services functions. Janson also served as Duke Energy's corporate secretary and senior vice president of ethics and compliance.

From 2008 to 2012, Janson served as president of Duke Energy's utility operations in Ohio and Kentucky, serving approximately 1 million natural gas and electric customers in southwest Ohio and approximately 230,000 customers in six Northern Kentucky counties.

During her career at Cinergy Corp., Janson served as corporate secretary and chief compliance officer. As senior counsel, she provided advice on general corporate, corporate governance and securities-related matters. As counsel for Cinergy, she provided research, advice and support for divestitures, mergers and acquisitions, and several internal clients including investor relations, shareholder services, corporate communications and government and regulatory affairs. She also served as corporate counsel to the international business unit. Prior to joining Cinergy, Janson was corporate attorney for The Cincinnati Gas & Electric Company (CG&E), playing a role in the merger of CG&E and PSI Energy, which formed Cinergy Corp.

She earned a Juris Doctor from the University of Cincinnati College of Law. She also holds a Bachelor of Arts degree in American Studies from Georgetown College in Georgetown, Ky. Janson is a member of the bar associations of Ohio and Kentucky, with legal experience that spans more than 30 years. She is a member of the DirectWomen Board Institute Class of 2011, a program designed to identify and promote accomplished female lawyers to serve on corporate boards of public companies.

Active in several community and professional activities, Janson is currently a member of the executive committee for the Charlotte Regional Business Alliance. She serves on the advisory board for Constellation Insurance Holdings Inc. Janson is a member of the Commercial Club of Cincinnati and the American Association of Blacks in Energy. She is also a member of the Johnson C. Smith University Mayor's Racial Equity Initiative Funder Advisory Committee and serves as a trustee for the Duke Energy Foundation. She is a past member of the board of trustees for Queens University of

Charlotte and director for Constellation Insurance Holdings Inc. insurance boards in Cincinnati – The Ohio National Life Insurance Company, Ohio National Life Assurance Corporation, and National Security Life and Annuity Company.

Janson and her husband, Chip, have two daughters.

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Cindy Lee serves as vice president, chief accounting officer and controller for Duke Energy. She is responsible for the accounting, financial reporting and internal controls for the corporation.

Before assuming her current position in May 2021, Lee served as Duke Energy's director of investor relations, where she had responsibility for fostering relationships with industry analysts and investors, managing the quarterly earnings calls, monitoring trends in investor markets and developing investor communication materials. She also participated on the team to deliver Duke Energy's inaugural ESG Investor Day in October 2020.

Lee has over 19 years of experience in the energy industry. She joined the company in 2002 as a senior financial analyst in St. Petersburg, Fla. Prior to joining investor relations, Lee held various leadership roles in asset accounting, financial reporting, and regulated and general accounting, including rate case support.

A native of Maryland, Lee earned her Bachelor of Arts degree in economics from Rollins College in Winter Park, Fla., and her MBA from Johns Hopkins University in Maryland.

She is a certified public accountant licensed in North Carolina. She is an alumna of Leadership Charlotte Class 41 and currently serves on Duke Energy's Diversity and Inclusion Council.

Lee and her husband, Randy, have a daughter and live in Charlotte.

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Karl Newlin serves as senior vice president, corporate development and treasurer for Duke Energy. As treasurer, he is responsible for financing and capital markets activities, liability management, liquidity and cash management, long-term investments and managing Duke Energy's relationships with the major credit rating agencies. As head of corporate development, he is responsible for the company's corporate development activities, as well as mergers and acquisitions. He assumed his current position in November 2018.

Previously, Newlin served as senior vice president and chief commercial officer for Duke Energy's natural gas business. In this role, he led the gas commercial operations, which includes supply, wholesale marketing, transportation and pipeline services, field customer service, sales and delivery, and business development. He was named to this position following Duke Energy's acquisition of Piedmont Natural Gas in October 2016.

Newlin joined Piedmont Natural Gas in 2010 to manage Piedmont's strategic planning functions, new business development activities and joint venture investments. In November 2011, he was appointed to the position of chief financial officer, assuming responsibility for Piedmont's accounting, controller, finance, treasurer, investor relations, insurance, credit policy, risk management and state regulatory affairs areas.

Prior to joining Piedmont Natural Gas, Newlin served as managing director of investment banking for Merrill Lynch & Co. in its New York and Los Angeles offices. He has extensive experience in the energy industry, leading teams in corporate financings and business transactions for natural gas distribution and midstream companies, electric utilities, independent power producers and clean energy companies.

Newlin earned his Bachelor of Business Administration degree from Southern Methodist University and his MBA from UCLA Anderson School of Management. He is a chartered financial analyst.

Newlin serves on the board of trustees of the Mint Museum and is a former board chair of the Arts & Science Council. In 2014, he was named "CFO of the Year" by the Charlotte Business Journal.

Newlin and his wife, Shannon, have two children.

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Louis Renjel is executive vice president and chief corporate affairs officer for Duke Energy. In this role, he is responsible for corporate communications, federal government affairs, strategic policy, sustainability, stakeholder engagement and the Duke Energy Foundation.

Before assuming his current position, Renjel served as Duke Energy's senior vice president of federal government and corporate affairs and, prior to that, as vice president of federal government affairs and strategic policy.

Renjel joined Duke Energy in March 2017 from Jacksonville, Fla.-based transportation company CSX Corp., where he served as vice president of strategic infrastructure. In this position since 2009, his responsibilities included aligning CSX's strategy with federal, state and local governmental advocacy; structuring and executing public-private partnerships; securing governmental approvals for large-scale critical infrastructure projects; and leading environmental and energy public policy initiatives. He also served as director of environmental and government affairs at CSX from 2006 to 2008.

Prior to joining CSX, Renjel served as director of government relations for Cummins Inc., where he was responsible for managing energy, environmental, transportation and corporate matters before Congress and the executive branch. His government relations experience also includes serving on the staff of the U.S. Chamber of Commerce.

Renjel's public sector experience includes serving as deputy staff director for the U.S. Senate Committee on Environment and Public Works, where he was the committee chairman's principal environmental policy and political advisor. Additionally, he served as legislative assistant to U.S. Sen. James M. Inhofe of Oklahoma and staff member on the U.S. House of Representatives Committee on Energy and Commerce.

He earned a Master of Business Administration degree from Duke University, a Master of Science degree in environmental sciences from Johns Hopkins University and a Bachelor of Arts degree in environmental studies from Randolph-Macon College.

Renjel and his wife, Nan, have a son and a daughter.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 8.4 million customers in the Southeast and Midwest. The company also distributes natural gas services to approximately 1.7 million customers in the Carolinas, Ohio, Kentucky and Tennessee. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 150 company traded on the New York Stock Exchange under the symbol DUK.

Brian Savoy serves as executive vice president and chief financial officer for Duke Energy. He oversees the company's financial function, including the controller's office, treasury, tax, risk management and insurance. These duties include accounting, cash management and overseeing risk control policies. He also has responsibility for corporate development and enterprise strategy, with a focus on transforming the company's generation and transmission assets to achieve its net-zero carbon emissions goals.

Before assuming his current position in September 2022, Savoy served as Duke Energy's executive vice president and chief strategy and commercial officer. In this role, he was responsible for enterprise strategy, commercial renewables, the natural gas business unit, business ventures and development, and relationship management and sales for large customer accounts.

Previously, Savoy served as the company's chief transformation and administrative officer, where he led the company's business transformation through digital innovation, new ways of working and process redesign. He had responsibility for the enterprise business services and technology team, including the information and technology, administrative services, supply chain and human resources organizations. Prior to that, Savoy served as Duke Energy's chief accounting officer and controller. He joined the company in 2001 as a manager in Duke Energy's energy trading unit, Duke Energy North America, and he was named director of trading and risk services later in that year. Savoy led derivative accounting and trading control functions for energy trading and marketing activities and was instrumental in the successful wind-down and disposition of Duke Energy North America in 2005.

Following Duke Energy's merger with Cinergy in 2006, he was appointed vice president and controller of the commercial power segments. In 2009, Savoy was named director of forecasting and analysis, where he played a significant role in addressing challenging business and strategic issues, including leading financial due diligence for the Duke Energy/Progress Energy merger completed in 2012.

Before joining Duke Energy, Savoy was a manager with the international accounting firm Deloitte & Touche. Savoy earned a Bachelor of Business Administration degree in accounting from Lamar University in Beaumont, Texas, and completed the Advanced Management Program at the Fuqua School of Business at Duke University in Durham, N.C. He is a certified public accountant in both Texas and Ohio.

Savoy serves on the board of trustees for the Duke Energy Foundation. He is a board member of the Electric Power Research Institute. He also serves on the board of trustees for Queens University of Charlotte and was a past advisory board member for the Belk College of Business at UNC Charlotte. He and his wife, Sabrina, along with their son and daughter, live in Charlotte, N.C.

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Harry Sideris is president of Duke Energy, one of the nation's largest energy holding companies. Sideris has an exceptional track record of leadership and accomplishment that spans operational, customer service, regulatory and stakeholder engagement experience over his 28 years in the energy industry.

As president, Sideris oversees Duke Energy's electric and gas utilities in the company's seven-state service area, including North Carolina, South Carolina, Florida, Indiana, Ohio, Kentucky and Tennessee. Sideris is responsible for all aspects of generation operations, nuclear, gas operations, customer service and delivery, power grid operations, the development of mass-market products and services, wholesale power, economic development, regulatory and legislative affairs, construction, and the company's long-term grid and generation strategies and solutions.

Before becoming president in April 2024, Sideris served as Duke Energy's executive vice president of customer experience, solutions and services. In addition to focusing on transmission, customer delivery and enhancing the customer experience, he was responsible for the company's electrification efforts, including long-term grid strategies and solutions. Sideris also had responsibility for the supply chain functions of the company's regulated and commercial operations. His previous roles at the company include serving as chief distribution officer, state president of Duke Energy's utility operations in Florida and senior vice president of environmental health and safety.

Sideris began his career at Progress Energy (formerly Carolina Power & Light) in 1996 and served in numerous operations, maintenance, technical and leadership roles across the company's generation fleet in the Carolinas and Florida. Following the merger between Duke Energy and Progress Energy in 2012, Sideris served as vice president of power generation for Duke Energy's fossil/hydro operations in the western regions of North Carolina and South Carolina.

Sideris holds a Bachelor of Science degree in chemical engineering from North Carolina State University and a Master of Business Administration degree from Campbell University. He also completed the Advanced Management Program at the University of Chicago.

He currently serves as a trustee of the Duke Energy Foundation and as a board member of the Association of Edison Illuminating Companies. He also co-chairs the National Utilities Diversity Council. Sideris grew up in Asheville, N.C. He and his wife, Catinna, have two daughters.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 8.4 million customers in the Southeast and Midwest. The company also distributes natural gas services to approximately 1.7 million customers in the Carolinas, Ohio, Kentucky and Tennessee. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 150 company traded on the New York Stock Exchange under the symbol DUK.

Amy Spiller is president of Duke Energy's utility operations in Ohio and Kentucky, which serve approximately 900,000 electric customers and 557,000 natural gas customers. She is accountable for advancing the company's rate and regulatory initiatives and managing the government relations, community affairs and stakeholder engagement functions throughout the region.

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

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

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

Amy serves on the boards of directors of 1NKY Alliance, Kentucky Chamber of Commerce, Mt. Auburn Community Development Corp. and Port of Greater Cincinnati Development Authority. In addition to serving on the boards of directors, Amy is also on the executive committees of the Cincinnati Center City Development Corp., Cincinnati USA Regional Chamber and REDI Cincinnati, the region's economic development initiative. She is a member of the Cincinnati Business Committee, the Cincinnati Futures Commission and the Ohio Business Roundtable. Amy is a past board member of Accountability and Credibility Together, Cintrifuse, the Cincinnati USA Convention & Visitors Bureau, the Cincinnati Youth Collaborative, and Red Bike, and she was a member of the steering committee for the Greater Cincinnati Minority Counsel Program. She is a graduate of the Cincinnati USA Regional Chamber's WE Lead program and, in 2015, was inducted into the Hall of Fame of Duke Energy's Business Women's Network employee resource group in Cincinnati. Amy was one of eight women honored with the YWCA Greater Cincinnati's 2021 Career Women of Achievement award.

A native of northern Michigan, Amy earned a bachelor's degree in economics and management from Albion College in Michigan and a law degree from Wake Forest University in Winston-Salem, N.C. She and her husband, Keith, have lived in Cincinnati for 30 years.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 8.2 million customers in the Southeast and Midwest. The company also distributes natural gas services to approximately 1.6 million customers in the Carolinas, Ohio, Kentucky and Tennessee. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 150 company traded on the New York Stock Exchange under the symbol DUK.

As senior vice president and president of Duke Energy's natural gas business, Brian Weisker is responsible for the company's regulated natural gas operations in the Carolinas, Ohio, Kentucky and Tennessee, including subsidiary Piedmont Natural Gas. In addition, he leads the gas commercial operations, which includes supply, wholesale marketing, transportation and pipeline services, field customer service, sales and delivery, and business development.

Prior to assuming his current position in April 2024, Weisker served as senior vice president and chief operations officer for Duke Energy's natural gas business, a position he held since January 2020. He led the gas utility operations, including construction, engineering, operations support and maintenance, asset management and integrity, operations performance, gas control, quality management and pipeline safety. Prior to that, he served as vice president of operational excellence within the natural gas business.

Weisker has more than 25 years of experience in the energy industry. He began his career as a nuclear submarine officer serving onboard three separate fast attack submarines from 1994 to 2002. After leaving military service, Weisker joined Cinergy Corp., where he held several corporate leadership roles from 2002 to 2006. Following Duke Energy's merger with Cinergy in 2006, he served as the plant manager at the East Bend, Allen and Marshall power plants. He was named vice president of coal combustion products, operations and maintenance in 2015.

A native of Cincinnati, Ohio, Weisker graduated from the U.S. Naval Academy with a Bachelor of Science degree in aerospace engineering. He also earned a Master of Business Administration from Tulane University.

Weisker serves as chair of the Operations Safety Regulatory Action Committee and as a member of the Operations Section Managing Committee for the American Gas Association. He serves as a member of the Common Ground Alliance Board of Directors, is a member of the Gas Technology Institute Operations Technology Development Board of Directors and co-chairs the American Heart Association's Greater Charlotte Heart Challenge campaign. Weisker is also a recipient of Duke Energy's James B. Duke Award, the company's highest employee award for outstanding contributions to Duke Energy's business success.

Weisker and his wife, Pamela, have two daughters and a son.

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CONFIDENTIAL PROPRIETARY TRADE SECRET

Employees elected to executive officer status since the utility's last rate case.

New to Role	Role	Effective Date	Replaced	Last Date in Role	Salary as of Last Date in Role
[redacted]	[redacted]	4/1/2024	[redacted]	3/31/2024	$ 323,729
[redacted]	[redacted]	1/1/2023	See Note 1		

Note 1: [redacted] was promoted to the senior management committee effective 1/1/2023. His role partially replaced [redacted], who retired on 6/30/2023. The remainder of [redacted] responsiblities were transferred to [redacted], a current executive.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

PUBLIC STAFF-DR-01-041
(As to Attachment only)

REQUEST:

Provide, in the format provided in Schedule K, the following information for Duke Kentucky's compensation and benefits, for the three most recent calendar years and the base period. Provide the information individually for each corporate officer and by category for Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly. Provide the amounts, in gross dollars, separately for total company operations and jurisdictional operations.

a. Regular salary or wages.

b. Overtime pay.

c. Excess vacation payout.

d. Standby/Dispatch pay.

e. Bonus and incentive pay.

f. Any other forms of incentives, including stock options or forms of deferred compensation (specify).

g. Other amounts paid and reported on the employees' W-2 (specify).

h. Healthcare benefit cost.

(1) Amount paid by Duke Kentucky.

(2) Amount paid by the employee.

i. Dental benefits cost.

(1) Amount paid by Duke Kentucky.

(2) Amount paid by the employee.

j. Vision benefits cost.

(1) Amount paid by Duke Kentucky.

(2) Amount paid by the employee.

k. Life insurance cost.

(1) Amount paid by Duke Kentucky.

(2) Amount paid by the employee.

l. Accidental death and disability benefits.

(1) Amount paid by Duke Kentucky.

(2) Amount paid by the employee.

m. Defined Benefit Retirement cost.

(1) Amount paid by Duke Kentucky.

(2) Amount paid by the employee.

n. Defined Contribution – 401(k) or similar plan cost. Provide the amount paid by Duke Kentucky.

o. Cost of any other benefit available to an employee, including fringe benefits (specify).

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment only)

Please see STAFF-DR-01-041 Confidential Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky, Inc.
Case No: 2024-00354
Salary & Benefit Data by Employee ***Year*** ***2021***

Employee Name	Title	Additional Notes	Regular	Overtime	Excess Vacation Payroll	Bonus/Incentive	Other	Sub-Total	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Contribution Retirement (401K)		Other Benefits		Subtotal	
									Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee
Corporate Officers																								
[redacted]			$ 236,250.00			$ 2,216,122.24	$ 179,738.91	$ 2,632,111.15																
			$ 177,187.50				$ 94,559.93	$ 271,747.43																
			$ 1,390,500.00	$ -	$ -	$ 14,308,054.33	$ 1,498,311.26	$ 17,196,865.59																
			$ 873,054.72	$ -	$ -	$ 3,335,385.10	$ 335,064.46	$ 4,543,504.28																
			$ 250,250.00			$ 2,287,759.57	$ 184,193.05	$ 2,722,202.62																
			$ 500,500.00				$ 45,128.28	$ 545,628.28																
			$ 775,674.96	$ -	$ -	$ 2,496,109.99	$ 252,336.16	$ 3,524,121.11																
			$ 288,385.96	$ -	$ -	$ 151,033.70	$ 12,049.94	$ 451,469.60																
			$ 131,594.29			$ 422,829.11	$ 29,744.37	$ 584,167.77																
			$ 187,500.00				$ 4,045.39	$ 191,545.39																
			$ 522,129.16	$ -	$ -	$ 676,605.52	$ 56,793.77	$ 1,255,528.45																
			$ 595,833.48	$ -	$ -	$ 648,786.56	$ 264,212.52	$ 1,508,832.56																
			$ 168,333.36			$ 581,742.36	$ 33,338.50	$ 783,414.22																
			$ 357,000.00			$ 85.92	$ 19,855.29	$ 376,941.21																
			$ 168,708.72			$ 714,655.61	$ 48,001.77	$ 931,366.10																
			$ 357,796.16	$ -	$ -	$ -	$ 29,098.03	$ 386,894.19																
			$ 316,710.08			$ 55,544.40	$ 21,501.51	$ 393,755.99																
			$ 300,000.00				$ 8,716.95	$ 308,716.95																
			$ 296,875.05				$ 7,569.58	$ 304,444.63																
			$ 19,791.67				$ 3,318.48	$ 23,110.15																
			$ 392,066.36			$ 501,979.90	$ 47,905.20	$ 941,951.46																
			$ 300,000.00			$ 85.94	$ 208,355.96	$ 508,441.90																
Total Amount			$ 8,606,141.47	$ -	$ -	$ 28,396,780.25	$ 3,383,839.31	$ 40,386,761.03																
[redacted]			$ 679.22	$ -	$ -	$ 6,371.35	$ 516.75	$ 7,567.32																
			$ 509.41	$ -	$ -	$ -	$ 271.86	$ 781.27																
			$ 15,990.75	$ -	$ -	$ 164,542.62	$ 17,230.58	$ 197,763.95																
			$ 20,429.48	$ -	$ -	$ 78,048.01	$ 7,840.51	$ 106,318.00																
			$ 1,438.94	$ -	$ -	$ 13,154.62	$ 1,059.11	$ 15,652.67																
			$ 1,438.94	$ -	$ -	$ -	$ 129.74	$ 1,568.68																
			$ 8,920.26	$ -	$ -	$ 28,705.26	$ 2,901.87	$ 40,527.39																
			$ 317.22	$ -	$ -	$ 166.14	$ 13.25	$ 496.61																
			$ 1,513.33	$ -	$ -	$ 4,862.53	$ 342.06	$ 6,717.92																
			$ 2,156.25	$ -	$ -	$ -	$ 46.52	$ 2,202.77																
			$ 6,004.49	$ -	$ -	$ 7,780.96	$ 653.13	$ 14,438.58																
			$ 6,852.09	$ -	$ -	$ 7,461.05	$ 3,038.44	$ 17,351.58																
			$ 1,935.83	$ -	$ -	$ 6,690.04	$ 383.39	$ 9,009.26																
			$ 4,105.50	$ -	$ -	$ 0.99	$ 228.34	$ 4,334.83																
			$ 1,940.15	$ -	$ -	$ 8,218.54	$ 552.02	$ 10,710.71																
			$ 2,571.66	$ -	$ -	$ -	$ 161.71	$ 2,733.37																
			$ 2,502.01	$ -	$ -	$ 438.80	$ 169.86	$ 3,110.67																
			$ 3,450.00	$ -	$ -	$ -	$ 100.24	$ 3,550.24																
			$ 15,636.04	$ -	$ -	$ -	$ 398.68	$ 16,034.72																
			$ 1,041.62	$ -	$ -	$ -	$ 174.65	$ 1,216.27																
			$ -	$ -	$ -	$ -	$ -	$ -																
			$ 3,450.00	$ -	$ -	$ 0.99	$ 2,396.09	$ 5,847.08																
KY Jurisdictional Retail Amount			$ 102,883.19	$ -	$ -	$ 326,441.90	$ 38,608.80	$ 467,933.89																
Managers																								
Total Amount			$ 17,733.52	$ -	$ -	$ 1,250.00	$ -	$ 18,983.52																
KY Jurisdictional Retail Amount			$ 17,733.52	$ -	$ -	$ 1,250.00	$ -	$ 18,983.52																
Supervisors																								
Total Amount			$ 406,902.48	$ -	$ -	$ 39,041.76	$ -	$ 445,944.24																
KY Jurisdictional Retail Amount			$ 406,902.48	$ -	$ -	$ 39,041.76	$ -	$ 445,944.24																
Exempt																								
Total Amount			$ 378,522.88	$ -	$ 3,337.92	$ 29,077.88	$ 148.53	$ 411,087.21																
KY Jurisdictional Retail Amount			$ 378,522.88	$ -	$ 3,337.92	$ 29,077.88	$ 148.53	$ 411,087.21																
Non-Union Non-Exempt																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Union																								
Total Amount			$ 12,614,519.25	$ 3,419,632.60	$ 64,909.24	$ 382,389.72	$ 235,425.84	$ 16,716,876.65																
KY Jurisdictional Retail Amount			$ 12,614,519.25	$ 3,419,632.60	$ 64,909.24	$ 382,389.72	$ 235,425.84	$ 16,716,876.65																
Total Amount			$ 22,023,819.60	$ 3,419,632.60	$ 68,247.16	$ 28,848,539.61	$ 3,619,413.68	$ 57,979,652.65	$ 2,626,112.14	$ 802,006.72	$ 103,804.40	$ 65,683.31	$ -	$ 23,248.56	$ 23,612.67	$ 97,197.49	$ 1,973.74	$ 16,660.15	$ 1,176,090.72	$ 1,992,832.94	$ 93,387.27	$ 38,119.78	$ 4,024,980.93	$ 3,035,748.95
KY Jurisdictional Retail Amount			$ 13,520,561.32	$ 3,419,632.60	$ 68,247.16	$ 778,201.26	$ 274,183.17	$ 18,060,825.51	$ 2,626,112.14	$ 802,006.72	$ 103,804.40	$ 65,683.31	$ -	$ 23,248.56	$ 23,612.67	$ 97,197.49	$ 1,973.74	$ 16,660.15	$ 1,176,090.72	$ 1,992,832.94	$ 93,387.27	$ 38,119.78	$ 4,024,980.93	$ 3,035,748.95

Labor Dollars (Regular though Other):
(1) Include actuals for 1/1/2021 - 12/31/2021.
(2) Bonus/Incentive includes (a) short-term incentive paid in the period for the prior year and (b) taxable income from Long-Term Incentive performance share and restricted stock unit vestings in the period. It does not represent what was expensed in the current year.

Duke Energy Kentucky, Inc.
Case No: 2024-00354
Salary & Benefit Data by Employee ***Year*** ***2021***

Employee Name	Title	Additional Notes	Regular	Overtime	Excess Vacation Payroll	Bonus/Incentive	Other	Sub-Total	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Contribution Retirement (401K)		Other Benefits		Subtotal	
									Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee

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.

Duke Energy Kentucky, Inc.
Case No: 2024-00354
Salary & Benefit Data by Employee ***Year*** ***2022***

Employee Name	Title	Additional Notes	Regular	Overtime	Excess Vacation Payroll	Bonus/Incentive	Other	Sub-Total	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Contribution Retirement (401K)		Other Benefits		Subtotal	
									Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee
Corporate Officers																								
[redacted]			$ 1,481,750.00			$ 17,112,592.47	$ 1,384,061.96	$ 19,978,404.43																
			$ 898,518.72			$ 4,441,332.77	$ 326,408.32	$ 5,666,259.81																
			$ 772,647.00			$ 3,769,759.82	$ 251,320.50	$ 4,793,727.32																
			$ 530,690.92			$ 3,523,581.21	$ 220,552.67	$ 4,274,824.80																
			$ 267,607.84				$ 32,672.58																	
			$ 317,818.52			$ 410,871.84	$ 28,566.53	$ 757,256.89																
			$ 316,512.60			$ 206,629.46	$ 6,239.86	$ 529,381.92																
			$ 536,937.04			$ 1,045,326.37	$ 60,190.66	$ 1,642,454.07																
			$ 651,867.36			$ 1,273,377.50	$ 69,477.93	$ 1,994,722.79																
			$ 185,640.00			$ 1,719,849.32	$ 43,534.24	$ 1,949,023.56																
			$ 395,199.04				$ 27,658.84	$ 422,857.88																
			$ 379,263.92			$ 1,516,358.25	$ 56,113.96	$ 1,951,736.13																
			$ 208,666.72				$ 18,604.58	$ 227,271.30																
			$ 494,859.52			$ 578,632.64	$ 13,658.49	$ 1,087,150.65																
			$ 478,125.00			$ 814,612.13	$ 54,500.82	$ 1,347,237.95																
			$ 504,687.68			$ 1,366,906.38	$ 53,981.96	$ 1,925,576.02																
			$ 405,694.84			$ 706,943.73	$ 45,046.45	$ 1,157,685.02																
Total Amount			$ 8,826,486.72	$ -	$ -	$ 38,486,773.89	$ 2,692,590.35	$ 49,705,570.54																
$ Allocated to Kentucky																								
[redacted]			$ 17,188.30	$ -	$ -	$ 198,506.07	$ 16,055.12	$ 231,749.49																
			$ 21,205.04	$ -	$ -	$ 104,815.45	$ 7,703.24	$ 133,723.73																
			$ 2,240.68	$ -	$ -	$ 10,932.30	$ 728.83	$ 13,901.81																
			$ 6,156.01	$ -	$ -	$ 40,873.54	$ 2,558.41	$ 49,587.96																
			$ 3,104.25	$ -	$ -	$ -	$ 379.00	$ 3,483.25																
			$ 349.60	$ -	$ -	$ 451.96	$ 31.42	$ 832.98																
			$ 3,671.55	$ -	$ -	$ 2,396.90	$ 72.38	$ 6,140.83																
			$ 6,228.47	$ -	$ -	$ 12,125.79	$ 698.21	$ 19,052.47																
			$ 7,561.66	$ -	$ -	$ 14,771.18	$ 805.94	$ 23,138.78																
			$ 2,153.42	$ -	$ -	$ 19,950.25	$ 505.00	$ 22,608.67																
			$ 9,326.70	$ -	$ -	$ -	$ 652.75	$ 9,979.45																
			$ 1,099.87	$ -	$ -	$ 4,397.44	$ 162.73	$ 5,660.04																
			$ 2,420.53	$ -	$ -	$ -	$ 215.81	$ 2,636.34																
			$ 3,661.96	$ -	$ -	$ 4,281.88	$ 101.07	$ 8,044.91																
			$ 5,546.25	$ -	$ -	$ 9,449.50	$ 632.21	$ 15,627.96																
			$ 26,594.62	$ -	$ -	$ 72,029.40	$ 2,844.59	$ 101,468.61																
			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ 118,508.91	$ -	$ -	$ 494,981.66	$ 34,146.71	$ 647,637.28																
Managers																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Supervisors																								
Total Amount			$ 347,345.97			$ 66,059.19		$ 413,405.16																
KY Jurisdictional Retail Amount			$ 347,345.97			$ 66,059.19		$ 413,405.16																
Exempt																								
Total Amount			$ 406,280.80			$ 59,544.99	$ 6,000.00	$ 471,825.79																
KY Jurisdictional Retail Amount			$ 406,280.80			$ 59,544.99	$ 6,000.00	$ 471,825.79																
Non-Union Non-Exempt																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Union																								
Total Amount			$ 12,910,758.58	$ 3,723,985.90	$ 47,333.44	$ 691,454.45	$ 455,820.26	$ 17,829,352.63																
KY Jurisdictional Retail Amount			$ 12,910,758.58	$ 3,723,985.90	$ 47,333.44	$ 691,454.45	$ 455,820.26	$ 17,829,352.63																
Total Amount			$ 22,490,872.07	$ 3,723,985.90	$ 47,333.44	$ 39,303,832.52	$ 3,154,410.61	$ 68,720,434.54	$ 2,981,018.91	$ 779,992.98	$ 99,390.26	$ 66,840.89	$ -	$ 23,889.94	$ 41,446.37	$ 87,764.40	$ 3,576.53	$ 16,233.35	$ 1,305,950.09	$ 2,154,600.31	$ 75,529.22	$ 33,948.24	$ 4,506,911.38	$ 3,163,270.11
KY Jurisdictional Retail Amount			$ 13,782,894.26	$ 3,723,985.90	$ 47,333.44	$ 1,312,040.29	$ 495,966.97	$ 19,362,220.86	$ 2,981,018.91	$ 779,992.98	$ 99,390.26	$ 66,840.89	$ -	$ 23,889.94	$ 41,446.37	$ 87,764.40	$ 3,576.53	$ 16,233.35	$ 1,305,950.09	$ 2,154,600.31	$ 75,529.22	$ 33,948.24	$ 4,506,911.38	$ 3,163,270.11

Labor Dollars (Regular though Other):
(1) Include actuals for 1/1/2022 - 12/31/2022.
(2) Bonus/Incentive includes (a) short-term incentive paid in the period for the prior year and (b) taxable income from Long-Term Incentive performance share and restricted stock unit vestings in the period. It does not represent what was expensed in the current year.

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.

Duke Energy Kentucky, Inc.
Case No: 2024-00354
Salary & Benefit Data by Employee ***Year*** ***2023***

Employee Name	Title	Additional Notes	Regular	Overtime	Excess Vacation Payroll	Bonus/Incentive	Other	Sub-Total	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Contribution Retirement (401K)		Other Benefits		Subtotal	
									Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee
Corporate Officers																								
[redacted]			1,500,000.00			17,028,489.77	1,473,095.76	$ 20,001,585.53																
			451,805.76		44,311.86	4,510,590.25	338,888.43	$ 5,345,596.30																
			796,452.00			3,657,391.75	292,617.74	$ 4,746,461.49																
			822,894.12			3,745,327.92	302,601.25	$ 4,870,823.29																
			331,603.72			400,581.94	39,232.48	$ 771,418.14																
			334,659.92			217,896.00	6,398.41	$ 558,954.33																
			550,797.04			932,849.12	64,600.78	$ 1,548,246.94																
			695,500.40			2,418,456.69	187,499.81	$ 3,301,456.90																
			632,559.52			1,882,893.46	142,951.42	$ 2,658,404.40																
			646,866.76			1,882,313.65	149,018.12	$ 2,678,198.53																
			515,445.60			1,048,737.22	69,891.18	$ 1,634,074.00																
			532,125.00			1,292,460.62	71,218.41	$ 1,895,804.03																
			536,156.40			954,560.92	64,669.97	$ 1,555,387.29																
			420,068.24			655,020.56	53,315.04	$ 1,128,403.84																
			732,586.08			1,893,085.90	141,983.32	$ 2,767,655.30																
Total Amount			$ 9,499,520.56	$ -	$ 44,311.86	$ 42,520,655.77	$ 3,397,982.12	$ 55,462,470.31																
$ Allocated to Kentucky																								
[redacted]			$ 17,100.00	$ -	$ -	$ 194,124.78	$ 16,793.29	$ 228,018.07																
			$ 10,527.07	$ -	$ 1,032.47	$ 105,096.75	$ 7,896.10	$ 124,552.39																
			$ 2,269.89	$ -	$ -	$ 10,423.57	$ 833.96	$ 13,527.42																
			$ 9,380.99	$ -	$ -	$ 42,696.74	$ 3,449.65	$ 55,527.38																
			$ 364.76	$ -	$ -	$ 440.64	$ 43.16	$ 848.56																
			$ 3,815.12	$ -	$ -	$ 2,484.01	$ 72.94	$ 6,372.07																
			$ 6,279.09	$ -	$ -	$ 10,634.48	$ 736.45	$ 17,650.02																
			$ 7,928.70	$ -	$ -	$ 27,570.41	$ 2,137.50	$ 37,636.61																
			$ 14,738.64	$ -	$ -	$ 43,871.42	$ 3,330.77	$ 61,940.83																
			$ 7,374.28	$ -	$ -	$ 21,458.38	$ 1,698.81	$ 30,531.47																
			$ 3,659.66	$ -	$ -	$ 7,446.03	$ 496.23	$ 11,601.92																
			$ 6,066.23	$ -	$ -	$ 14,734.05	$ 811.89	$ 21,612.17																
			$ 27,791.45	$ -	$ -	$ 49,479.28	$ 3,352.14	$ 80,622.87																
			$ -	$ -	$ -	$ -	$ -	$ -																
			$ 17,069.26	$ -	$ -	$ 44,108.90	$ 3,308.21	$ 64,486.37																
KY Jurisdictional Retail Amount			$ 134,365.14	$ -	$ 1,032.47	$ 574,569.44	$ 44,961.10	$ 754,928.15																
Managers																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Supervisors																								
Total Amount			$ 282,894.72			$ 30,562.14		$ 313,456.86																
KY Jurisdictional Retail Amount			$ 282,894.72			$ 30,562.14		$ 313,456.86																
Exempt																								
Total Amount			$ 417,142.47			$ 43,101.70		$ 460,244.17																
KY Jurisdictional Retail Amount			$ 417,142.47			$ 43,101.70		$ 460,244.17																
Non-Union Non-Exempt																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Union																								
Total Amount			$ 12,733,693.13	$ 3,636,254.36	$ 19,745.40	$ 652,239.10	$ 201,341.62	$ 17,243,273.61																
KY Jurisdictional Retail Amount			$ 12,733,693.13	$ 3,636,254.36	$ 19,745.40	$ 652,239.10	$ 201,341.62	$ 17,243,273.61																
Total Amount			$ 22,933,250.88	$ 3,636,254.36	$ 64,057.26	$ 43,246,558.71	$ 3,599,323.74	$ 73,479,444.95	$ 1,549,880.55	$ 677,728.74	$ 129,402.10	$ 57,120.43	$ -	$ 21,048.25	$ 30,233.15	$ 69,342.15	$ 1,984.47	$ 14,889.59	$ 1,290,147.87	$ 2,012,935.43	$ 98,340.63	$ 28,476.37	$ 3,099,988.77	$ 2,881,540.96
KY Jurisdictional Retail Amount			$ 13,568,095.46	$ 3,636,254.36	$ 20,777.87	$ 1,300,472.38	$ 246,302.72	$ 18,771,902.79	$ 1,549,880.55	$ 677,728.74	$ 129,402.10	$ 57,120.43	$ -	$ 21,048.25	$ 30,233.15	$ 69,342.15	$ 1,984.47	$ 14,889.59	$ 1,290,147.87	$ 2,012,935.43	$ 98,340.63	$ 28,476.37	$ 3,099,988.77	$ 2,881,540.96

Labor Dollars (Regular though Other):
(1) Include actuals for 1/1/2023 - 12/31/2023.
(2) Bonus/Incentive includes (a) short-term incentive paid in the period for the prior year and (b) taxable income from Long-Term Incentive performance share and restricted stock unit vestings in the period. It does not represent what was expensed in the current year.

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.

Duke Energy Kentucky, Inc.
Case No: 2024-00354
Salary & Benefit Data by Employee

Base Period 3/1/2024 - 2/28/2025

Employee Name	Title	Additional Notes	Regular	Overtime	Excess Vacation Payroll	Bonus/Incentive	Other	Sub-Total	Health Benefits Cost		Dental Benefits		Vision		Life Insurance		AD&D		Defined Contribution Retirement (401K)		Other Benefits		Subtotal	
									Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee	Duke	Employee
	Corporate Officers																							
[redacted]			$ 750,000.00			$ 1,739,062.50	$ 1,482,754.78	$ 3,971,817.28																
			$ 450,000.00			$ 527,649.45	$ 293,816.46	$ 1,271,465.91																
			$ 171,609.00			$ 98,859.37	$ 29,956.02	$ 300,424.39																
			$ 173,456.76			$ 110,856.09	$ 3,622.36	$ 287,935.21																
			$ 282,744.36			$ 222,590.87	$ 69,975.66	$ 575,310.89																
			$ 378,000.00			$ 460,769.03	$ 220,397.21	$ 1,059,166.24																
			$ 428,135.00			$ 398,117.13	$ 178,168.87	$ 1,004,421.00																
			$ 348,306.48			$ 428,549.21	$ 175,100.57	$ 951,956.26																
			$ 289,863.00			$ 319,504.37	$ 86,541.30	$ 695,908.67																
			$ 281,456.52			$ 313,539.07	$ 91,252.38	$ 686,247.97																
			$ 134,887.00				$ 1,734.10	$ 136,621.10																
			$ 386,483.76			$ 412,537.52	$ 170,448.94	$ 969,470.22																
Total Amount			$ 4,074,941.88	$ -	$ -	$ 5,032,034.61	$ 2,803,768.65	$ 11,910,745.14																
[redacted]			$ 8,925.00	$ -	$ -	$ 20,694.84	$ 17,644.78	$ 47,264.62																
			$ 1,338.75	$ -	$ -	$ 1,569.76	$ 874.10	$ 3,782.61																
			$ 188.77	$ -	$ -	$ 108.75	$ 32.95	$ 330.47																
			$ 2,064.14	$ -	$ -	$ 1,319.19	$ 43.11	$ 3,426.44																
			$ 3,364.66	$ -	$ -	$ 2,648.83	$ 832.71	$ 6,846.20																
			$ 4,498.20	$ -	$ -	$ 5,483.15	$ 2,622.73	$ 12,604.08																
			$ 10,189.61	$ -	$ -	$ 9,475.19	$ 4,240.42	$ 23,905.22																
			$ 4,144.85	$ -	$ -	$ 5,099.74	$ 2,083.70	$ 11,328.29																
			$ 3,449.37	$ -	$ -	$ 3,802.10	$ 1,029.84	$ 8,281.31																
			$ 14,887.31	$ -	$ -	$ 16,584.27	$ 4,826.69	$ 36,298.27																
			$ -	$ -	$ -	$ -	$ -	$ -																
			$ 9,198.31	$ -	$ -	$ 9,818.39	$ 4,056.68	$ 23,073.38																
KY Jurisdictional Retail Amount			$ 62,248.97	$ -	$ -	$ 76,604.21	$ 38,287.71	$ 177,140.89																
	Managers																							
Total Amount			$ 58,275.17			$ 7,635.22		$ 65,910.39																
KY Jurisdictional Retail Amount			$ 58,275.17			$ 7,635.22		$ 65,910.39																
	Supervisors																							
Total Amount			$ 314,182.48			$ 53,017.04		$ 367,199.52																
KY Jurisdictional Retail Amount			$ 314,182.48			$ 53,017.04		$ 367,199.52																
	Exempt																							
Total Amount			$ 128,244.99			$ 23,893.03		$ 152,138.02																
KY Jurisdictional Retail Amount			$ 128,244.99			$ 23,893.03		$ 152,138.02																
	Non-Union Non-Exempt																							
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
	Union																							
Total Amount			$ 6,359,901.60	$ 1,957,911.61	$ 5,246.39	$ 563,431.19	$ 81,200.64	$ 8,967,691.43																
KY Jurisdictional Retail Amount			$ 6,359,901.60	$ 1,957,911.61	$ 5,246.39	$ 563,431.19	$ 81,200.64	$ 8,967,691.43																
Total Amount			$ 10,935,546.12	$ 1,957,911.61	$ 5,246.39	$ 5,680,011.09	$ 2,884,969.29	$ 21,463,684.50	$ 2,182,669.88	$ 692,770.22	$ 110,709.87	$ 58,649.70	$ -	$ 16,203.96	$ 21,571.56	$ 70,361.78	$ 1,968.35	$ 14,625.08	$ 1,473,840.34	$ 2,330,689.14	$ 77,879.77	$ 29,961.52	$ 3,868,639.77	$ 3,213,261.40
KY Jurisdictional Retail Amount			$ 6,922,853.21	$ 1,957,911.61	$ 5,246.39	$ 724,580.69	$ 119,488.35	$ 9,730,080.25	$ 2,182,669.88	$ 692,770.22	$ 110,709.87	$ 58,649.70	$ -	$ 16,203.96	$ 21,571.56	$ 70,361.78	$ 1,968.35	$ 14,625.08	$ 1,473,840.34	$ 2,330,689.14	$ 77,879.77	$ 29,961.52	$ 3,868,639.77	$ 3,213,261.40

Labor Dollars (Regular though Other):
(1) Includes actuals for 3/1/24 - 8/31/24. Forecasted labor dollars are not included for the remainder of the base period (9/1/24 - 2/28/25).
(2) Bonus/Incentive includes (a) short-term incentive paid in the period for the prior year and (b) taxable income from Long-Term Incentive performance share and restricted stock unit vestings in the period. It does not represent what was expensed in the current year.
(3) Corporate Officers include the officers included on Schedule G-3.

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.
(5) Actuals included for 3/1/2024 - 8/31/2024; Budgeted dollars for employer costs provided for 9/1/2024 - 2/28/2025; Forecasted dollars provided for employee costs for 9/1/2024 - 2/28/2025 as these are not budgeted.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-042

REQUEST:

For each benefit listed in Item 41 above for which 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 Company witness Shannon A. Caldwell's Direct Testimony beginning on page 34 at the question: "What portion of the health and insurance costs of benefits do employees pay?"

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-043

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 (e.g., single, 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:

Please see STAFF-DR-01-043 Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell

	MONTHLY EMPLOYEE CONTRIBUTIONS*				MONTHLY EMPLOYER CONTRIBUTIONS			
MEDICAL PLAN OPTION	***Individual Only***	***Individual + Spouse***	***Individual + Child(ren)***	***Individual + Family***	***Individual Only***	***Individual + Spouse***	***Individual + Child(ren)***	***Individual + Family***
Health Savings Plan 1 - Deductible $2,500 Individual / $5,000 Family	$127.00	$304.00	$154.00	$327.00	$536.00	$1,288.00	$974.00	$1,399.00
Health Savings Plan 2 - Deductible $1,600 Individual / $3,200 Family	$179.00	$538.00	$332.00	$577.00	$562.00	$1,242.00	$929.00	$1,351.00
PPO - Deductible $600 Individual / $1,200 Family	$330.00	$921.00	$614.00	$1,004.00	$517.00	$1,114.00	$829.00	$1,202.00

	MONTHLY EMPLOYEE CONTRIBUTIONS				MONTHLY EMPLOYER CONTRIBUTIONS			
PLAN	***Individual Only***	***Individual + Spouse***	***Individual + Child(ren)***	***Individual + Family***	***Individual Only***	***Individual + Spouse***	***Individual + Child(ren)***	***Individual + Family***
Dental PPO	$14.00	$33.00	$35.00	$59.00	$29.00	$55.00	$60.00	$93.00
Dental HMO	$0.00	$0.00	$0.00	$0.00	$16.65	$31.32	$37.52	$57.53

	MONTHLY EMPLOYEE CONTRIBUTIONS				MONTHLY EMPLOYER CONTRIBUTIONS			
PLAN	***Individual Only***	***Individual + Spouse***	***Individual + Child(ren)***	***Individual + Family***	***Individual Only***	***Individual + Spouse***	***Individual + Child(ren)***	***Individual + Family***
Vision	$6.88	$13.76	$14.44	$21.81	$0.00	$0.00	$0.00	$0.00

*Employees can reduce their medical contributions for medical coverage by $80/month if they qualify for the non-tobacco user discount and by an additional $80/month if their covered spouses/domestic partners also qualify for the non-tobacco user discount. Employees can further reduce their contributions by up to $33/month if they complete certain wellness activities, and another $12.50/month if their spouses/domestic partners also complete certain wellness activities.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-044

REQUEST:

Provide each medical insurance policy that Duke Kentucky currently maintains.

RESPONSE:

Duke Energy does not provide insurance to employees through an insurance carrier. See STAFF-DR-01-044 Attachments 1 through 6, which are the self-insured Summary Plan Descriptions for group medical plans.

PERSON RESPONSIBLE: Shannon A. Caldwell

Active Medical Plan

Health Savings Plan 1 option

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: UnitedHealthcare Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: CVS Caremark Prescription Drug Guide (includes Summary of Prescription Drug Benefits)
- SECTION IV: Teladoc Medical Experts' Services

Duke Energy Active Medical Plan
General Information

(Enterprise)

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Active Medical Plan (Medical Plan) provides information that is applicable to the Medical Plan coverage options available to eligible non-union and represented employees. 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 1, 2024 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

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

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

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300.

Eligibility

Eligible Employees

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

To be an eligible employee, you must satisfy each of the following requirements:

- you are identified in and paid through Duke Energy's payroll system as an employee of Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the Company, as appropriate); and

- you are classified by your Company as either a regular employee or a fixed-term employee.

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

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

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

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

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

Eligible Dependents

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

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

Spouse Eligibility

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

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

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

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

Domestic Partner Eligibility

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

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

Generally, for medical coverage of a taxpayer's domestic partner to be tax-free to the taxpayer, the domestic partner must qualify as the taxpayer's tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code. See *Cost of Coverage* below for additional information regarding the tax treatment of your domestic partner's medical coverage.

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

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

Child Eligibility

Your child is:

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

whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**

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

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

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

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

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

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

Surviving Spouse, Domestic Partner and Child Eligibility

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

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

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

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

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage.

If your spouse/domestic partner and/or dependent children elect survivor coverage, they may drop their survivor coverage at any time during the calendar year, regardless of whether they experience a work/life event for which mid-year changes are allowed. See *Mid-Year Changes* for additional information about work/life events for which mid-year changes are allowed.

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 continue coverage under the Medical Plan following your death as the survivor of an active employee.

Please note: new enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage take effect on Jan. 1, 2024. Under these new enrollment requirements, if you are an eligible retiree and you do not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of your retirement date (or within 31 days after your COBRA continuation coverage under the Medical Plan ends), or if you decline or drop Duke Energy-sponsored pre-65 retiree medical coverage at any point thereafter, you cannot enroll yourself or your eligible dependents in Duke Energy-sponsored pre-65 retiree medical, dental or vision coverage at any future date. This means that if your spouse/domestic partner who is an eligible retiree continues Medical Plan coverage as the survivor of an active employee, and does not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of retiring, your spouse/domestic partner will not be able to enroll in pre-65 retiree medical, dental or vision coverage at any future date.

Please refer to the Summary Plan Descriptions for the Duke Energy Retiree Medical Plan, the Duke Energy Retiree Dental Plan and the Duke Energy Retiree Vision Plan for additional information.

Employee and Retiree Couples

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

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days

following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

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

If a Dependent Becomes Ineligible

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

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

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

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

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

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

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

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

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

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

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

Enrolling in the Medical Plan

When You Are First Eligible

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

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

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

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

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

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

You also may decline coverage altogether.

During Annual Enrollment

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

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

Other Opportunities to Enroll

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

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

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

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

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

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

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

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

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

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

If You Are Rehired

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

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

Cost of Coverage

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

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

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

If you elect coverage for a domestic partner, you will need to confirm whether your covered domestic partner is your tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code. If your covered domestic partner is your tax dependent for federal income tax purposes, contributions for your domestic partner's coverage will be deducted from your pay on a pre-tax basis each pay period. If your covered domestic partner is not your tax dependent for federal income tax purposes, the portion of your contribution required to cover the domestic partner under the Medical Plan is deducted on a pre-tax basis and the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner will appear as imputed income on your pay advice statements and is subject to applicable taxes. As a result, please make sure to indicate your domestic partner's tax dependent status when you enroll to ensure proper tax treatment for your coverage. 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.

Duke Energy WellPower Rewards

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

Eligibility and Redeeming Rewards

Information about the eligibility requirements for participating in Duke Energy WellPower Rewards and redeeming any rewards you earn is included in the Duke Energy WellPower Rewards materials sent to you with Annual Enrollment materials and throughout the year. This information also is available on the Duke Energy Portal.

Duke Energy WellPower Rewards Activities

The activities that you and/or your spouse/domestic partner must complete to receive rewards may vary with each program cycle. Review the Duke Energy WellPower Rewards materials sent to you with Annual Enrollment materials and throughout the year, for additional information on the program cycle's activities and requirements.

The Medical Plan is committed to helping you achieve your best health. Rewards for participating in Duke Energy WellPower Rewards are generally available to all eligible employees. If you think you might be unable to meet a standard for a reward under Duke Energy WellPower Rewards, you might qualify for an opportunity to earn the same reward by different means. Contact a Vitality Customer Service Specialist at 866-567-0705 and a representative will work with you (and, if you wish, your doctor) to find activities with the same reward that are right for you in light of your health status.

Non-Tobacco User Discount

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

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

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

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

If you do not complete the Attestation during enrollment, or, if you complete the Attestation and attest to being a tobacco user but you either (1) do not enroll in the Tobacco Cessation Program as described below by the applicable deadline or (2) do not complete the Tobacco Cessation Program described below by the applicable deadline, you (and your spouse/domestic partner) will not receive the non-tobacco user discount for Medical Plan coverage. Tobacco user status does not carry over from year to year for Medical Plan coverage.

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

If you misrepresent your tobacco user status (or the tobacco user status of your spouse/domestic partner) in the Attestation, or if you (or your spouse/domestic partner) become a tobacco user after completing the Attestation as a non-tobacco user and you do not notify the Duke Energy myHR Service Center of the change in tobacco user status, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take

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

appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Non-Tobacco User Discount – Tobacco Cessation Program for Active Employees

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

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) intend to complete the Tobacco Cessation Program, which includes agreeing to enrollment with Quit For Life and completing your enrollment within 31 days of the date that you make your new hire coverage elections, and
    - complete the Tobacco Cessation Program within seven months of the date that you make your new hire coverage elections[2] – or –
- If you are enrolling during annual enrollment, you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) intend to complete the Tobacco Cessation Program, which includes agreeing to enrollment with Quit For Life and completing your enrollment by Dec. 31, and
    - complete the Tobacco Cessation Program on or before the following June 30.

To complete the Tobacco Cessation Program, you (and/or your covered spouse/domestic partner) must have a minimum of five interactions with a coach.

You may contact the Duke Energy myHR Service Center if you have questions about the Tobacco Cessation Program.

[2] If you (and/or your covered spouse/domestic partner) enrolled in the Tobacco Cessation Program and you properly attested while enrolling in benefits as a newly eligible employee that you (and/or your covered spouse/domestic partner) would timely complete the Tobacco Cessation Program, but you (and/or your spouse/domestic partner) have not yet reached your seven month completion deadline for the Tobacco Cessation Program by the annual enrollment deadline, you will qualify for the non-tobacco user discount if you also properly attest during annual enrollment that you (and/or your spouse/domestic partner) will complete the Tobacco Cessation Program by the original seven month completion deadline and you (and/or your spouse/domestic partner) complete the Tobacco Cessation Program by the original seven month completion deadline.

If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must call Quit For Life and complete your enrollment within 31 days of the date that you make your new hire coverage elections. If you are enrolling during annual enrollment, you must call Quit For Life by December 31 to help you complete your enrollment in the Tobacco Cessation Program. **It is your responsibility to complete your enrollment in the Tobacco Cessation Program by the applicable deadline.**

You (and/or your spouse/domestic partner) will not be required to pay for the cost of the Tobacco Cessation Program. Please note that the Tobacco Cessation Program takes up to six months to complete. You can begin the Tobacco Cessation Program as soon as you complete your enrollment. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the Tobacco Cessation Program in any future year, you will be required to again complete the Tobacco Cessation Program process described above.

If You Do Not Successfully Complete the Tobacco Cessation Program

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

If You Misrepresent Information Related to the Non-Tobacco User Discount and/or the Tobacco Cessation Program

If you misrepresent any information related to the non-tobacco user discount and/or the Tobacco Cessation Program, including, but not limited to, your enrollment with Quit For Life, or if you do not complete the Tobacco Cessation Program by the applicable deadline, Duke Energy reserves the right to recover any contribution amounts you should have paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of health and insurance coverage and/or discharge, and to take other appropriate action.

Termination of Coverage for Non-Payment

Your coverage under the Medical Plan (and all other Duke Energy-sponsored plans in which you are enrolled and for which payments are required) 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 for your coverage under the Medical Plan (and any other Duke Energy-sponsored plans under which you want to continue coverage) must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If your coverage under the Medical Plan is reinstated under this provision and then subsequently terminated again for non-payment, you will not be entitled to reinstatement of your coverage under the Medical Plan, or under any other Duke Energy-sponsored plan for which payments are required, at any later date. 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.

Note: If your Medical Plan coverage is terminated for non-payment while you are on an approved leave of absence, the termination of your Medical Plan coverage will be treated as an affirmative drop of Medical Plan coverage, rather than as a termination of Medical Plan coverage due to non-payment. This means that if you return to active employment with the Company, you may be eligible to have your Medical Plan coverage reinstated (in the previous coverage option and at the previous coverage level) on the date of your return to active employment.

When Coverage and Contributions Begin

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

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

Mid-Year Changes

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

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

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

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

- Your legal marital status changes
  - you get married

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

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,

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

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

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

When You Enroll a Dependent Mid-Year

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

When Mid-Year Coverage and Contribution Changes Are Effective

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

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

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

- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death.

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

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

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

If You Become Disabled

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

When You Reach Age 65

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

If You Become Entitled to Medicare

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

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

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

Termination of Coverage

When Coverage Ends

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

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

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

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, generally within 60 days of the qualifying event. See *COBRA Continuation Coverage* below for additional information about the timing of COBRA elections.

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

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

If You Leave the Company

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

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

If You Retire

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

Please note: new enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage take effect on Jan. 1, 2024. Under these new enrollment requirements, if you are an eligible retiree and you do not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of your retirement date (or within 31 days after your COBRA continuation coverage under the Medical Plan ends), or if you decline or drop Duke Energy-sponsored pre-65 retiree medical coverage at any point thereafter, you cannot enroll yourself or your eligible dependents in Duke Energy-sponsored pre-65 retiree medical, dental or vision coverage at any future date. Please refer to the Summary Plan Descriptions for the Duke Energy Retiree Medical Plan, the Duke Energy Retiree Dental Plan and the Duke Energy Retiree Vision Plan for additional information.

COBRA Continuation Coverage

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

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

Continued Coverage for You

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

- termination of your employment (for reasons other than gross misconduct); or

- a reduction of your work hours.

Continued Coverage for Your Dependents

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

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

Newborn and Adopted Children

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

In Case of Disability

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

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

If You Become Covered by Medicare

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

For example, suppose you are actively employed on January 1, 2024, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2025, your eligible dependents would be eligible for continued coverage until the later of:

- 36 months following the date you become covered for Medicare – January 1, 2027; or
- 18 months following your termination of employment – July 1, 2026

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2027 if COBRA continuation coverage is elected.

Multiple Qualifying Events

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

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

Procedures to Obtain Continued Coverage

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

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

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

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

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

Election Period

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

- the date coverage terminates by reason of the qualifying event, or

- the date notification of the right to elect continued coverage is mailed to you and your covered dependents.

Type of Coverage

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

Cost

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

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

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

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

Conversion Privilege

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

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

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

Your Role

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

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

You must notify the applicable Claims Administrator if a provider:

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

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

Other Important Information

Plan Sponsor

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

Duke Energy Corporation
525 South Tryon Street
Charlotte, NC 28202
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Active Health & Welfare Benefit Plans, plan number 505.

Funding

The Company provides benefits under the Medical Plan from its general assets.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (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 (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
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
525 South Tryon Street – DEP14C
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.

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
525 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

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

Claims Determination Procedures

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

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

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

exhausted your one-time reinstatement opportunity, (v) requests to change your tobacco user status, which includes requests to complete the Tobacco Cessation Program after the communicated deadline or (vi) requests for the Company to record/count wellness activities completed after the communicated deadline.

Claims for Medical Plan Benefits

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

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

Eligibility or Enrollment Claims

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

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

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

Initial Claim

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

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

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

- any additional information you want considered.

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

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

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

In the case of an Eligibility or Enrollment Claim relating to your failure to enroll your newborn or newly adopted child in Medical Plan coverage within 31 calendar days of your child's date of birth or adoption, Claims and Appeals Management will approve the Eligibility or Enrollment Claim notwithstanding your failure to timely enroll your child in Medical Plan coverage, but only if (1) you contact the Duke Energy myHR Service Center within 60 calendar days of your child's date of birth or adoption to enroll your child in Medical Plan coverage and (2) you submit a claim initiation form and all other required documentation, in accordance with the instructions specified on the claim initiation form, within 75 calendar days of your child's date of birth or adoption. If Claims and Appeals Management approves your Eligibility or Enrollment Claim, your child's Medical Plan coverage will be effective retroactive to your child's date of birth if a newborn or date of adoption for a newly adopted child. If Claims and Appeals Management denies your Eligibility or Enrollment Claim, you (or your authorized representative) will be notified of the adverse determination in writing as described below.

Adverse Determination

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

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

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA

following an adverse determination on review and any time limits for filing such a civil action;

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

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

Appeal of Adverse Determination

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

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

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person)

consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

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

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

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

- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

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

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

Voluntary External Review Program

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

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

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

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

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

- a general description of the reason for the request for external review, including information sufficient to identify the claim;

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

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

Legal Action

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

Discretionary Authority

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

Right to Change or Terminate the Medical Plan

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

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

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

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

and other Medical Plan participants and beneficiaries. No one, including the Company, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

Keep Us Informed

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

A Final Note

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

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

Benefit Booklet

Duke Energy Active Medical Plan
Health Savings Plan 1 Option

Effective: January 1, 2024
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

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

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

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

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

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

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Active Medical Plan's Health Savings Plan 1 Option works. If you have questions call the number on 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://digital.alight.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. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

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. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses*

as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, in certain circumstances if you are currently receiving treatment for Covered Health Services from a provider or health care facility whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's or health care facility's contract, you may be eligible to request continued care from your current provider or health care facility at the Network Benefit level for specified conditions and timeframes up to 90 days. This provision applies if you are undergoing a course of treatment for a serious and complex condition from the provider or health care facility, undergoing a course of institutional or in-patient care from the provider or health care facility, scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or health care facility with respect to such a surgery, pregnant and undergoing a course of treatment for pregnancy from the provider or determined to be terminally ill (as defined in Section *1861(dd)(3)(A) of the Social Security Act*) and receiving treatment for such illness from the provider or health care facility. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 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

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

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

  Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Provider or Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, or any Annual Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of Section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.

- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  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 non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, and Deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable Coinsurance or Deductible.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible

Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Covered Persons (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- Ancillary Services received at certain Network facilities on a non-Emergency basis;
- non-Ancillary Services received at certain Network facilities on a non-Emergency basis;
- Emergency Health Services;
- Air Ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or its designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, and Deductible.

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, or the Recognized Amount when applicable, 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.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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

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

Coinsurance

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

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

Out-of-Pocket Maximum

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

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

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

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

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	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.

Travel and Lodging (For Travel and Lodging related to complex medical conditions see Section 7: *Clinical Programs And Resources)*

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such Covered Health Services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their home address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year, will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services 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 your ID card.

To obtain prior authorization, call the number on 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

Payment Terms & Features

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

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

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

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

[3]Generally the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Schedule of Benefits

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for certain Covered Health Services are based on the Recognized Amount as defined in Section 12, *Glossary*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 80% after you meet the Network Annual Deductible *Air Ambulance* 80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 60% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible
Cellular and Gene Therapy	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under	Non-Network Benefits are not available.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	each Covered Health Service category in this section.	
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	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.	
Congenital Heart Disease (CHD) Surgery Services Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	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.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 2: *How the Plan Works*.	*True Emergency* 80% after you meet the Annual Deductible *Non-True Emergency* 80% after you meet the Annual Deductible	*True Emergency* 80% after you meet the Network Annual Deductible *Non-True Emergency* 80% after you meet the Network Annual Deductible
Fertility Preservation for Iatrogenic Infertility See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Fertility Services See Section 5, *Additional Coverage Details*, for limits.	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.	
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	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	in your CVS Caremark Prescription Drug Benefit Booklet	
Hearing Aids	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services Inpatient. Outpatient including Partial Hospitalization/Intensive Outpatient Treatment. Virtual Behavioral Health Therapy & Coaching.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible **Designated Network (AbleTo Therapy 360)** 100% after you meet the Annual Deductible; Benefits for the Initial	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	Consultation will be paid at 100%	
Neonatal Services	See Section 6, *Clinical Programs & Resources*, for Program Details.	
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Nutritional Counseling Up to 12 visits per condition per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery (The Plan pays Benefits only for Covered Health Services provided through *Bariatric Resource Services*) See *Obesity Surgery* in Section 5, *Additional Coverage Details*.	80% after you meet the Annual Deductible	Non-Network Benefits are not available.
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 Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable	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**
Annual Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 2, *How the Plan Works*, under *Eligible Expenses*.		
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.	
Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
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	100%	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 ■ All other services See Rehabilitation Services-Outpatient Therapy in Section 5, Additional Coverage Details, for limits	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Administrator or search for a Network program on www.myuhc.com. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	100% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible

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 For Dialysis services, Non-Network Benefits are not available
Transplantation Services Non-Network Benefits include services provided at a facility that is not a Designated Provider and services provided at a non-Network facility. See *Transplantation Services* in Section 5, *Additional Coverage Details*.	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.	
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
24/7 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	Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
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]Please obtain prior authorization before receiving Covered Health Services, as described in Section 5, Additional Coverage Details.

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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. For Non-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), 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.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

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
For Non-Network Benefits, 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 UnitedHealthcare 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 facility participating in the CHD Resource Services Program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs and Resources* 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.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items	Insulin pumps and pump supplies and continuous glucose monitors for the management and treatment of diabetes based upon your medical needs. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under the Plan's prescription drug benefit.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.

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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits for dedicated speech generating 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.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

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 two business days 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 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 two business days 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.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Fertility Services*. This Benefit limit also includes services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.

Fertility Services

Therapeutic services for the treatment of fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to InVitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection - ICSI.

  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).

- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- Insemination procedures artificial insemination (AI) and intrauterine insemination (IUI).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the *SPD*. Benefits for diagnostic tests are described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Physician's Office Services – Sickness and Injury*.

Enhanced Benefit Coverage

Donor Coverage: The Plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The Plan will not pay for donor charges associated with compensation or administrative services.

Criteria to be eligible for Benefits

- You do not need to have a diagnosis of Infertility in order to be eligible to receive services described above.

To be eligible for fertility services, you must meet the following:

- You are a female:
  - under age 44 and using own oocytes (eggs), or
  - under age 55 and using donor oocytes (eggs).

  Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Child Dependents are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce Infertility/sterility.

Any combination of Network Benefits and Non-Network Benefits are limited to $25,000 per Covered Person for medical Benefits during the entire period you are covered under the Plan. There is a separate prescription drug lifetime maximum under your CVS Caremark Prescription Drug Benefit. This limit includes Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and for related services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services.*

Charges for the following apply toward the Infertility lifetime maximum:

- Hospital outpatient facility.
- Surgeon's and assistant surgeon's fees.
- Anesthesia.
- Lab and x-ray.
- Diagnostic services.
- Physician's office visits.
- Consultations.
- Injections.

Fertility Solutions (FS) Program

Please see Section 6, *Clinical Programs & Resources* for details.

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 provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

For questions about your Gender Dysphoria Benefits under this Plan, please call the number on your ID card.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

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.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $2,500 as a single purchase (including repair/replacement) per hearing impaired ear every 36 months.

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 from the Claims Administrator five business days before receiving services, including nutritional foods and Private Duty Nursing 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 from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Kaia Health

A mobile app for on-demand, personalized support to help relieve pain and live healthier. Connect with Kaia: http://startkaia.com/uhc.

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 under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

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 Genetic Testing, stress echocardiography and transthoracic echocardiogram, and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you do not obtain prior authorization from the Claims Administrator 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 CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received. If you do not 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

The AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you fail to obtain prior authorization from or to provide notification to the Claims 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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

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

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network, Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

If you fail to obtain prior authorization from or to provide notification to the Claims 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 twelve individual sessions per calendar year for each medical condition.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18.
- You have a 6-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under the Plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 6*, Clinical Programs and Resources* for more information on the BRS program.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs and Resources* 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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications for the treatment of Infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Inflammatory Injectable Medications (site of care). If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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*.

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

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).

- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Fertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This Benefit limit also includes services as described under *Fertility Preservation for Iatrogenic Infertility*.

Benefits for Assisted Reproductive Technology (ART) for related services as described under *Fertility Services* do not include the Preimplantation genetic testing for the specific genetic disorder.

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.

The Plan does not provide coverage for:

- Doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Post-delivery – services/treatment for the newborn of a dependent daughter.

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 Resources*, 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 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 your ID card.

Private Duty Nursing - Outpatient

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

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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

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

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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 stroke;
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals 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 the following be provided:

- medical records
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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, or Congenital Anomaly. Rehabilitation services will be reviewed after 40 visits for medical necessity.

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

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

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

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

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

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

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

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

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

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

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

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

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

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

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Claims Administrator or search for a Network program on www.myuhc.com**.**

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

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification to the Claims Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing.

If you fail to obtain prior authorization from or to provide notification to the Claims 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 cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization 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 do not 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, 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 including CAR-T cell therapy for malignancies 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 including CAR-T cell therapy for malignancies, 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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs and Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

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.

24/7 Virtual Visits

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

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.
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility 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, bio microscopy, tonometry, visual acuity, subjective, refraction, accommodative function, binocular function).

Wigs

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

Any combination of Network Benefits and Non-Network Benefits is limited to one wig/hair piece up to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including Complex Medical Conditions Programs & Services.

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.

Consumer Solutions and Self-Service Tools

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 your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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 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;
- Access all of the content and wellness topics from NurseLine℠;
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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**.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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 your ID card.

Complex Medical Conditions Programs & Services

Bariatric Resource Services (BRS)

Your Plan offers the Bariatric Resource Services (BRS) program. The BRS program provides you with:

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

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Cancer Resource Services (CRS) Program

Your Plan offers a Cancer Resource Services (CRS) Program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

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 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).*

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD

surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Kidney Resource Services (KRS) Program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS Program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS Program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS Program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Specialist Management Solutions Program

A Surgical Advocate is a surgical solution that opens the door to quality, affordable outpatient specialty and surgical care and is part of your UnitedHealthcare Duke Energy Team. A Surgical Advocate will work closely with you on every aspect of your surgery to ensure the highest quality of care. Services include connecting you with specialists/ surgeons to help you choose the most appropriate setting for your outpatient surgery/procedures.

Specialties may include, but are not limited to:

- Cardiovascular

- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine*
- Ophthalmology
- Orthopedic*
- Pain Management
- Podiatry
- Urology
- Women's Health

*For Orthopedic and Musculoskeletal care, surgical advocates partner with registered orthopedic nurses to help you:

- Manage your pain; and
- Understand your treatment options.
- Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier. Available at no extra cost as part of your health plan. Visit: http://startkaia.com/uhc

If you are planning an inpatient knee, hip or spine procedure, you are required to enroll in the Specialist Management Solutions Program prior to surgery otherwise there is no coverage. You may also be required to use a center of excellence designated facility. The nurses can help you:

- Find a designated provider and facility for your surgery;
- Find other resources such as physical therapists and durable medical equipment;
- Coordinate your surgery with the designated facility; and
- Prepare for both your surgery and recovery.

For inpatient back, knee, hip or spine surgeries, if you live within **50** miles of a designated facility, use of the designated facility is also required. If you reside more than **50** miles from a designated provider and facility, a Travel & Lodging benefit is available for both inpatient and outpatient procedures.

If you or a family member will be having an upcoming surgery or want to enroll in the program, please call the number on your ID card and ask to speak to a surgical advocate.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions, you may be eligible to participate in a disease management program at no additional 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
- 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 your ID card.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

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 Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person 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 Specialist Management Solutions 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 Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Wellness Programs

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 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 your ID card.

Real Appeal

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no Deductibles, or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the Plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

As a program participant, you can always call your nurse with any questions or concerns you might have.

Fertility Solutions

Fertility Solutions is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on fertility treatment options.
- Access to specialized Network facilities and Physicians for fertility services.
- Provides education, specialized clinical counseling, treatment options and access to national Network of premier fertility treatment clinics.

The Plan pays Benefits for the fertility services described above when provided by Designated Providers participating in the Fertility Solutions program.

Covered Persons who do not live within a 60-mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment.

For fertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.

- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

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, animal-assisted 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 dedicated speech generating 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 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding.

8. Powered and non-powered exoskeleton devices.

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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

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.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

8. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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.
   - 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, except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.

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*.
- Urinary catheters for which Benefits are provided as described under *Urinary Catheters* 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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

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.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins.
    - 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 as described under *Wigs* in Section 5, *Additional Coverage Details*.

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 impairment 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. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

18. Intracellular micronutrient testing.

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.

Reproduction

1. The following fertility treatment-related services:

   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to a Gestational Carrier or Surrogate:

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.

4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen
   - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. The reversal of voluntary sterilization.

6. Health care services and related expenses for 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) or medically necessary termination of pregnancy through the first 16 weeks of pregnancy.

7. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

8. Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

9. Fertility treatment following unsuccessful reversal of voluntary sterilization.

10. Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

11. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

12. Elective fertility preservation.

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 animal organs.

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 *Complex Medical Conditions Travel and Lodging Assistance Program* described in Section 6, *Clinical Programs and Resources*, and except as identified under *Travel and Lodging* in Section 2, *How the Plan Works*. Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

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

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

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

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

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

7. Rest cures.

8. Services of personal care attendants.

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

Vision and Hearing

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

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

3. 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. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone

anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

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.

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*.

12. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

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 your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

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

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

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes 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 Benefit.*

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

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

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

Explanation of Benefits (EOB)

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

- information sufficient to identify the claim involved;
- the specific reason or reasons for the denial;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;

- if an internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If you would like paper copies of the EOBs, you may call the number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

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

How to Appeal a Denied Claim

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

- The patient's name and ID number as shown on the ID card.
- The provider's name.

- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

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

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

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy, or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

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

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

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In

addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action, and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**

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

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

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

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

Concurrent Care Claims

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

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

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

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The

IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

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

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final decision on the claim under the internal appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary plan and the plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(2) If both parents have the same birthday, the plan that covered the parent longest is the Primary plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or

health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the Custodial Parent.

b) The plan covering the Custodial Parent's spouse.

c) The plan covering the non-Custodial Parent.

d) The plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan, and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services 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, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary plan paid, the Plan will pay the difference.

You will be responsible for any applicable Coinsurance or Annual 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is **a**n Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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 Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.

- Individuals with end-stage renal disease, for a limited period of time.

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 an opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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 carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

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

Does This Plan Have the Right of Recovery?

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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- 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, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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 you that are payable under the Plan. If the refund is due from a person or organization other than you, 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 payment in connection with services provided to persons under other plans for which the Claims Administrator processes 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 either:

- 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

UnitedHealthcare has agreements in place that govern the relationships between it, the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 administer payment of 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 are not responsible 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination of or modifications to the Plan.

The Claims Administrator is not the Plan Administrator of the Plan, as that term is used in *ERISA*. The Claims Administrator is a named fiduciary of the Plan, as that term is used in *ERISA*, solely with respect to the Claims Administrator's authority to decide claims for Benefits under the Plan and appeals of denied claims for Benefits under the Plan. If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

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.

Interpretation of Benefits

Duke Energy and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Duke Energy and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims

Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Duke Energy may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Duke Energy does so in any particular case shall not in any way be deemed to require Duke Energy to do so in other similar cases.

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, including provider billing and provider payment records. 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Coinsurance as described in Section 4, Plan Highlights.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

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.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible). The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, 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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations*.

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6, *Clinical Programs and Resources*, "Covered Person" means all domestic Employees who are eligible for and enrolled in the Plan and their Dependents age 18 and over who are eligible for and enrolled 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.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

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

Designated Dispensing Entity - a pharmacy, provider, 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 Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 Service(s) – 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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.

Fertility Solutions (FS) – a Program administered by UnitedHealthcare or its affiliates made available to you by the Company. The FS Program provides:

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

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

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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 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, service 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), service site 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. UHCprovider.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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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 – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a

condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a Program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS Program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 medications or products administered in connection with a Covered Health Service by a Physician.

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

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

Plan – The Health Savings Plan 1 Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

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

Pregnancy - includes all of the following:

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

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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

- Services exceed the scope of Intermittent Care in the home.

- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Coinsurance and applicable Annual Deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified

health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - 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.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

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

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

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

ATTACHMENT III – NONDISCRIMINATION & 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 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 UnitedHealth**c**are Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The 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: 1-800-368-1019, 800-537-7697 (TDD)

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

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the 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 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	¯(=™ ¬φ¯ xi ™Ɱ‹ ⌡ M å ®8 H ı; Ş≠é 8 } é µ+ñ" ⌂ µ Lâ MC: ∫ ™ ` Mɟ - ‹ Ωα(Ғ xĚ ®↓ +™8 å ÷b¯‹ é +· {(€ xât' 8 U8 MU ¬ aě M· ¸ €) ®0™ ł ¶⌂ 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 nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	š ĂąĽ¯ð Ę š ĂœĘĽ đĽ œ, Ž ă ĂIJĘ - Ly ě ă lĘ¹ ĸ ĂIJĘ Ž ž lĆ ¹ lĆ=Þ č Ilę¹ lĎŇ – ¹ Ę l¯œ Í ő ĄĽ ĂĽ Þd'Ă –Şlę ő ĄĽĂ Ă› Œ –ĄĽĂ ¹ » Ă (Ű) ĚŇĚ ¾ã Ą TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	[illegible] TTY 711
10. Cherokee	¯ Šľě ýğ ŔŮą² Ŕ ŔľĽ Ŕ ŻþαŦ Đ Źź ğ ř ³ ýń Ŕ−þř Ŕ þŮĽ ř Ŕ Đ¯ⁿ Ľ ŔŽ, ¹ ŀďĽ Ň 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	p y t éá~ t ÜAgz éy r r T t épy Ü¨ x ÜÅÜy ÜRy ÜÉp à y ~ ~ Ü ë T ás aÜ g éJ x ÜÅz Üy Ükoá~ t pRà a {~ Ü p y ÜÜÉgq Ē Ü ID aÜnu {t à Jfà y ÜRU u é kë , □ y Éw { vë t wR { Xu { aë a {ë ñ r wÜ ë TTY 600
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 निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल,फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti 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	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိၣ်ဟ့ၣ်အပ့ၤဘၣ်န့ၣ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိၣ်ဟ့ၣ်အပ့ၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကျဲ အကးအလိၤဒီးဆီၣ်လီၤနီၢ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	□□□ □□□ □□□ □□□ □□□ □□ □□□□ □□ □□ □□□ □□□□. □□□□ □□□□ □□□□ □□□□□ ID□□□ □□□ □□ □□ □□□□□ □□□□ 0□□ □□□□□. 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 پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	IæĔij ŵâŴ♦ Ŵ♠ Ē ♦ǾĠn ☻Ĕij ♣Ā♥ ĥýĔĉ Ħ◦ ĒŴÅij ☼ĔĀā Ĕij Ŵĥ ij ℓ Ĕā Ĕ☼ĉ ♂IæĔij Ŵŵ æĔĨ ♣ǾĔ♥. ĥý ĉ ŵǾĉ ♂ij Ĕ♥ ℓ Ĕā Ĕ,ħIJ□ ♠ĈĔĈ▪ Ĕ♥ ĥ◦ ☻ħIJ◦ Ēąn ŵĔąn ā Ē▪ ĔŴ☻Ŵĩ♦Ǿ Ēñ ĩ ǾĨ ij ąn♦ ā Ē▪ ĔŴ☻☼ĉ ♂IæĔij , ♠♦ ĥ◦ ☻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.
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

Language	Translated Taglines
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 wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	k Ç-h Ñ Ü S p j Ås-z ~Ä ã { | ~T k ~R k Ñ j \ ~v Åt ç k p • p k \ v o m~R Ä \ ~v | Öm Ç-z Å X w U k Ç-h Ñ Ö l p w~o S U h Å Ä k Ñ ^ X f ~ç Åt r v ç Ü o r v f Å Å ~U 711 k Ñ ~ \ v Ü 0 m Ü
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
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

Language	Translated Taglines
	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] 0 . TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	Z| ºPj ≠a zæ¬ | Î øPΘ†H ‼¢Å| l'Ï Ñ̃y Pvº x ←∑ º Çx º́z †z ΏΩĆq Θ†OŰH ` øÉ ` ø┼VPε ∂] ` → q áv ¢←ÖŰÑ→Ñ Pj Ì H ↕ Ţ ‖ΩÑЬ \ Θ™ŰÑz╬æH q g •Aα †ź å v l ╨j ȩΓ _Ü ₽v zæ ø ï̋ ĹЬ ź ↕ ,Ö0 φ H ź ä Ĺ┼□TTY 711
55. Thai	•¥¬Ã∏∏∏Ë%µ¢"•»'¬´å√ÕΔË Δ"£çœ€,∫ ¡ 'À'£œ®¥%µçµ√%åå•å,´ ça√ Õ¢∂çœ®'ƒ£œÂ¬ º Δ¡ 'À' ,º ƒµ,∏ƒ.ä∏∑ËÕ¬'√Δ£,∏¿ƒ∏Ëå∫ ª ∂ƒº ƒ'Ò∂»ÀÕƒ"· Ω Ã£¡ 'ø£œ®¥ · Δçµ 0 ÃÕƒ"Ω∏Ë»'¬ª ¢øƒå®∏®'ƒ%µ∫Õƒœ'ƒø€ ,º ƒµ,∏ƒ∑ËÕ¬'√Δ£ 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

Language	Translated Taglines
	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 קארטל , דרוקט 0. TTY 711 ID
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 Active Medical Plan

TABLE OF CONTENTS

SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 66,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at **www.Caremark.com** to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

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

SECTION 2 – HOW THE PROGRAM WORKS

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

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option[1].

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

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

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

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

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

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

You can fill a prescription for up to a 30-day supply at any of over 66,000 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. 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 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 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 by calling 800-378-5697.

- **Option 2:** Use the CVS Caremark mobile app on your smart phone to photograph and submit your prescription.

- **Option 3:** 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 coinsurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service Pharmacy 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 automatic refill service.

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. Coverage requires enrollment in the Fertility Solutions Program. Please call 877-214-2930 to enroll. Once enrollment is completed, infertility agents will be covered at 100% after the standard coinsurance and/or deductible, as applicable, up to $10,000 per person per lifetime, then the participant pays 100% of the cost of the drug.
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime)
- Anti obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

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

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

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

Medical Plan and Health Savings Account

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

Medical Plan and Health Care Spending Account

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

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

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

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

Refer to the prescription drug benefit summary on page 21 for more information about applicable coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Preventive Medications

CVS Caremark maintains a list of certain medications prescribed to prevent the occurrence/re-occurrence of chronic illnesses. This list is referred to as the Preventive Therapy Drug List. Under your HSP option, preventive medications included on the Preventive Therapy Drug List are covered at 100% and are not subject to your HSP option's coinsurance 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. Note: the Preventive Therapy Drug List excludes brand medications except in circumstances where there is no generic equivalent available.

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:

- COVID-19
- Dengue Fever
- 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)
- RSV (Adult)
- 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.

Caremark Cost Saver® & GoodRx®

Beginning January 1, 2024, your prescription drug program coordinates with GoodRx. This means that when the GoodRx price for a generic, non-specialty drug is lower than the amount you would pay under the Medical Plan's prescription drug coverage, you will automatically pay the lower GoodRx price when you check out at your pharmacy, and 100% of the GoodRx price will apply to your applicable Medical Plan annual deductible. If you have any questions about GoodRx, contact CVS Caremark Customer Service at 888-797-8912.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

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

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

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

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

Maximum Drug Limitation Program

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

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

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

Prior Authorization

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

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

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

Drug Utilization Reviews

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

SECTION 5 – COORDINATION OF BENEFITS

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

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

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

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

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2024, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2025 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 whose initial effective date with CVS Caremark is January 1, 2024 would have 45 days (until February 14, 2024) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

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

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

Reviews & Appeals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To the extent required by applicable law:

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

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

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Excludes brand medications if there is a generic available.	**$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 coinsurance are applied toward your out-of-pocket maximum and are included for purposes of determining whether you have reached your out-of-pocket maximum.

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

Teladoc Medical Experts' Services for the Duke Energy Active Medical Plan

January 1, 2024

Table of Contents

An Introduction to Teladoc Medical Experts Services

Duke Energy Corporation (Duke Energy) offers comprehensive coverage under the Duke Energy Active Medical Plan (Plan) that includes medical, surgical, hospitalization, prescription drug, wellness and disease management benefits, as well as expert medical opinions and certain onsite health care services. This booklet provides a summary of the expert medical opinion services available under the Plan through Teladoc Medical Experts, and is part of the summary plan description for the Plan.

Duke Energy is making the Teladoc Medical Experts services described in this booklet (Teladoc Medical Experts Services) available to you because it recognizes the challenges and stresses that can occur when you are uncertain about a medical diagnosis or treatment plan, and wants to provide resources to help you make medical decisions with confidence.

Teladoc Medical Experts provides medical information only and does not provide medical care, diagnosis or treatment. The information you receive from Teladoc Medical Experts is intended to supplement, not replace, the medical care provided by your treating physician, and to help you and your treating physician make informed decisions regarding your diagnosis and/or treatment plan. Many doctors find that collaboration with other experts is very helpful, especially in complex situations. Teladoc Medical Experts enables doctors to collaborate in a new way.

The Teladoc Medical Experts' Services

Eligibility to Use the Teladoc Medical Experts Services

You are eligible to use the Teladoc Medical Experts Services only if you are enrolled in the Plan, and your dependents are eligible to use the Teladoc Medical Experts Services only if they are enrolled in the Plan.

You are not eligible to use the Teladoc Medical Experts Services if you are not enrolled in the Plan, and your dependents are not eligible to use the Teladoc Medical Experts Services if they are not enrolled in the Plan.

See the Eligibility section of the Duke Energy Active Medical Plan General Information booklet for more information about the Plan's eligibility requirements.

Description of the Teladoc Medical Experts Services

You have access to the following Teladoc Medical Experts Services:

1. **"Expert Medical Opinion"** is a service whereby a Teladoc Medical Expert reviews your diagnosis and/or treatment plan and provides a detailed recommendation. Teladoc Medical Experts collects all of your records, images and test samples and provides them to a Teladoc Medical Expert for review. The Teladoc Medical Expert reviews everything in detail and creates a comprehensive report, either confirming what you've been told by your treating physician or recommending a change. You can share this report with your treating physician to help you and your treating physician make treatment decisions.

2. **"Critical Care Expert Review"** is an Expert Review as described above, but for individuals in an in-patient medical setting experiencing a traumatic or catastrophic event such as traumatic brain injury, spinal cord injury, multi-organ failure, serious burns or premature birth. With a Critical

Care Expert Review, Teladoc Medical Experts will address, in real time, your immediate and highly complex needs. Critical Care Expert Reviews are available 24 hours a day, 7 days a week, 365 days a year.

Cost for Teladoc Medical Experts Services

Teladoc Medical Experts Services are offered to you at no cost. The Plan covers all Teladoc Medical Experts costs. If you decide to obtain additional tests and/or services based on the information you obtain from Teladoc Medical Experts, these additional tests and/or services, as applicable, may be covered under the terms of the Plan, or you may have to pay for these additional tests and services out-of-pocket. Refer to the other portions of the Plan's Summary Plan Description for additional information regarding covered services and benefits under the Plan.

Do I Have to Travel or Collect My Own Medical Records?

No. You make a call to Teladoc Medical Experts and they handle everything for you. All of your contact with Teladoc Medical Experts is over the phone or the Internet. You do not need to travel or contact your doctor(s) to obtain records, images or other information related to your medical case. In rare situations, if you doctor(s) does not respond to Teladoc Medical Experts' requests for records we may ask you to contact your doctor(s) directly.

What Type of Information Does Teladoc Medical Experts Provide?

Teladoc Medical Experts provides medical information only and does not provide medical care, diagnosis or treatment. The information you receive from Teladoc Medical Experts is intended to help you and your treating physician make informed decisions regarding your diagnosis and/or treatment plan. You remain in full control of your healthcare decision making, and you can decide whether to share the report with your treating physician. Teladoc Medical Experts will not share your report with your treating physician without your authorization.

How Does Teladoc Medical Experts Expert Medical Opinion Process Work?

- You call 1-800-835-2362 or visit Teladoc.com/MedicalExperts.
- A dedicated Teladoc Medical Experts Physician will have an in-depth discussion with you about your medical condition and obtain a full health history.
- With your written approval, Teladoc Medical Experts will collect all appropriate medical records, images and test samples.
- The Teladoc Medical Experts clinical team will then conduct a comprehensive analysis of your case and select the most appropriate Teladoc Medical Expert(s).
- The Teladoc Medical Expert(s) will review your case and provide Teladoc Medical Experts with a detailed report that includes his or her recommendations.
- Teladoc Medical Experts will share the report with you, but will not share the report with your treating physician without your consent.

Throughout the process, the Teladoc Medical Experts Member Advocate is available to answer your questions. Depending on your case, your Teladoc Medical Experts Member Advocate also may follow up with you to see if you need any other help.

How Will Teladoc Medical Experts Work With My Treating Physician?

Teladoc Medical Experts share the Teladoc Medical Expert's findings with you – and only with you. Teladoc Medical Experts will not share the report with your treating physician without your consent. The goal is to provide useful information so that you and your treating physician can make more informed decisions together regarding treatment.

Can Teladoc Medical Experts Services be Used in Emergency Situations?

For urgent medical situations where immediate intervention is requested, Teladoc Medical Experts Services are not an option. In these situations, Teladoc Medical Experts may be able to provide you with appropriate questions to ask your provider before you proceed with treatment. However, you should seek immediate treatment as directed by your doctor. Once your condition has stabilized, Teladoc Medical Experts can evaluate your case for future treatment options.

Am I required to use Teladoc Medical Experts Services?

No. Participation is completely voluntary.

How Will Teladoc Medical Experts Maintain My Privacy?

Teladoc Medical Experts complies with all relevant state and federal laws and regulations regarding privacy and confidentiality, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To provide the Teladoc Medical Experts Services, Teladoc Medical Experts will need to collect, use and disclose your protected health information (PHI). When you initiate the Teladoc Medical Experts Services, you will be provided with more detailed information regarding the Teladoc Medical Experts Services and the confidentiality of your PHI.

How to File a Claim or an Appeal

Request

In order to initiate the Teladoc Medical Experts Services, you should call 1-800-835-2362 or visit Teladoc.com/MedicalExperts. A request to use the Teladoc Medical Experts Services is referred to throughout this document as a "Claim".

Teladoc Medical Experts has been given responsibility for reviewing initial Claims and reviewing all Claim denials. Neither Duke Energy nor the Duke Energy Benefits Committee has any discretionary authority with respect to the review of initial Claims or the review of Claim denials.

Denial

It is very unlikely that you would be denied the use of Teladoc Medical Experts Services. However, if your Claim is denied, you have the rights outlined in this section. The denial, reduction or termination of a service, supply, or benefit is called an "Adverse Benefit Determination". With respect to the Teladoc Medical Experts Services, reasons for such an Adverse Benefit Determination may include, but are not limited to:

- Your eligibility for the Teladoc Medical Experts Services, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit); or
- Your intention to use the Teladoc Medical Experts Services for litigation or legal reasons (*e.g.*, for purposes of a medical malpractice case); or
- Your request to use the Teladoc Medical Experts Services for an excluded diagnosis (*e.g.,* for a mental health condition); or
- Your request to use certain Teladoc Medical Experts Services when you do not have a sufficient or recent diagnostic history (with or without a diagnosis); or
- Your refusal to sign an authorization form for Teladoc Medical Experts to collect your medical information when such information is necessary for the type of service you requested.

In the event of an Adverse Benefit Determination, Teladoc Medical Experts will provide you or your representative with notice of such Adverse Benefit Determination (Notice of Adverse Benefit Determination) within 30 days after receiving your Claim. However, if more time is needed to make a determination as to whether to deny your Claim due to matters beyond Teladoc Medical Experts' control, Teladoc Medical Experts will notify you or your representative that an extension is needed (Extension Notice). Teladoc Medical Experts will provide you with this Extension Notice within 30 days of receiving your Claim. 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 your original Claim.

If an extension is needed because necessary information is missing from your Claim, the Extension Notice will specify what information is needed (Request for Information). The determination period will be suspended on the date Teladoc Medical Experts sends such a Request for Information, and the determination period will resume on the date you or your representative responds to the Request for Information. You will have at least 45 days to respond to the Request for Information.

Notice of Adverse Determination

In the event of an Adverse Benefit Determination, in whole or in part, you (or your authorized representative) will be notified of the Adverse Benefit Determination in writing or electronically. Your Notice of Adverse Benefit Determination will provide you or your representative with the following information:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific references to the pertinent Plan provisions on which the Adverse Benefit Determination is based;
- a description of any additional information or material necessary to process the Claim properly and an explanation of why such information or material is necessary;
- an explanation of the review procedures applicable to your request for Teladoc Medical Experts Services and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) following any final Adverse Benefit Determination on review and any time limits for filing such a civil action; and
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request.

Appeal of Adverse Determination

If your Claim is denied, upon receipt of your Notice of Adverse Benefit Determination you (or your authorized representative) have 180 calendar days to appeal the Adverse Benefit Determination. If you (or your authorized representative) do not file an appeal within 180 days after receipt of the Notice of Adverse Benefit Determination, your Claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue.

If you choose to submit an appeal of your Adverse Benefit Determination, you must send a written appeal (Notice of Appeal of Adverse Benefit Determination) to the following address:

Teladoc Medical Experts Medical Director
Teladoc Health, Inc.
1250 Hancock St., Suite 501N
Quincy, MA 02169

When reviewing your Notice of Appeal of Adverse Benefit Determination, Teladoc Medical Experts will consider any new information that you provide that was not available or utilized when the initial determination was made. Someone at Teladoc Medical Experts, other than an individual involved in the initial determination or a subordinate of such individual, will make the determination on appeal.

Teladoc Medical Experts will notify you of its decision on your appeal within 60 days of its receipt of your Notice of Appeal of Adverse Benefit Determination. Teladoc Medical Experts' decision is referred to as "Notice of Adverse Benefit Determination on Appeal."

Every Notice of Adverse Benefit Determination on Appeal will be provided in writing or electronically and will include Teladoc Medical Experts' ultimate determination and, if such determination is an adverse determination, will include:

- the specific reason or reasons for the Adverse Benefit Determination on appeal;
- specific references to the pertinent Plan provisions on which the Adverse Benefit 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 regarding your right to bring a civil action under Section 502(a) of ERISA following any final Adverse Benefit Determination on your appeal 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 Benefit Determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request; 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."

After completing all mandatory appeal levels, you have the right to bring a civil action under 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 and appeals process. You may not initiate a legal action against Teladoc Medical Experts, the Company, the Plan or the Plan Administrator until you have completed the appeal process. No legal action may be brought more than one year following a final decision on the Claim under the appeal process. 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 and denied Claims on review includes the full power and discretion to interpret the Teladoc Medical Experts Services and to make factual determinations, with Teladoc Medical Experts' decisions, interpretations and factual determinations controlling. Requests for information regarding individual Claims, or review of a denied Claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial Claim, or to decide the denied Claim on review, as applicable.

Active Medical Plan

Health Savings Plan 2 option

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: UnitedHealthcare Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: CVS Caremark Prescription Drug Guide (includes Summary of Prescription Drug Benefits)
- SECTION IV: Teladoc Medical Experts' Services

Duke Energy Active Medical Plan
General Information

(Enterprise)

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Active Medical Plan (Medical Plan) provides information that is applicable to the Medical Plan coverage options available to eligible non-union and represented employees. 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 1, 2024 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

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

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

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300.

Eligibility

Eligible Employees

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

To be an eligible employee, you must satisfy each of the following requirements:

- you are identified in and paid through Duke Energy's payroll system as an employee of Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the Company, as appropriate); and

- you are classified by your Company as either a regular employee or a fixed-term employee.

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

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

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

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

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

Eligible Dependents

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

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

Spouse Eligibility

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

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

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

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

Domestic Partner Eligibility

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

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

Generally, for medical coverage of a taxpayer's domestic partner to be tax-free to the taxpayer, the domestic partner must qualify as the taxpayer's tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code. See *Cost of Coverage* below for additional information regarding the tax treatment of your domestic partner's medical coverage.

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

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

Child Eligibility

Your child is:

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

whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**

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

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

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

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

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

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

Surviving Spouse, Domestic Partner and Child Eligibility

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

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

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

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

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage.

If your spouse/domestic partner and/or dependent children elect survivor coverage, they may drop their survivor coverage at any time during the calendar year, regardless of whether they experience a work/life event for which mid-year changes are allowed. See *Mid-Year Changes* for additional information about work/life events for which mid-year changes are allowed.

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 continue coverage under the Medical Plan following your death as the survivor of an active employee.

Please note: new enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage take effect on Jan. 1, 2024. Under these new enrollment requirements, if you are an eligible retiree and you do not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of your retirement date (or within 31 days after your COBRA continuation coverage under the Medical Plan ends), or if you decline or drop Duke Energy-sponsored pre-65 retiree medical coverage at any point thereafter, you cannot enroll yourself or your eligible dependents in Duke Energy-sponsored pre-65 retiree medical, dental or vision coverage at any future date. This means that if your spouse/domestic partner who is an eligible retiree continues Medical Plan coverage as the survivor of an active employee, and does not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of retiring, your spouse/domestic partner will not be able to enroll in pre-65 retiree medical, dental or vision coverage at any future date.

Please refer to the Summary Plan Descriptions for the Duke Energy Retiree Medical Plan, the Duke Energy Retiree Dental Plan and the Duke Energy Retiree Vision Plan for additional information.

Employee and Retiree Couples

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

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days

following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

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

If a Dependent Becomes Ineligible

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

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

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

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

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

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

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

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

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

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

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

Enrolling in the Medical Plan

When You Are First Eligible

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

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

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

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

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

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

You also may decline coverage altogether.

During Annual Enrollment

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

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

Other Opportunities to Enroll

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

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

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

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

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

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

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

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

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

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

If You Are Rehired

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

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

Cost of Coverage

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

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

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

If you elect coverage for a domestic partner, you will need to confirm whether your covered domestic partner is your tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code. If your covered domestic partner is your tax dependent for federal income tax purposes, contributions for your domestic partner's coverage will be deducted from your pay on a pre-tax basis each pay period. If your covered domestic partner is not your tax dependent for federal income tax purposes, the portion of your contribution required to cover the domestic partner under the Medical Plan is deducted on a pre-tax basis and the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner will appear as imputed income on your pay advice statements and is subject to applicable taxes. As a result, please make sure to indicate your domestic partner's tax dependent status when you enroll to ensure proper tax treatment for your coverage. 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.

Duke Energy WellPower Rewards

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

Eligibility and Redeeming Rewards

Information about the eligibility requirements for participating in Duke Energy WellPower Rewards and redeeming any rewards you earn is included in the Duke Energy WellPower Rewards materials sent to you with Annual Enrollment materials and throughout the year. This information also is available on the Duke Energy Portal.

Duke Energy WellPower Rewards Activities

The activities that you and/or your spouse/domestic partner must complete to receive rewards may vary with each program cycle. Review the Duke Energy WellPower Rewards materials sent to you with Annual Enrollment materials and throughout the year, for additional information on the program cycle's activities and requirements.

The Medical Plan is committed to helping you achieve your best health. Rewards for participating in Duke Energy WellPower Rewards are generally available to all eligible employees. If you think you might be unable to meet a standard for a reward under Duke Energy WellPower Rewards, you might qualify for an opportunity to earn the same reward by different means. Contact a Vitality Customer Service Specialist at 866-567-0705 and a representative will work with you (and, if you wish, your doctor) to find activities with the same reward that are right for you in light of your health status.

Non-Tobacco User Discount

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

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

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

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

If you do not complete the Attestation during enrollment, or, if you complete the Attestation and attest to being a tobacco user but you either (1) do not enroll in the Tobacco Cessation Program as described below by the applicable deadline or (2) do not complete the Tobacco Cessation Program described below by the applicable deadline, you (and your spouse/domestic partner) will not receive the non-tobacco user discount for Medical Plan coverage. Tobacco user status does not carry over from year to year for Medical Plan coverage.

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

If you misrepresent your tobacco user status (or the tobacco user status of your spouse/domestic partner) in the Attestation, or if you (or your spouse/domestic partner) become a tobacco user after completing the Attestation as a non-tobacco user and you do not notify the Duke Energy myHR Service Center of the change in tobacco user status, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take

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

appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Non-Tobacco User Discount – Tobacco Cessation Program for Active Employees

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

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) intend to complete the Tobacco Cessation Program, which includes agreeing to enrollment with Quit For Life and completing your enrollment within 31 days of the date that you make your new hire coverage elections, and
    - complete the Tobacco Cessation Program within seven months of the date that you make your new hire coverage elections[2] – or –
- If you are enrolling during annual enrollment, you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) intend to complete the Tobacco Cessation Program, which includes agreeing to enrollment with Quit For Life and completing your enrollment by Dec. 31, and
    - complete the Tobacco Cessation Program on or before the following June 30.

To complete the Tobacco Cessation Program, you (and/or your covered spouse/domestic partner) must have a minimum of five interactions with a coach.

You may contact the Duke Energy myHR Service Center if you have questions about the Tobacco Cessation Program.

[2] If you (and/or your covered spouse/domestic partner) enrolled in the Tobacco Cessation Program and you properly attested while enrolling in benefits as a newly eligible employee that you (and/or your covered spouse/domestic partner) would timely complete the Tobacco Cessation Program, but you (and/or your spouse/domestic partner) have not yet reached your seven month completion deadline for the Tobacco Cessation Program by the annual enrollment deadline, you will qualify for the non-tobacco user discount if you also properly attest during annual enrollment that you (and/or your spouse/domestic partner) will complete the Tobacco Cessation Program by the original seven month completion deadline and you (and/or your spouse/domestic partner) complete the Tobacco Cessation Program by the original seven month completion deadline.

If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must call Quit For Life and complete your enrollment within 31 days of the date that you make your new hire coverage elections. If you are enrolling during annual enrollment, you must call Quit For Life by December 31 to help you complete your enrollment in the Tobacco Cessation Program. **It is your responsibility to complete your enrollment in the Tobacco Cessation Program by the applicable deadline.**

You (and/or your spouse/domestic partner) will not be required to pay for the cost of the Tobacco Cessation Program. Please note that the Tobacco Cessation Program takes up to six months to complete. You can begin the Tobacco Cessation Program as soon as you complete your enrollment. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the Tobacco Cessation Program in any future year, you will be required to again complete the Tobacco Cessation Program process described above.

If You Do Not Successfully Complete the Tobacco Cessation Program

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

If You Misrepresent Information Related to the Non-Tobacco User Discount and/or the Tobacco Cessation Program

If you misrepresent any information related to the non-tobacco user discount and/or the Tobacco Cessation Program, including, but not limited to, your enrollment with Quit For Life, or if you do not complete the Tobacco Cessation Program by the applicable deadline, Duke Energy reserves the right to recover any contribution amounts you should have paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of health and insurance coverage and/or discharge, and to take other appropriate action.

Termination of Coverage for Non-Payment

Your coverage under the Medical Plan (and all other Duke Energy-sponsored plans in which you are enrolled and for which payments are required) 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 for your coverage under the Medical Plan (and any other Duke Energy-sponsored plans under which you want to continue coverage) must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If your coverage under the Medical Plan is reinstated under this provision and then subsequently terminated again for non-payment, you will not be entitled to reinstatement of your coverage under the Medical Plan, or under any other Duke Energy-sponsored plan for which payments are required, at any later date. 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.

Note: If your Medical Plan coverage is terminated for non-payment while you are on an approved leave of absence, the termination of your Medical Plan coverage will be treated as an affirmative drop of Medical Plan coverage, rather than as a termination of Medical Plan coverage due to non-payment. This means that if you return to active employment with the Company, you may be eligible to have your Medical Plan coverage reinstated (in the previous coverage option and at the previous coverage level) on the date of your return to active employment.

When Coverage and Contributions Begin

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

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

Mid-Year Changes

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

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

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

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

- Your legal marital status changes
  - you get married

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

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,

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

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

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

When You Enroll a Dependent Mid-Year

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

When Mid-Year Coverage and Contribution Changes Are Effective

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

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

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

- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death.

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

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

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

If You Become Disabled

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

When You Reach Age 65

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

If You Become Entitled to Medicare

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

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

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

Termination of Coverage

When Coverage Ends

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

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

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

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, generally within 60 days of the qualifying event. See *COBRA Continuation Coverage* below for additional information about the timing of COBRA elections.

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

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

If You Leave the Company

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

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

If You Retire

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

Please note: new enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage take effect on Jan. 1, 2024. Under these new enrollment requirements, if you are an eligible retiree and you do not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of your retirement date (or within 31 days after your COBRA continuation coverage under the Medical Plan ends), or if you decline or drop Duke Energy-sponsored pre-65 retiree medical coverage at any point thereafter, you cannot enroll yourself or your eligible dependents in Duke Energy-sponsored pre-65 retiree medical, dental or vision coverage at any future date. Please refer to the Summary Plan Descriptions for the Duke Energy Retiree Medical Plan, the Duke Energy Retiree Dental Plan and the Duke Energy Retiree Vision Plan for additional information.

COBRA Continuation Coverage

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

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

Continued Coverage for You

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

- termination of your employment (for reasons other than gross misconduct); or

- a reduction of your work hours.

Continued Coverage for Your Dependents

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

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

Newborn and Adopted Children

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

In Case of Disability

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

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

If You Become Covered by Medicare

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

For example, suppose you are actively employed on January 1, 2024, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2025, your eligible dependents would be eligible for continued coverage until the later of:

- 36 months following the date you become covered for Medicare – January 1, 2027; or
- 18 months following your termination of employment – July 1, 2026

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2027 if COBRA continuation coverage is elected.

Multiple Qualifying Events

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

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

Procedures to Obtain Continued Coverage

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

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

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

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

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

Election Period

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

- the date coverage terminates by reason of the qualifying event, or

- the date notification of the right to elect continued coverage is mailed to you and your covered dependents.

Type of Coverage

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

Cost

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

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

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

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

Conversion Privilege

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

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

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

Your Role

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

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

You must notify the applicable Claims Administrator if a provider:

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

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

Other Important Information

Plan Sponsor

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

Duke Energy Corporation
525 South Tryon Street
Charlotte, NC 28202
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Active Health & Welfare Benefit Plans, plan number 505.

Funding

The Company provides benefits under the Medical Plan from its general assets.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (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 (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
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
525 South Tryon Street – DEP14C
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.

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
525 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

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

Claims Determination Procedures

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

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

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

exhausted your one-time reinstatement opportunity, (v) requests to change your tobacco user status, which includes requests to complete the Tobacco Cessation Program after the communicated deadline or (vi) requests for the Company to record/count wellness activities completed after the communicated deadline.

Claims for Medical Plan Benefits

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

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

Eligibility or Enrollment Claims

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

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

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

Initial Claim

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

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

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

- any additional information you want considered.

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

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

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

In the case of an Eligibility or Enrollment Claim relating to your failure to enroll your newborn or newly adopted child in Medical Plan coverage within 31 calendar days of your child's date of birth or adoption, Claims and Appeals Management will approve the Eligibility or Enrollment Claim notwithstanding your failure to timely enroll your child in Medical Plan coverage, but only if (1) you contact the Duke Energy myHR Service Center within 60 calendar days of your child's date of birth or adoption to enroll your child in Medical Plan coverage and (2) you submit a claim initiation form and all other required documentation, in accordance with the instructions specified on the claim initiation form, within 75 calendar days of your child's date of birth or adoption. If Claims and Appeals Management approves your Eligibility or Enrollment Claim, your child's Medical Plan coverage will be effective retroactive to your child's date of birth if a newborn or date of adoption for a newly adopted child. If Claims and Appeals Management denies your Eligibility or Enrollment Claim, you (or your authorized representative) will be notified of the adverse determination in writing as described below.

Adverse Determination

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

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

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA

following an adverse determination on review and any time limits for filing such a civil action;

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

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

Appeal of Adverse Determination

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

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

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person)

consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

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

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

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

- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

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

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

Voluntary External Review Program

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

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

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

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

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

- a general description of the reason for the request for external review, including information sufficient to identify the claim;

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

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

Legal Action

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

Discretionary Authority

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

Right to Change or Terminate the Medical Plan

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

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

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

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

and other Medical Plan participants and beneficiaries. No one, including the Company, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

Keep Us Informed

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

A Final Note

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

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

Benefit Booklet

Duke Energy Active Medical Plan
Health Savings Plan 2 Option

Effective: January 1, 2024
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

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

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

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

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

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

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

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's Health Savings Plan 2 Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://digital.alight.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. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

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. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses*

as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, in certain circumstances if you are currently receiving treatment for Covered Health Services from a provider or health care facility whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's or health care facility's contract, you may be eligible to request continued care from your current provider or health care facility at the Network Benefit level for specified conditions and timeframes up to 90 days. This provision applies if you are undergoing a course of treatment for a serious and complex condition from the provider or health care facility, undergoing a course of institutional or in-patient care from the provider or health care facility, scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or health care facility with respect to such a surgery, pregnant and undergoing a course of treatment for pregnancy from the provider or determined to be terminally ill (as defined in section *1861(dd)(3)(A) of the Social Security Act*) and receiving treatment for such illness from the provider or health care facility. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 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

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

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

  Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Provider or Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, or any Annual Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of Section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.

- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.
- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  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 non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, and Deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable Coinsurance or Deductible.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Covered Persons (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- Ancillary Services received at certain Network facilities on a non-Emergency basis;
- non-Ancillary Services received at certain Network facilities on a non-Emergency basis;
- Emergency Health Services;
- Air Ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or it's designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, and Deductible.

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, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits (other than Benefits for Network preventive care services). The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to almost all Covered Health Services under the Plan, including Covered Health Services provided through the prescription drug program for Network Benefits only. The only Covered Health Services under the Plan to which the Annual Deductible does not apply are Network preventive care services and certain

preventive medications and vaccines which are covered at 100% by the Plan even before you meet your Annual Deductible.

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

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

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual Deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Coinsurance

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

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

Out-of-Pocket Maximum

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

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

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

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

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

Travel and Lodging (For Travel and Lodging related to complex medical conditions see Section 7: *Clinical Programs And Resources)*

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such Covered Health Services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their home address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year, will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services 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 your ID card.

To obtain prior authorization, call the number on 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please

note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

Payment Terms & Features

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

Plan Features	Network	Non-Network
Annual Deductible[1]		
■ Individual	$1,600	$3,200
■ Family (cumulative Annual Deductible[2])	$3,200	$6,400
Annual Out-of-Pocket Maximum[1]		
■ Individual (enrolled in single coverage)	$3,500	$7,000
■ Individual (enrolled in family coverage)	$6,850	$14,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$7,000	$14,000
Lifetime Maximum Benefit[3] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

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

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

[3]Generally the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Schedule of Benefits

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for certain Covered Health Services are based on the Recognized Amount as defined in Section 12, *Glossary*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 80% after you meet the Network Annual Deductible *Air Ambulance* 80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 60% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible
Cellular and Gene Therapy	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under	Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	each Covered Health Service category in this section.	
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers	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.	
Congenital Heart Disease (CHD) Surgery Services Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	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.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 2: *How the Plan Works*.	*True Emergency* 80% after you meet the Annual Deductible *Non-True Emergency* 80% after you meet the Annual Deductible	*True Emergency* 80% after you meet the Network Annual Deductible *Non-True Emergency* 80% after you meet the Network Annual Deductible
Fertility Preservation for Iatrogenic Infertility See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Fertility Services See Section 5, *Additional Coverage Details*, for limits	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.	
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your CVS Caremark Prescription Drug Benefit Booklet	
Hearing Aids	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital – Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Virtual Behavioral Health Therapy & Coaching.	**Designated Network (AbleTo Therapy 360)** 100% after you meet the Annual	Non-Network Benefits are not available.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	Deductible; Benefits for the Initial Consultation will be paid at 100%.	
Neonatal Services	See Section 6, *Clinical Programs & Resources,* for program information.	
Neurobiological Disorders – Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling Up to 12 visits per condition per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery (The Plan pays Benefits only for Covered Health Services provided through *Bariatric Resource Services*) See *Obesity Surgery* in Section 5, *Additional Coverage Details*.	80% after you meet the Annual Deductible	Non-Network Benefits are not available
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**
Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable Annual Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 2, *How the Plan Works*, under *Eligible Expenses*.		
Physician's Office Services – Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services See Section 5, *Additional Coverage Details*, for limits.	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	100%	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
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.	
Rehabilitation Services – Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Scopic Procedures – Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient. Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Administrator or search for a Network program on www.myuhc.com.	100% 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**
■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible For dialysis services, Non-Network Benefits are not available.
Transplantation Services Non-Network Benefits include services provided at a facility that is not a Designated Provider and services provided at a non-Network facility. See *Transplantation Services* in Section 5, *Additional Coverage Details.*	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.	
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
24/7 Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a	80% after you meet the Annual Deductible	Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.		
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]Please obtain prior authorization before receiving Covered Health Services, as described in Section 5, *Additional Coverage Details*.

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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. For Non-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

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
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you do not 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 UnitedHealthcare 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 facility participating in the CHD Resource Services Program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items	Insulin pumps and pump supplies and continuous glucose monitors for the management and treatment of diabetes based upon your medical needs. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under the Plan's prescription drug benefit.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.

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 do not 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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits for dedicated speech generating 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.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

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 do not 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 two business days 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 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 two business days 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.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Fertility Services*. This Benefit limit also includes services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services*. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.

Fertility Services

Therapeutic services for the treatment of fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to InVitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection - ICSI.

  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- Insemination procedures artificial insemination (AI) and intrauterine insemination (IUI).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the *SPD*. Benefits for diagnostic tests are described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Physician's Office Services – Sickness and Injury*.

Enhanced Benefit Coverage

Donor Coverage: The Plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The Plan will not pay for donor charges associated with compensation or administrative services.

Criteria to be eligible for Benefits

- You do not need to have a diagnosis of Infertility in order to be eligible to receive services described above.

To be eligible for fertility services, you must meet the following:

- You are a female:
  - under age 44 and using own oocytes (eggs), or
  - under age 55 and using donor oocytes (eggs).

Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Child Dependents are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

Any combination of Network Benefits and Non-Network Benefits are limited to $25,000 per Covered Person for medical Benefits during the entire period you are covered under the Plan. There is a separate prescription drug lifetime maximum under your CVS Caremark Prescription Drug Benefit. This limit includes Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and for related services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services.*

Charges for the following apply toward the Infertility lifetime maximum:

- Hospital outpatient facility.
- Surgeon's and assistant surgeon's fees.
- Anesthesia.
- Lab and x-ray.
- Diagnostic services.
- Physician's office visits.
- Consultations.
- Injections.

Fertility Solutions (FS) Program

Please see Section 6, *Clinical Programs & Resources* for details.

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 provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

For questions about your Gender Dysphoria Benefits under this Plan, please call the number on your ID card.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

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.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $2,500 as a single purchase (including repair/replacement) per hearing impaired ear every 36 months.

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 from the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you do not 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions,.

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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 under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

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 Genetic Testing, stress echocardiography and transthoracic echocardiogram, and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you do not obtain prior authorization from the Claims Administrator 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 CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received. If you do not 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

The AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for the initial consultation, Covered Persons with a high Deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no Deductibles, or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from or to provide notification to the Claims 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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

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

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you do not obtain prior authorization from or to provide notification to the Claims 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 twelve individual sessions per calendar year for each medical condition.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under the Plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 6*, Clinical Programs and Resources* for more information on the BRS program.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications for the treatment of Infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a

particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Inflammatory Injectable Medications (site of care). If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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*.

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

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Fertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This Benefit limit also includes services as described under *Fertility Preservation for Iatrogenic Infertility*.

Benefits for Assisted Reproductive Technology (ART) for related services as described under *Fertility Services* do not include the Preimplantation genetic testing for the specific genetic disorder.

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.

The Plan does not provide coverage for:

- Doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Post-delivery – services/treatment for the newborn of a dependent daughter.

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 do not 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 Resources*, 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 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 your ID card.

Private Duty Nursing - Outpatient

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

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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

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

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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions,.

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 stroke;
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals 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 the following be provided:

- medical records,
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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, or Congenital Anomaly. Rehabilitation services will be reviewed after 40 visits for medical necessity.

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

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

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or

Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

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

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

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

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

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

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

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

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

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

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

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, , 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions,.

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Claims Administrator or search for a Network program on www.myuhc.com**.**

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

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification to the Claims Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from or to provide notification to the Claims 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 cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization 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 do not 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, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you do not 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 including CAR-T cell therapy for malignancies 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 including CAR-T cell therapy for malignancies, 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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

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.

24/7 Virtual Visits

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for:

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

Wigs

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

Any combination of Network Benefits and Non-Network Benefits is limited to one wig/hairpiece up to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including Complex Medical Conditions Programs & Services.

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.

Consumer Solutions and Self-Service Tools

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[SM] 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 your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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 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;
- Access all of the content and wellness topics from NurseLine℠;
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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**.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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 your ID card.

Complex Medical Conditions Programs & Services

Bariatric Resource Services (BRS)

Your Plan offers the Bariatric Resource Services (BRS) program. The BRS program provides you with:

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

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Cancer Resource Services (CRS) Program

Your Plan offers a Cancer Resource Services (CRS) Program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

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 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)*.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based the Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Kidney Resource Services (KRS) Program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS Program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS Program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS Program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Specialist Management Solutions Program

A Surgical Advocate is a surgical solution that opens the door to quality, affordable outpatient specialty and surgical care and is part of your UnitedHealthcare Duke Energy Team. A Surgical Advocate will work closely with you on every aspect of your surgery to ensure the highest quality of care. Services include connecting you with specialists/ surgeons to help you choose the most appropriate setting for your outpatient surgery/procedures.

Specialties may include, but are not limited to:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine*
- Ophthalmology
- Orthopedic*
- Pain Management
- Podiatry
- Urology
- Women's Health

*For Orthopedic and Musculoskeletal care, surgical advocates partner with registered orthopedic nurses to help you:

- Manage your pain; and
- Understand your treatment options.
- Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier. Available at no extra cost as part of your health plan. Visit: http://startkaia.com/uhc.

If you are planning an inpatient knee, hip or spine procedure, you are required to enroll in the Specialist Management Solutions Program prior to surgery otherwise there is no coverage. You may also be required to use a center of excellence designated facility. The nurses can help you:

- Find a designated provider and facility for your surgery;
- Find other resources such as physical therapists and durable medical equipment;
- Coordinate your surgery with the designated facility; and
- Prepare for both your surgery and recovery.

For inpatient back, knee, hip or spine surgeries, if you live within **50** miles of a designated facility, use of the designated facility is also required. If you reside more than **50** miles from a designated provider and facility, a Travel & Lodging benefit is available for both inpatient and outpatient procedures.

If you or a family member will be having an upcoming surgery or want to enroll in the program, please call the number on your ID card and ask to speak to a surgical advocate.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional 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
- 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 your ID card.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

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 Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person 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 Specialist Management Solutions 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 Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Wellness Programs

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 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 your ID card.

Real Appeal

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no Deductibles, or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management

by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

As a program participant, you can always call your nurse with any questions or concerns you might have.

Fertility Solutions

Fertility Solutions is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on fertility treatment options.
- Access to specialized Network facilities and Physicians for fertility services.
- Education, specialized clinical counseling, treatment options and access to national Network of premier fertility treatment clinics.

The Plan pays Benefits for the fertility services described above when provided by Designated Providers participating in the Fertility Solutions program.

Covered Persons who do not live within a 60-mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment.

For fertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

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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, animal-assisted 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 dedicated speech generating 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 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding.

8. Powered and non-powered exoskeleton devices.

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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

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.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

8. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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.
   - 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. except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.

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*.
- Urinary catheters for which Benefits are provided as described under *Urinary Catheters* 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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

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.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins.
    - 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 as described under *Wigs* in Section 5, *Additional Coverage Details* .

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 impairment 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. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

18. Intracellular micronutrient testing.

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.

Reproduction

1. The following fertility treatment-related services:

   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to a Gestational Carrier or Surrogate:

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.

4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen.
   - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. The reversal of voluntary sterilization.

6. Health care services and related expenses for 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) or medically necessary termination of pregnancy through the first 16 weeks of pregnancy.

7. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

8. Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

9. Fertility treatment following unsuccessful reversal of voluntary sterilization.

10. Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

11. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

12. Elective fertility preservation.

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 animal organs.

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 *Complex Medical Conditions Travel and Lodging Assistance Program* described in Section 6, *Clinical Programs and Resources*, and except as identified under *Travel and Lodging* in Section 2, *How the Plan Works.* Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance

transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

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

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

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

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

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

7. Rest cures.

8. Services of personal care attendants.

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

Vision and Hearing

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

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

3. 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. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

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.

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*.

12. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

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 your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.

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

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

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

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

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes 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 Benefit.*

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

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

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

Explanation of Benefits (EOB)

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

- information sufficient to identify the claim involved;
- the specific reason or reasons for the denial;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your right to bring a

civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action;

- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If you would like paper copies of the EOBs, you may call the number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

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

How to Appeal a Denied Claim

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

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

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

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

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy, or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to

your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

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

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for

the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision

UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	
Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

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

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

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

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.

- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously

provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

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

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final

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

SECTION 9 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.

- **Secondary Plan.** The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary plan and the plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the plan that covered the parent longest is the Primary plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the Custodial Parent.

b) The plan covering the Custodial Parent's spouse.

c) The plan covering the non-Custodial Parent.

d) The plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as

an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services 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, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary plan paid, the Plan will pay the difference.

You will be responsible for any applicable Coinsurance or Annual 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is **a**n Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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 Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.

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 an opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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 carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

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

Does This Plan Have the Right of Recovery?

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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- 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, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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 you that are payable under the Plan. If the refund is due from a person or organization other than you, 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 payment in connection with services provided to persons under other plans for which the Claims Administrator processes 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 either:

- 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

UnitedHealthcare has agreements in place that govern the relationships between it, the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 administer payment of 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 are not responsible 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination of or modifications to the Plan.

The Claims Administrator is not the Plan Administrator of the Plan, as that term is used in ERISA. The Claims Administrator is a named fiduciary of the Plan, as that term is used in ERISA, solely with respect to the Claims Administrator's authority to decide claims for Benefits under the Plan and appeals of denied claims for Benefits under the Plan. If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

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.

Interpretation of Benefits

Duke Energy and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Duke Energy and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Duke Energy may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Duke Energy does so in any particular case shall not in any way be deemed to require Duke Energy to do so in other similar cases.

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, including provider billing and provider payment records. 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Coinsurance as described in Section 4, *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

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.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible). The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, 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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations*.

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6. *Clinical Programs and Resources*, "Covered Person" means all domestic Employees who are eligible for and enrolled in the Plan and their Dependents age 18 and over who are eligible for and enrolled 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.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

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

Designated Dispensing Entity - a pharmacy, provider, 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 Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
    b. The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
    c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 Service(s) – 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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.

Fertility Solutions (FS) – a Program administered by UnitedHealthcare or its affiliates made available to you by Duke Energy. The FS Program provides:

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

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

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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 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, service 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), service site 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. UHCprovider.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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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 – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a

condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a Program administered by UnitedHealthcare or its affiliates made available to you by Duke Energy. The NRS Program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 medications or products administered in connection with a Covered Health Service by a Physician.

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

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

Plan – The Health Savings Plan 2 Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

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

Pregnancy - includes all of the following:

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

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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

- Services exceed the scope of Intermittent Care in the home.

- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Coinsurance and applicable Annual Deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - 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**.**

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

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

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

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

ATTACHMENT III – NONDISCRIMINATION & 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 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 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: 1-800-368-1019, 800-537-7697 (TDD)

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

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the 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 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	¯(=™ ¬φ¯ xi ™ ‹ ⌡ M å ®8 H ı; Ş≠é 8 } é µ+ñ" ⌂ µ Ů â M Ć: ∫ ™ ` Ɱ - ‹ Ωα(₣ xĚ ®↓ +™8 å ÷b¯ ‹ é +˙ {(€ xâ ť 8 Ů8 MŮ ¬ aě M˙ ¸ €) ®0™ ł· ¶⌂ 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 nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	š ĂąĿ¯ð Ę š ĂđĘĿ đĿ¹ œę, Ž ă ĂIJĘ - Iÿ ě ă lĘ¹ κ ĂIJĘ Ž ž lĆ ¹ IĆ⁼Þ č Ilę¹ IĎŇ – ¹ Ę Ł¯œ Í ą ĂĿ Þd'Ă –Ş lę őĄIĂ Ă› œĘ –ĄIĂ ¹ ⁰ Ă (Ű) ĚŇĚ ¾ ã ĂĄ TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	[illegible] TTY 711
10. Cherokee	¯ Šľě ýğ ŔŮą² Ŕ ŔľĽ Ŕ ŻþαŦ Đ Źź ğ ř ³ ýń Ŕ−þř Ŕ þŮĽ ř Ŕ Đ¯ⁿ Ľ ŔŽ, ¹ ŀďĽ Ň 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	p y t éá~ t ÜAgz éy r r T t ép y Ü¨ x ÜÅÜy ÜRy ÜÉp à y ~ ~ Ü ë T ás aÜ g éJâx ÜÅz Üy Ükoá~ t pRà a {~ Ü p y ÜÜÉgq Ē Ü ID aÜnu {t à Jfâ ày ÜRU u é kë , □ y Éw { vët t wx { Xu { aë a {ë ñ r wÜ ë TTY 600
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 निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल,फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti 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

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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	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိာ်ဟ့ၣ်အ ပ့ၤဘၣ်န့ၣ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိာ်ဟ့ၣ်အပှၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကဲ့ အကးအလိၤဒီးဆီၣ်လီၤနီၣ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	□□□ □□□ □□□ □□□ □□□ □□ □□□□ □□ □□□ □□□ □□□□. □□□□ □□□□ □□□□ □□□ □□ ID□□□ □□□ □□ □□ □□□□□ □□□□ 0□□ □□□□□. 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 پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	IæĔij ŵâŵ♦ Ŵ♠ Ēĩ♦ǾĠųn ☻Ĕij ♣æĀ♥ ĥŷǼĉ Ħ◦ ĒŴǾ▪Áij ☼æĔĀā Ĕij Ŵĥ'ų ij ℓ Ĕā Ĕ☼ĉ ♂IæĔij ŵæ▪ŵ ♀æĔĨ ♣ǿæĔ♥. ĥŷæ ĉ ŵǾĉ ♂ij Ĕ♥ ℓ Ĕā Ĕ,ħIJ□ ŵ♠Ĉ ĔĈ ▪ Ĕ♥ ĥ◦ ☻ħIJ◦ Ēāų'n āŵĔ◦ų'n ā Ē▪ ĔŴ♣☻Ŵĩ♦Ǿ Ēñ ĩ ǾĀĨ ij 'nų♦ ā Ē▪ ĔŴ♣☻☼ĉ ♂IæĔij , æ☻♦ ĥ◦ ☻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.
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 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

Language	Translated Taglines
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 wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	k Ç-h Ñ Ü S p j Ås ~z ~Ä ã { | ~T k ~R k Ñ ~j \ ~v Åt Ç k p • p k \ v o m~RÄ \ ~v | Öm Ç~z ÅX w U k Ç~h Ñ Ö l p w~o S U h ÅÄ k Ñ ^ X f ~ç Åt ~v ç Ü o r v f Å Å ~U 711 k Ñ ~ \ v Ü 0 m Ü
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
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

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	faʹatalosagaina se tagata faʹaliliu, 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	ܚܩܘܟܘܢ ܐܝܬܠܘܟܘܢ ܢܩܘܒܠܬܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܡܓܢܢܐ ܕܐܝܠܗ ܥܠ ܦܬܩܐ ܕܣܘܟܠܐ ܘܕܘܫ 0 . TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	Z| ºPj ≠a zæ| | Î øPΘ†H !! ¢Å| l'Ï Ñÿ Pv º x ←∑ º Çx ºź †z ΏĆq Θ†OŰH ` øÉ ` ø┼VPε ∂] ` →} q áv ¢←ÖŰÑ→Ñ Pj Ì H ↨ Ŧ ║ΩÑЬ \ ΘTMŰÑ╩æH q g •Aα †ź ẙ v1 ╩j ę Γ _Ü ₽v zæ øï ĹЬ ź ↨ ,Ö0 φ H ź ï å Ĺ┼□TTY 711
55. Thai	•¥¬ÃĦĦ Ë%µ¢"•»'¬´ å√ÕÜé∆"£çeÉ,∫ ¡ 'À£o®•¥%µçµ√%oå•å,´ çå√ Õ¢∂ç®'ƒ£œÅ¬ º ∆¡ 'À ,º ƒµ,∏ƒ. ä∏∑ÕÕ¬'√∆£,∏¿ƒ∏Ëé∫ ª ∂ƒº ƒ'©ì∂»ÃÌÕƒ"· Ω∫Ã£¡ 'ø£œ®•¥ · ∆ç¢µ 0 ÃÌÕƒ"Ω¶Ë•»'¬ª ¢øƒå®∏®'ƒ%µç ÕƒÜé'ƒøu ,º ƒµ,∏ƒ∑ÕÕ¬'√∆£ 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

Language	Translated Taglines
	kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייַ מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן קארטל , דרוקט 0. TTY 711 ID
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 Active Medical Plan

TABLE OF CONTENTS

SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 66,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at **www.Caremark.com** to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

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

SECTION 2 – HOW THE PROGRAM WORKS

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

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option[1].

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

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

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

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

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

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

You can fill a prescription for up to a 30-day supply at any of over 66,000 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. 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 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 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 by calling 800-378-5697.

- **Option 2:** Use the CVS Caremark mobile app on your smart phone to photograph and submit your prescription.

- **Option 3:** 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 coinsurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service Pharmacy 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 automatic refill service.

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. Coverage requires enrollment in the Fertility Solutions Program. Please call 877-214-2930 to enroll. Once enrollment is completed, infertility agents will be covered at 100% after the standard coinsurance and/or deductible, as applicable, up to $10,000 per person per lifetime, then the participant pays 100% of the cost of the drug.
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime)
- Anti obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

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

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

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

Medical Plan and Health Savings Account

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

Medical Plan and Health Care Spending Account

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

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

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

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

Refer to the prescription drug benefit summary on page 21 for more information about applicable coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Preventive Medications

CVS Caremark maintains a list of certain medications prescribed to prevent the occurrence/re-occurrence of chronic illnesses. This list is referred to as the Preventive Therapy Drug List. Under your HSP option, preventive medications included on the Preventive Therapy Drug List are covered at 100% and are not subject to your HSP option's coinsurance 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. Note: the Preventive Therapy Drug List excludes brand medications except in circumstances where there is no generic equivalent available.

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:

- COVID-19
- Dengue Fever
- 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)
- RSV (Adult)
- 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.

Caremark Cost Saver® & GoodRx®

Beginning January 1, 2024, your prescription drug program coordinates with GoodRx. This means that when the GoodRx price for a generic, non-specialty drug is lower than the amount you would pay under the Medical Plan's prescription drug coverage, you will automatically pay the lower GoodRx price when you check out at your pharmacy, and 100% of the GoodRx price will apply to your applicable Medical Plan annual deductible. If you have any questions about GoodRx, contact CVS Caremark Customer Service at 888-797-8912.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

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

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

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

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

Maximum Drug Limitation Program

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

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

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

Prior Authorization

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

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

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

Drug Utilization Reviews

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

SECTION 5 – COORDINATION OF BENEFITS

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

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

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

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

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2024, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2025 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 whose initial effective date with CVS Caremark is January 1, 2024 would have 45 days (until February 14, 2024) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

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

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

Reviews & Appeals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To the extent required by applicable law:

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

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

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Excludes brand medications if there is a generic available.	**$0**	**$0**
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Annual In-Network Deductible The deductible is a combined medical and prescription drug deductible.	$1,600 per year for individual coverage / $3,200* per year for family coverage	
Out-of-Pocket Maximum** The out-of-pocket maximum is a combined medical and prescription drug out-of-pocket maximum.	$3,500 per year for individual coverage / $7,000*** per year for family coverage	

*The deductible is a true family deductible. The full $3,200 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 coinsurance are applied toward your out-of-pocket maximum and are included for purposes of determining whether you have reached your out-of-pocket maximum.

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

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Teladoc Medical Experts' Services for the Duke Energy Active Medical Plan

January 1, 2024

Table of Contents

An Introduction to Teladoc Medical Experts Services

Duke Energy Corporation (Duke Energy) offers comprehensive coverage under the Duke Energy Active Medical Plan (Plan) that includes medical, surgical, hospitalization, prescription drug, wellness and disease management benefits, as well as expert medical opinions and certain onsite health care services. This booklet provides a summary of the expert medical opinion services available under the Plan through Teladoc Medical Experts, and is part of the summary plan description for the Plan.

Duke Energy is making the Teladoc Medical Experts services described in this booklet (Teladoc Medical Experts Services) available to you because it recognizes the challenges and stresses that can occur when you are uncertain about a medical diagnosis or treatment plan, and wants to provide resources to help you make medical decisions with confidence.

Teladoc Medical Experts provides medical information only and does not provide medical care, diagnosis or treatment. The information you receive from Teladoc Medical Experts is intended to supplement, not replace, the medical care provided by your treating physician, and to help you and your treating physician make informed decisions regarding your diagnosis and/or treatment plan. Many doctors find that collaboration with other experts is very helpful, especially in complex situations. Teladoc Medical Experts enables doctors to collaborate in a new way.

The Teladoc Medical Experts' Services

Eligibility to Use the Teladoc Medical Experts Services

You are eligible to use the Teladoc Medical Experts Services only if you are enrolled in the Plan, and your dependents are eligible to use the Teladoc Medical Experts Services only if they are enrolled in the Plan.

You are not eligible to use the Teladoc Medical Experts Services if you are not enrolled in the Plan, and your dependents are not eligible to use the Teladoc Medical Experts Services if they are not enrolled in the Plan.

See the Eligibility section of the Duke Energy Active Medical Plan General Information booklet for more information about the Plan's eligibility requirements.

Description of the Teladoc Medical Experts Services

You have access to the following Teladoc Medical Experts Services:

1. **"Expert Medical Opinion"** is a service whereby a Teladoc Medical Expert reviews your diagnosis and/or treatment plan and provides a detailed recommendation. Teladoc Medical Experts collects all of your records, images and test samples and provides them to a Teladoc Medical Expert for review. The Teladoc Medical Expert reviews everything in detail and creates a comprehensive report, either confirming what you've been told by your treating physician or recommending a change. You can share this report with your treating physician to help you and your treating physician make treatment decisions.

2. **"Critical Care Expert Review"** is an Expert Review as described above, but for individuals in an in-patient medical setting experiencing a traumatic or catastrophic event such as traumatic brain injury, spinal cord injury, multi-organ failure, serious burns or premature birth. With a Critical

Care Expert Review, Teladoc Medical Experts will address, in real time, your immediate and highly complex needs. Critical Care Expert Reviews are available 24 hours a day, 7 days a week, 365 days a year.

Cost for Teladoc Medical Experts Services

Teladoc Medical Experts Services are offered to you at no cost. The Plan covers all Teladoc Medical Experts costs. If you decide to obtain additional tests and/or services based on the information you obtain from Teladoc Medical Experts, these additional tests and/or services, as applicable, may be covered under the terms of the Plan, or you may have to pay for these additional tests and services out-of-pocket. Refer to the other portions of the Plan's Summary Plan Description for additional information regarding covered services and benefits under the Plan.

Do I Have to Travel or Collect My Own Medical Records?

No. You make a call to Teladoc Medical Experts and they handle everything for you. All of your contact with Teladoc Medical Experts is over the phone or the Internet. You do not need to travel or contact your doctor(s) to obtain records, images or other information related to your medical case. In rare situations, if you doctor(s) does not respond to Teladoc Medical Experts' requests for records we may ask you to contact your doctor(s) directly.

What Type of Information Does Teladoc Medical Experts Provide?

Teladoc Medical Experts provides medical information only and does not provide medical care, diagnosis or treatment. The information you receive from Teladoc Medical Experts is intended to help you and your treating physician make informed decisions regarding your diagnosis and/or treatment plan. You remain in full control of your healthcare decision making, and you can decide whether to share the report with your treating physician. Teladoc Medical Experts will not share your report with your treating physician without your authorization.

How Does Teladoc Medical Experts Expert Medical Opinion Process Work?

- You call 1-800-835-2362 or visit Teladoc.com/MedicalExperts.
- A dedicated Teladoc Medical Experts Physician will have an in-depth discussion with you about your medical condition and obtain a full health history.
- With your written approval, Teladoc Medical Experts will collect all appropriate medical records, images and test samples.
- The Teladoc Medical Experts clinical team will then conduct a comprehensive analysis of your case and select the most appropriate Teladoc Medical Expert(s).
- The Teladoc Medical Expert(s) will review your case and provide Teladoc Medical Experts with a detailed report that includes his or her recommendations.
- Teladoc Medical Experts will share the report with you, but will not share the report with your treating physician without your consent.

Throughout the process, the Teladoc Medical Experts Member Advocate is available to answer your questions. Depending on your case, your Teladoc Medical Experts Member Advocate also may follow up with you to see if you need any other help.

How Will Teladoc Medical Experts Work With My Treating Physician?

Teladoc Medical Experts share the Teladoc Medical Expert's findings with you – and only with you. Teladoc Medical Experts will not share the report with your treating physician without your consent. The goal is to provide useful information so that you and your treating physician can make more informed decisions together regarding treatment.

Can Teladoc Medical Experts Services be Used in Emergency Situations?

For urgent medical situations where immediate intervention is requested, Teladoc Medical Experts Services are not an option. In these situations, Teladoc Medical Experts may be able to provide you with appropriate questions to ask your provider before you proceed with treatment. However, you should seek immediate treatment as directed by your doctor. Once your condition has stabilized, Teladoc Medical Experts can evaluate your case for future treatment options.

Am I required to use Teladoc Medical Experts Services?

No. Participation is completely voluntary.

How Will Teladoc Medical Experts Maintain My Privacy?

Teladoc Medical Experts complies with all relevant state and federal laws and regulations regarding privacy and confidentiality, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To provide the Teladoc Medical Experts Services, Teladoc Medical Experts will need to collect, use and disclose your protected health information (PHI). When you initiate the Teladoc Medical Experts Services, you will be provided with more detailed information regarding the Teladoc Medical Experts Services and the confidentiality of your PHI.

How to File a Claim or an Appeal

Request

In order to initiate the Teladoc Medical Experts Services, you should call 1-800-835-2362 or visit Teladoc.com/MedicalExperts. A request to use the Teladoc Medical Experts Services is referred to throughout this document as a "Claim".

Teladoc Medical Experts has been given responsibility for reviewing initial Claims and reviewing all Claim denials. Neither Duke Energy nor the Duke Energy Benefits Committee has any discretionary authority with respect to the review of initial Claims or the review of Claim denials.

Denial

It is very unlikely that you would be denied the use of Teladoc Medical Experts Services. However, if your Claim is denied, you have the rights outlined in this section. The denial, reduction or termination of a service, supply, or benefit is called an "Adverse Benefit Determination". With respect to the Teladoc Medical Experts Services, reasons for such an Adverse Benefit Determination may include, but are not limited to:

- Your eligibility for the Teladoc Medical Experts Services, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit); or
- Your intention to use the Teladoc Medical Experts Services for litigation or legal reasons (*e.g.*, for purposes of a medical malpractice case); or
- Your request to use the Teladoc Medical Experts Services for an excluded diagnosis (*e.g.,* for a mental health condition); or
- Your request to use certain Teladoc Medical Experts Services when you do not have a sufficient or recent diagnostic history (with or without a diagnosis); or
- Your refusal to sign an authorization form for Teladoc Medical Experts to collect your medical information when such information is necessary for the type of service you requested.

In the event of an Adverse Benefit Determination, Teladoc Medical Experts will provide you or your representative with notice of such Adverse Benefit Determination (Notice of Adverse Benefit Determination) within 30 days after receiving your Claim. However, if more time is needed to make a determination as to whether to deny your Claim due to matters beyond Teladoc Medical Experts' control, Teladoc Medical Experts will notify you or your representative that an extension is needed (Extension Notice). Teladoc Medical Experts will provide you with this Extension Notice within 30 days of receiving your Claim. 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 your original Claim.

If an extension is needed because necessary information is missing from your Claim, the Extension Notice will specify what information is needed (Request for Information). The determination period will be suspended on the date Teladoc Medical Experts sends such a Request for Information, and the determination period will resume on the date you or your representative responds to the Request for Information. You will have at least 45 days to respond to the Request for Information.

Notice of Adverse Determination

In the event of an Adverse Benefit Determination, in whole or in part, you (or your authorized representative) will be notified of the Adverse Benefit Determination in writing or electronically. Your Notice of Adverse Benefit Determination will provide you or your representative with the following information:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific references to the pertinent Plan provisions on which the Adverse Benefit Determination is based;
- a description of any additional information or material necessary to process the Claim properly and an explanation of why such information or material is necessary;
- an explanation of the review procedures applicable to your request for Teladoc Medical Experts Services and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) following any final Adverse Benefit Determination on review and any time limits for filing such a civil action; and
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request.

Appeal of Adverse Determination

If your Claim is denied, upon receipt of your Notice of Adverse Benefit Determination you (or your authorized representative) have 180 calendar days to appeal the Adverse Benefit Determination. If you (or your authorized representative) do not file an appeal within 180 days after receipt of the Notice of Adverse Benefit Determination, your Claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue.

If you choose to submit an appeal of your Adverse Benefit Determination, you must send a written appeal (Notice of Appeal of Adverse Benefit Determination) to the following address:

Teladoc Medical Experts Medical Director
Teladoc Health, Inc.
1250 Hancock St., Suite 501N
Quincy, MA 02169

When reviewing your Notice of Appeal of Adverse Benefit Determination, Teladoc Medical Experts will consider any new information that you provide that was not available or utilized when the initial determination was made. Someone at Teladoc Medical Experts, other than an individual involved in the initial determination or a subordinate of such individual, will make the determination on appeal.

Teladoc Medical Experts will notify you of its decision on your appeal within 60 days of its receipt of your Notice of Appeal of Adverse Benefit Determination. Teladoc Medical Experts' decision is referred to as "Notice of Adverse Benefit Determination on Appeal."

Every Notice of Adverse Benefit Determination on Appeal will be provided in writing or electronically and will include Teladoc Medical Experts' ultimate determination and, if such determination is an adverse determination, will include:

- the specific reason or reasons for the Adverse Benefit Determination on appeal;
- specific references to the pertinent Plan provisions on which the Adverse Benefit 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 regarding your right to bring a civil action under Section 502(a) of ERISA following any final Adverse Benefit Determination on your appeal 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 Benefit Determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request; 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."

After completing all mandatory appeal levels, you have the right to bring a civil action under 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 and appeals process. You may not initiate a legal action against Teladoc Medical Experts, the Company, the Plan or the Plan Administrator until you have completed the appeal process. No legal action may be brought more than one year following a final decision on the Claim under the appeal process. 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 and denied Claims on review includes the full power and discretion to interpret the Teladoc Medical Experts Services and to make factual determinations, with Teladoc Medical Experts' decisions, interpretations and factual determinations controlling. Requests for information regarding individual Claims, or review of a denied Claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial Claim, or to decide the denied Claim on review, as applicable.

Active Medical Plan

PPO option

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: UnitedHealthcare Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: CVS Caremark Prescription Drug Guide (includes Summary of Prescription Drug Benefits)
- SECTION IV: Teladoc Medical Experts' Services

Duke Energy Active Medical Plan
General Information

(Enterprise)

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Active Medical Plan (Medical Plan) provides information that is applicable to the Medical Plan coverage options available to eligible non-union and represented employees. 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 1, 2024 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

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

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

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300.

Eligibility

Eligible Employees

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

To be an eligible employee, you must satisfy each of the following requirements:

- you are identified in and paid through Duke Energy's payroll system as an employee of Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the Company, as appropriate); and

- you are classified by your Company as either a regular employee or a fixed-term employee.

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

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

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

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

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

Eligible Dependents

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

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

Spouse Eligibility

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

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

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

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

Domestic Partner Eligibility

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

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

Generally, for medical coverage of a taxpayer's domestic partner to be tax-free to the taxpayer, the domestic partner must qualify as the taxpayer's tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code. See *Cost of Coverage* below for additional information regarding the tax treatment of your domestic partner's medical coverage.

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

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

Child Eligibility

Your child is:

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

whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**

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

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

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

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

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

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

Surviving Spouse, Domestic Partner and Child Eligibility

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

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

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

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

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage.

If your spouse/domestic partner and/or dependent children elect survivor coverage, they may drop their survivor coverage at any time during the calendar year, regardless of whether they experience a work/life event for which mid-year changes are allowed. See *Mid-Year Changes* for additional information about work/life events for which mid-year changes are allowed.

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 continue coverage under the Medical Plan following your death as the survivor of an active employee.

Please note: new enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage take effect on Jan. 1, 2024. Under these new enrollment requirements, if you are an eligible retiree and you do not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of your retirement date (or within 31 days after your COBRA continuation coverage under the Medical Plan ends), or if you decline or drop Duke Energy-sponsored pre-65 retiree medical coverage at any point thereafter, you cannot enroll yourself or your eligible dependents in Duke Energy-sponsored pre-65 retiree medical, dental or vision coverage at any future date. This means that if your spouse/domestic partner who is an eligible retiree continues Medical Plan coverage as the survivor of an active employee, and does not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of retiring, your spouse/domestic partner will not be able to enroll in pre-65 retiree medical, dental or vision coverage at any future date.

Please refer to the Summary Plan Descriptions for the Duke Energy Retiree Medical Plan, the Duke Energy Retiree Dental Plan and the Duke Energy Retiree Vision Plan for additional information.

Employee and Retiree Couples

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

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days

following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

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

If a Dependent Becomes Ineligible

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

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

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

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

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

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

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

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

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

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

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

Enrolling in the Medical Plan

When You Are First Eligible

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

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

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

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

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

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

You also may decline coverage altogether.

During Annual Enrollment

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

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

Other Opportunities to Enroll

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

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

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

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

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

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

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

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

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

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

If You Are Rehired

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

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

Cost of Coverage

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

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

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

If you elect coverage for a domestic partner, you will need to confirm whether your covered domestic partner is your tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code. If your covered domestic partner is your tax dependent for federal income tax purposes, contributions for your domestic partner's coverage will be deducted from your pay on a pre-tax basis each pay period. If your covered domestic partner is not your tax dependent for federal income tax purposes, the portion of your contribution required to cover the domestic partner under the Medical Plan is deducted on a pre-tax basis and the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner will appear as imputed income on your pay advice statements and is subject to applicable taxes. As a result, please make sure to indicate your domestic partner's tax dependent status when you enroll to ensure proper tax treatment for your coverage. 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.

Duke Energy WellPower Rewards

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

Eligibility and Redeeming Rewards

Information about the eligibility requirements for participating in Duke Energy WellPower Rewards and redeeming any rewards you earn is included in the Duke Energy WellPower Rewards materials sent to you with Annual Enrollment materials and throughout the year. This information also is available on the Duke Energy Portal.

Duke Energy WellPower Rewards Activities

The activities that you and/or your spouse/domestic partner must complete to receive rewards may vary with each program cycle. Review the Duke Energy WellPower Rewards materials sent to you with Annual Enrollment materials and throughout the year, for additional information on the program cycle's activities and requirements.

The Medical Plan is committed to helping you achieve your best health. Rewards for participating in Duke Energy WellPower Rewards are generally available to all eligible employees. If you think you might be unable to meet a standard for a reward under Duke Energy WellPower Rewards, you might qualify for an opportunity to earn the same reward by different means. Contact a Vitality Customer Service Specialist at 866-567-0705 and a representative will work with you (and, if you wish, your doctor) to find activities with the same reward that are right for you in light of your health status.

Non-Tobacco User Discount

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

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

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

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

If you do not complete the Attestation during enrollment, or, if you complete the Attestation and attest to being a tobacco user but you either (1) do not enroll in the Tobacco Cessation Program as described below by the applicable deadline or (2) do not complete the Tobacco Cessation Program described below by the applicable deadline, you (and your spouse/domestic partner) will not receive the non-tobacco user discount for Medical Plan coverage. Tobacco user status does not carry over from year to year for Medical Plan coverage.

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

If you misrepresent your tobacco user status (or the tobacco user status of your spouse/domestic partner) in the Attestation, or if you (or your spouse/domestic partner) become a tobacco user after completing the Attestation as a non-tobacco user and you do not notify the Duke Energy myHR Service Center of the change in tobacco user status, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take

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

appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Non-Tobacco User Discount – Tobacco Cessation Program for Active Employees

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

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) intend to complete the Tobacco Cessation Program, which includes agreeing to enrollment with Quit For Life and completing your enrollment within 31 days of the date that you make your new hire coverage elections, and
    - complete the Tobacco Cessation Program within seven months of the date that you make your new hire coverage elections[2] – or –
- If you are enrolling during annual enrollment, you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) intend to complete the Tobacco Cessation Program, which includes agreeing to enrollment with Quit For Life and completing your enrollment by Dec. 31, and
    - complete the Tobacco Cessation Program on or before the following June 30.

To complete the Tobacco Cessation Program, you (and/or your covered spouse/domestic partner) must have a minimum of five interactions with a coach.

You may contact the Duke Energy myHR Service Center if you have questions about the Tobacco Cessation Program.

[2] If you (and/or your covered spouse/domestic partner) enrolled in the Tobacco Cessation Program and you properly attested while enrolling in benefits as a newly eligible employee that you (and/or your covered spouse/domestic partner) would timely complete the Tobacco Cessation Program, but you (and/or your spouse/domestic partner) have not yet reached your seven month completion deadline for the Tobacco Cessation Program by the annual enrollment deadline, you will qualify for the non-tobacco user discount if you also properly attest during annual enrollment that you (and/or your spouse/domestic partner) will complete the Tobacco Cessation Program by the original seven month completion deadline and you (and/or your spouse/domestic partner) complete the Tobacco Cessation Program by the original seven month completion deadline.

If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must call Quit For Life and complete your enrollment within 31 days of the date that you make your new hire coverage elections. If you are enrolling during annual enrollment, you must call Quit For Life by December 31 to help you complete your enrollment in the Tobacco Cessation Program. **It is your responsibility to complete your enrollment in the Tobacco Cessation Program by the applicable deadline.**

You (and/or your spouse/domestic partner) will not be required to pay for the cost of the Tobacco Cessation Program. Please note that the Tobacco Cessation Program takes up to six months to complete. You can begin the Tobacco Cessation Program as soon as you complete your enrollment. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the Tobacco Cessation Program in any future year, you will be required to again complete the Tobacco Cessation Program process described above.

If You Do Not Successfully Complete the Tobacco Cessation Program

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

If You Misrepresent Information Related to the Non-Tobacco User Discount and/or the Tobacco Cessation Program

If you misrepresent any information related to the non-tobacco user discount and/or the Tobacco Cessation Program, including, but not limited to, your enrollment with Quit For Life, or if you do not complete the Tobacco Cessation Program by the applicable deadline, Duke Energy reserves the right to recover any contribution amounts you should have paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of health and insurance coverage and/or discharge, and to take other appropriate action.

Termination of Coverage for Non-Payment

Your coverage under the Medical Plan (and all other Duke Energy-sponsored plans in which you are enrolled and for which payments are required) 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 for your coverage under the Medical Plan (and any other Duke Energy-sponsored plans under which you want to continue coverage) must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If your coverage under the Medical Plan is reinstated under this provision and then subsequently terminated again for non-payment, you will not be entitled to reinstatement of your coverage under the Medical Plan, or under any other Duke Energy-sponsored plan for which payments are required, at any later date. 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.

Note: If your Medical Plan coverage is terminated for non-payment while you are on an approved leave of absence, the termination of your Medical Plan coverage will be treated as an affirmative drop of Medical Plan coverage, rather than as a termination of Medical Plan coverage due to non-payment. This means that if you return to active employment with the Company, you may be eligible to have your Medical Plan coverage reinstated (in the previous coverage option and at the previous coverage level) on the date of your return to active employment.

When Coverage and Contributions Begin

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

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

Mid-Year Changes

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

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

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

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

- Your legal marital status changes
  - you get married

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

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,

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

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

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

When You Enroll a Dependent Mid-Year

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

When Mid-Year Coverage and Contribution Changes Are Effective

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

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

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

- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death.

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

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

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

If You Become Disabled

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

When You Reach Age 65

If you continue to work past age 65, Medical Plan coverage for you and your covered dependents will continue as long as you remain an eligible employee, your covered dependents remain eligible dependents and you pay any required contributions. If you continue to work past age 65, your Medical Plan coverage will be primary to Medicare for you and any covered dependents over age 65, except in certain situations related to an end stage renal disease diagnosis.

If You Become Entitled to Medicare

If you are "not actively at work" and you become entitled to Medicare, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). For these purposes, you are considered to be "not actively at work" if you are not actively working as an employee or you have been receiving long-term disability benefits for six months or longer. Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare.

If you elect to terminate your coverage under the Medical Plan when you become entitled to Medicare, any of your eligible dependents who are covered under the Medical Plan and are not eligible for Medicare may continue coverage under the Medical Plan until reaching age 65.

If you are "not actively at work" because you have been receiving long-term disability benefits for six months or longer and you and/or a covered dependent enroll in a Medicare prescription drug plan for a calendar year, you and/or your covered dependent will not be eligible for coverage under the Medical Plan for that calendar year. Therefore, Medical Plan coverage ends for a calendar year for individuals who enroll in a Medicare prescription drug plan mid-year. Such individuals may be able to enroll for Medical Plan coverage at the next annual enrollment if Medicare prescription drug coverage is dropped for the following calendar year.

Termination of Coverage

When Coverage Ends

Your coverage under the Medical Plan will cease on the earliest of the following dates:

- the last day of the month in which your employment ends, unless you elect to continue coverage under COBRA;
- the last day of the month in which you cease to be an eligible employee or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the last day of the month in which a work stoppage begins;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, or on the last day of the month in which the dependent loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms generally must be completed and received within 60 days of the event or notification, whichever is later. See *COBRA Continuation Coverage* below for additional information about the timing of COBRA elections.

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, generally within 60 days of the qualifying event. See *COBRA Continuation Coverage* below for additional information about the timing of COBRA elections.

See *If a Dependent Becomes Ineligible* for a description of what happens when you either do or do not report your divorce or the end of your domestic partner relationship within 31 calendar days.

To drop coverage for your former spouse/domestic partner, contact the Duke Energy myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end on the last day of the month in which your employment terminates, unless you elect to continue coverage under COBRA.

See *If You Are Rehired* for a description of what happens if you are reemployed by the Company after your termination of employment.

If You Retire

If you are an eligible retiree, you may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you have not reached age 65 when you retire, or individual coverage through a Medicare exchange if you are age 65 or older when you retire. Additional information about your coverage options will be provided to you when you retire.

Please note: new enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage take effect on Jan. 1, 2024. Under these new enrollment requirements, if you are an eligible retiree and you do not enroll in Duke Energy-sponsored pre-65 retiree medical coverage within 31 days of your retirement date (or within 31 days after your COBRA continuation coverage under the Medical Plan ends), or if you decline or drop Duke Energy-sponsored pre-65 retiree medical coverage at any point thereafter, you cannot enroll yourself or your eligible dependents in Duke Energy-sponsored pre-65 retiree medical, dental or vision coverage at any future date. Please refer to the Summary Plan Descriptions for the Duke Energy Retiree Medical Plan, the Duke Energy Retiree Dental Plan and the Duke Energy Retiree Vision Plan for additional information.

COBRA Continuation Coverage

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), you, your spouse and eligible dependent children may elect to continue Medical Plan coverage if certain qualifying events occur. Although domestic partners are not entitled to continuation coverage under COBRA, the Company will apply the same rules to a domestic partner as to a spouse.

There also may be other coverage options available to you and your family if you experience a qualifying event. For example, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

Continued Coverage for You

You may continue coverage for yourself and your covered eligible dependents under the Medical Plan for up to 18 months if you lose coverage under the Medical Plan due to:

- termination of your employment (for reasons other than gross misconduct); or

- a reduction of your work hours.

Continued Coverage for Your Dependents

Your covered dependents may continue their coverage under the Medical Plan for up to 36 months if they lose coverage as a result of your:

- death;
- divorce;
- termination of domestic partner status; or
- dependent child ceasing to be a dependent as defined by the Medical Plan.

Newborn and Adopted Children

If you give birth or adopt a child while you are on COBRA continuation coverage, you may enroll your new child for COBRA coverage within 31 calendar days following the date of the birth or adoption. Your newborn or adopted child will be a "qualified beneficiary." This means that your child will have independent election rights and multiple qualifying event rights. (Refer to *Multiple Qualifying Events*.)

In Case of Disability

You and your covered dependents may be eligible for up to 29 months of continued coverage if you or your dependents receive a determination from the Social Security Administration stating that you or your dependents were disabled at the time you elected COBRA coverage or at any time during the first 60 days of COBRA coverage, provided the disability lasts at least until the end of the 18-month period of continuation coverage.

You must notify the Duke Energy myHR Service Center of any Social Security Administration disability determination in writing within the initial 18-month coverage period and within 60 days of the determination. Your verbal notice is not binding until confirmed in writing and the Duke Energy myHR Service Center receives a copy of the Social Security disability determination. You also must notify the Duke Energy myHR Service Center within 30 days of the date you are determined by the Social Security Administration to no longer be disabled.

If You Become Covered by Medicare

If you become entitled to Medicare while you are an active employee and you later experience a qualifying event (e.g., a termination of employment), you and your dependents may be eligible for continued coverage when the qualifying event occurs. If COBRA is elected, coverage for your covered dependents will extend 36 months from the date you first became covered by Medicare or the maximum coverage period for the qualifying event (18 months in the case of termination of employment or reduction in hours) whichever is later.

For example, suppose you are actively employed on January 1, 2024, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2025, your eligible dependents would be eligible for continued coverage until the later of:

- 36 months following the date you become covered for Medicare – January 1, 2027; or
- 18 months following your termination of employment – July 1, 2026

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2027 if COBRA continuation coverage is elected.

Multiple Qualifying Events

If your dependents experience more than one qualifying event while COBRA coverage is active, they may be eligible for an additional period of continued coverage not to exceed 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the Medical Plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. This period would not exceed a total of 36 months from the date of the loss of your coverage due to your termination (the first qualifying event).

Procedures to Obtain Continued Coverage

Both you and the Company have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the Duke Energy myHR Service Center within 60 days when one of these qualifying events occurs:

- you become divorced;
- your domestic partner relationship ends;
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan; or
- you or an eligible dependent is determined to be disabled by the Social Security Administration.

If these procedures are not followed, or if notice is not provided to the Duke Energy myHR Service Center during the 60-day notice period, then your covered dependents will lose their rights to elect COBRA coverage.

For other qualifying events, such as your death, termination of employment or reduction in work hours, it is the Company's responsibility to notify the COBRA administrator.

Election Period

The Company's COBRA administrator will notify you or your covered dependents of your right to elect continued coverage. Each qualified beneficiary has independent election rights and has 60 days to elect coverage, beginning on the later of:

- the date coverage terminates by reason of the qualifying event, or

- the date notification of the right to elect continued coverage is mailed to you and your covered dependents.

Type of Coverage

If you choose continued coverage, you will initially have the same medical coverage you had on the day before your qualifying event. During your COBRA continuation period, any changes to the medical coverage of similarly situated active employees also will apply to your medical coverage as a COBRA qualified beneficiary. In addition, if your COBRA continuation period extends into a future plan year, you will be able to change your Medical Plan COBRA election for the following plan year during annual enrollment to the same extent that similarly situated active employees are able to change their Medical Plan elections for the following plan year during annual enrollment.

Cost

You and your covered dependents will be required to pay 102% of the full group cost for your continued coverage. The 2% is intended to cover administrative fees. The contributions are paid on an after-tax basis.

You will be asked to pay for coverage in monthly installments. Your first payment will be retroactive to the date of your qualifying event and will be due no later than 45 days after the date you elected continued coverage. Coverage will be effective once the initial premium is paid. Once payment is received, notification of coverage will be passed on to the applicable Claims Administrator. You may refile claims that may have been denied between your benefits termination and your election to continue coverage. You will be required to make monthly payments thereafter, with a 30-day grace period. If the cost or benefits change in the future for active employees, the changes also will affect continued coverage under COBRA. You will be notified of any changes in the cost or benefits associated with your coverage.

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

- the COBRA participant fails to make the required contribution on time;
- the Company terminates the Medical Plan for all employees; or
- the COBRA participant becomes covered under another group medical plan (as an employee or otherwise) after the election of COBRA coverage.

Conversion Privilege

The Medical Plan has no conversion privilege. This means that you are not able to convert your coverage under the Medical Plan to an individual policy upon your termination from the Company or when coverage ends.

Qualified Medical Child Support Orders (QMCSOs)

If the Company receives notification that, as a result of a QMCSO, you are required to provide Medical Plan coverage for a dependent child, the Company will:

- notify you (and any other person named in the order) of receipt of the order; and
- within a reasonable period of time (up to 30 days), determine if the child is eligible for coverage under the Medical Plan and notify you in writing of the decision.

As appropriate to the court order, the child will be enrolled for medical coverage, unless there are legal proceedings that dispute the determination. If the court order is disputed, claims processing will be delayed until the dispute is resolved.

If the child's covered expenses are paid by a custodial parent or legal guardian who is not a participant in the Medical Plan, reimbursement of these expenses will be made directly to the custodial parent or legal guardian if required by the order. Custodial parents and legal guardians also may sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment of providers to the custodial parent.

If you do not comply with the procedures required by the order, the Company may change your coverage status to that required by the court order and deduct the appropriate contributions from your pay at the direction of the court.

Your Role

As a participant in the Medical Plan, please follow the guidelines below.

- File accurate claims. If someone else (other than the provider) files a claim on your behalf, you must review the form before you sign it.
- Review the explanation of benefits when it is returned to you. Make sure that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered.
- Never allow another person to seek medical treatment under your identity.
- Provide complete and accurate information on claim forms and any other forms; answer all questions to the best of your knowledge.

You must notify the applicable Claims Administrator if a provider:

- bills you for services or treatment that you have never received;
- asks you to sign a blank claim form; or
- asks you to undergo tests that you feel are not needed.

Any covered person who knowingly intends to defraud the Medical Plan will be considered guilty of fraud. If you are concerned about any of the charges that appear on a bill or explanation of benefits form or if you know of or suspect any illegal activity, call the applicable Claims Administrator at the toll-free number on your I.D. card. All calls are strictly confidential.

Other Important Information

Plan Sponsor

Duke Energy Corporation is the sole sponsor of the Medical Plan. The Company address, telephone number and employer identification number (EIN) are:

Duke Energy Corporation
525 South Tryon Street
Charlotte, NC 28202
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Active Health & Welfare Benefit Plans, plan number 505.

Funding

The Company provides benefits under the Medical Plan from its general assets.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (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 (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
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
525 South Tryon Street – DEP14C
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.

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
525 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claims Determination Procedures

There are two different types of claims that may be made under the Medical Plan…Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already

exhausted your one-time reinstatement opportunity, (v) requests to change your tobacco user status, which includes requests to complete the Tobacco Cessation Program after the communicated deadline or (vi) requests for the Company to record/count wellness activities completed after the communicated deadline.

Claims for Medical Plan Benefits

The Claims Administrators for your Medical Plan options have the authority to decide initial Claims for Medical Plan Benefits, as the Initial Claim Administrators, and denied Claims for Medical Plan Benefits on review, as the Denied Claim Reviewers. The Company has no discretionary authority with respect to Claims for Medical Plan Benefits.

Claims submission procedures for your Medical Plan benefits are described in the Medical Plan booklets for the Medical Plan options in which you participate. You also can obtain additional information by calling the Duke Energy myHR Service Center. To file a valid Claim for Medical Plan Benefits, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in the Medical Plan booklets applicable to the Medical Plan options in which you participate and any updating materials.

Eligibility or Enrollment Claims

The Benefits Committee has appointed Duke Energy Human Resources to decide Eligibility or Enrollment Claims as the Initial Claim Administrator. Duke Energy Human Resources has delegated its authority to decide Eligibility or Enrollment Claims to Alight Solutions Claims and Appeals Management.

The Benefits Committee has appointed the Claims Committee to perform the fair and impartial review of denied Eligibility or Enrollment Claims on appeal as the Denied Claim Reviewer. The Company has no discretionary authority with respect to the Claims Committee's final determinations regarding Eligibility or Enrollment Claims on appeal.

To file a valid Eligibility or Enrollment Claim, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in this General Information booklet and any updating materials.

Initial Claim

If you have an Eligibility or Enrollment Claim, you (or your authorized representative) must submit a claim initiation form. This form can be obtained by calling the Duke Energy myHR Service Center.

The claim form must be submitted in writing to the address on the form and include:

- a statement that the claim is a "Claim for Eligibility/Enrollment" and identification of the Medical Plan;
- your name, Social Security number, mailing address and daytime telephone number;
- a complete description of the claim, including the eligibility/enrollment issue presented;
- dependent information, if applicable; and

- any additional information you want considered.

A "Claim for Eligibility/Enrollment" must be received by Claims and Appeals Management within 12 months after the date on which you are claiming eligibility/enrollment should have occurred. If your claim is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Claims and Appeals Management will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Claims and Appeals Management's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice also will specify what information is needed. The determination period will be suspended on the date Claims and Appeals Management sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have at least 45 days to respond to the request for information.

In the case of an Eligibility or Enrollment Claim relating to your failure to enroll your newborn or newly adopted child in Medical Plan coverage within 31 calendar days of your child's date of birth or adoption, Claims and Appeals Management will approve the Eligibility or Enrollment Claim notwithstanding your failure to timely enroll your child in Medical Plan coverage, but only if (1) you contact the Duke Energy myHR Service Center within 60 calendar days of your child's date of birth or adoption to enroll your child in Medical Plan coverage and (2) you submit a claim initiation form and all other required documentation, in accordance with the instructions specified on the claim initiation form, within 75 calendar days of your child's date of birth or adoption. If Claims and Appeals Management approves your Eligibility or Enrollment Claim, your child's Medical Plan coverage will be effective retroactive to your child's date of birth if a newborn or date of adoption for a newly adopted child. If Claims and Appeals Management denies your Eligibility or Enrollment Claim, you (or your authorized representative) will be notified of the adverse determination in writing as described below.

Adverse Determination

In the event of an adverse eligibility or enrollment determination, in whole or in part, you (or your authorized representative) will be notified of the adverse determination in writing.

An adverse determination notification for an Eligibility or Enrollment Claim will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA

following an adverse determination on review and any time limits for filing such a civil action;

- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to the Claims Committee within 180 calendar days after receipt of the adverse determination. If your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

A request to the Claims Committee must be submitted in writing to:

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person)

consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

You will be allowed to review the claim file and to provide evidence and testimony as part of the internal claims and appeals process. The Claims Committee will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Medical Plan (or at the direction of the Medical Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the Claims Committee will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. You will be notified regarding the decision on your appeal within 60 days after receipt of the appeal.

The determination of your appeal will be in writing and, if adverse, will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement about your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances;
- the following statement: 'You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency'; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and

- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder. Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

For additional information on filing an Eligibility or Enrollment Claim or filing an appeal of an adverse determination, you should contact the Claims Committee.

Voluntary External Review Program

Once you have exhausted the internal claims and appeals process, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and only for certain types of adverse benefit determinations, as defined by federal regulations.

If your claim is eligible for external review under applicable federal regulations and you wish to file a request for external review, you must submit your request within four months of the date of your receipt of the Claims Committee's final internal adverse determination on your appeal. If your request for external review is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it. Contact the Claims Committee for more information on how to file a request for external review of your appeal.

The Claims Committee will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later. If you fail to provide the required information by the applicable deadline, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

If your claim is eligible for external review, the Claims Committee will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner as outlined in federal regulations and other applicable guidance. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;

- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to you or the Medical Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

The external review program is completely voluntary, so you only have to exhaust your internal claim and appeal administrative review rights under the Medical Plan in order to bring a civil action against the Medical Plan. Contact the Claims Committee for more information about the Medical Plan's external review procedures.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the internal claim and appeal procedure. You may not initiate a legal action against the Claims Administrators, the Medical Plan, the Company, or the Plan Administrator until you have completed the internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

Authority to decide initial claims (including claims for Medical Plan benefits) under the Medical Plan and denied claims on review (including denied claims for Medical Plan benefits on review) under the Medical Plan includes the full power and discretion to interpret Medical Plan provisions and to make factual determinations, with the Initial Claim Administrators' and the Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim, or to decide the denied claim on review, as applicable.

Right to Change or Terminate the Medical Plan

Duke Energy Corporation reserves the right to amend or terminate the Medical Plan in any respect and at any time. For example, the Medical Plan may be discontinued in part or in its entirety, or what the Medical Plan or Medical Plan option covers or what benefits it provides may be changed. Cost sharing between the Company and covered individuals also is subject to change, which may include initiating or increasing contributions required of employees, retirees, other former employees and their dependents.

The amendment or termination of the Medical Plan may affect the benefits or benefit coverage not only of active employees (and their dependents), but also of former active employees who retired (and their dependents), became disabled, died or whose Company employment has otherwise terminated (and their dependents), and also of any covered person who began receiving benefit coverage or payments prior to the amendment or termination. If such a termination or amendment occurs, affected participants will be notified. The right to amend or terminate the Medical Plan may be exercised by Duke Energy Corporation, or its authorized delegates, and any amendment shall be in writing.

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

[5] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

and other Medical Plan participants and beneficiaries. No one, including the Company, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's internal claims procedures.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Medical Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters, Duke Energy Portal announcements and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

The Medical Plan, this SPD and your Medical Plan participation are not employment contracts, and do not give any employee the right to continue to be employed by the Company. Employees may resign and are subject to discipline, discharge or layoff as if the SPD had never been published and the Medical Plan had never gone into effect.

Benefit Booklet

Duke Energy Active Medical Plan
PPO Option

Effective: January 1, 2024
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Active Medical Plan's PPO Option. It includes summaries of:

- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions and Limitations;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Duke Energy is solely responsible for paying Benefits described in this Benefit Booklet.

IMPORTANT
The healthcare service, supply or pharmaceutical product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 12, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Active Medical Plan's PPO Option works. If you have questions call the number on your ID card.

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's PPO Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://digital.alight.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. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

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. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, in certain circumstances if you are currently receiving treatment for Covered Health Services from a provider or health care facility whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's or health care facility's contract, you may be eligible to request continued care from your current provider or health care facility at the Network Benefit level for specified conditions and timeframes up to 90 days. This provision applies if you are undergoing a course of treatment for a serious and complex condition from the provider or health care facility, undergoing a course of institutional or in-patient care from the provider or health care facility, scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or health care facility with respect to such a surgery, pregnant and undergoing a course of treatment for pregnancy from the provider or determined to be terminally ill (as defined in *section 1861(dd)(3)(A) of the Social Security Act*) and receiving treatment for such illness from the provider or health care facility. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 number on your ID card.

UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, UnitedHealthcare may require you to select a single Network Physician to provide and coordinate all future Covered Health Services. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Physician for you. If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

Duke Energy has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

  Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Provider or Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any Annual Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of Section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.

- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  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 non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment, or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment and Deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or Deductible.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Covered Persons (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- *Ancillary Services received at certain Network facilities on a non-Emergency basis;*
- *non-Ancillary Services received at certain Network facilities on a non-Emergency basis;*
- *Emergency Health Services;*
- *Air Ambulance services; or*
- *Emergency ground ambulance transportation;*

then, in such circumstances, the Claims Administrator, or its designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, Copayment, and Deductible.

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, or the Recognized Amount when applicable, 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.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual Deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible, but Copays do count

toward the Out-of-Pocket-Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate medical and prescription drug Out-of-Pocket Maximums for the Plan's PPO Option. If your eligible out-of-pocket expenses in a calendar year exceed the applicable annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The medical Copays and Coinsurance amounts are applied toward the Plan's annual ***medical*** Out-of-Pocket Maximums. This means that once you satisfy your applicable annual ***medical*** Out-of-Pocket Maximums, you do not have to pay any further Copays or Coinsurance amounts for Covered Health Services that are medical expenses. However, if you satisfy the Plan's separate annual ***prescription drug*** Out-of-Pocket Maximums but have not yet satisfied your applicable annual ***medical*** Out-of-Pocket Maximums, you still have to pay any applicable Copay or Coinsurance amount for Covered Health Services which are medical expenses until you satisfy your applicable annual ***medical*** Out-of-Pocket Maximums.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your applicable Network and non- Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	No
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
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, or the Recognized Amount when applicable.	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.

Travel and Lodging (For Travel and Lodging related to complex medical conditions see Section 7: *Clinical Programs And Resources)*

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such Covered Health Services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their home address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services 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 your ID card.

To obtain prior authorization, call the number on 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

Payment Terms & Features

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]		
■ Physician's Office Services – Primary Physician	$25	Not Applicable
■ Physician's Office Services - Specialist	$40	Not Applicable
■ 24/7 Virtual Visits	$25	Not Applicable
Annual Deductible[2]		
■ Individual	$600	$1,200
■ Family (not to exceed the applicable Individual amount per Covered Person)	$1,200	$2,400
Annual Out-of-Pocket Maximum[2]		
■ Individual	$2,500	$5,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$5,000	$10,000
Lifetime Maximum Benefit[3] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. A Copay does not apply when you visit a non-Network provider.

[2]Copays do not apply toward the Annual Deductible. Copays do apply toward the medical Out-of-Pocket Maximum. The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services.

[3]Generally the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs;

rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for certain Covered Health Services, are based on the Recognized Amount as defined in Section 12, *Glossary*.

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network**
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	Office Visit: PCP: $25 then 100% Specialist: $40 then 100% Outpatient setting: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 80% after you meet the Network Annual Deductible *Air Ambulance* 80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 60% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Network Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Cellular and Gene Therapy	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.	Non-Network Benefits are not available.
Clinical Trials Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	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.	
Congenital Heart Disease (CHD) Surgery Services Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	Office Visit: PCP: $25 then 100% Specialist: $40 then 100%	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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section.	
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 2: *How the Plan Works*.	*True Emergency* 80% after you meet the Annual Deductible *Non True Emergency* 80% after you meet the Annual Deductible	*True Emergency* 80% after you meet the Network Annual Deductible *Non True Emergency* 80% after you meet the Network Annual Deductible
Fertility Preservation for Iatrogenic Infertility See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Fertility Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
See Section 5, *Additional Coverage Details*, for limits	under each Covered Health Service category in this section.	
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	
Hearing Aids	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	*Physician's office* 100% *All other locations* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment ■ Virtual Behavioral Health Therapy & Coaching.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible **<u>Designated Network (AbleTo Therapy 360)</u>** 100%	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Neonatal Services	See Section 6, *Clinical Programs & Resources,* for Program Details.	
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling Up to 12 visits per condition per calendar year	Office Visit: PCP: $25 then 100% Specialist: $40 then 100% Outpatient Setting: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery (The Plan pays Benefits only for Covered Health Services provided through *Bariatric Resource Services*) See *Obesity Surgery* in Section 5, *Additional Coverage Details*.	80% after you meet the Annual Deductible	Non-Network Benefits are not available.
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	Office Visit: PCP: $25 then 100% Specialist: $40 then 100% Outpatient Setting: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable Annual Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 2, *How the Plan Works*, under *Eligible Expenses*.	<u>Office Visit:</u> PCP: $25 then 100% Specialist: $40 then 100% <u>Outpatient Setting:</u> 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury (Copay is per visit) - Primary Physician - Specialist Physician	100% after you pay a $25 Copay 100% after you pay a $40 Copay	60% 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.	
Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100% 100%	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible 60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Colonoscopy	100%	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.	
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services	100% for Office Visits Outpatient setting 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ All other services (Copay is per visit)		
- Primary Physician	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
- Specialist Physician	100% after you pay a $40 Copay	60% after you meet the Annual Deductible
- Outpatient setting	80% after you meet the Annual Deductible	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	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**
Up to 150 days per Covered Person per calendar year		
Substance-Related and Addictive Disorders Services ■ Inpatient Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Administrator or search for a Network program on www.myuhc.com. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment	100% 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	<u>Office Visit:</u> PCP: $25 then 100% Specialist: $40 then 100%	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	<u>Office Visit:</u> PCP $25 then 100% Specialist: $40 then 100% <u>All other places of service:</u> 80% after you meet the Annual Deductible For Dialysis Services: 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible For Dialysis services, Non-Network Benefits are not available
Transplantation Services		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Non-Network Benefits include services provided at a facility that is not a Designated Provider and services provided at a non-Network facility. See *Transplantation Services* in Section 5, *Additional Coverage Details.*	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.	
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
24/7 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.	100% after you pay a $25 Copay	Non-Network Benefits are not available.
Vision Examinations (Copay is per visit)	*Routine Vision Examination:* 100% *Non-Routine Vision and refraction eye examination:*	
■ Primary Physician	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $40 Copay	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] Please obtain prior authorization before receiving Covered Health Services, as described in Section 5, *Additional Coverage Details.*

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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. For Non-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

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
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises.
If you do not 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 UnitedHealthcare 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 facility participating in the CHD Resource Services Program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items	Insulin pumps and pump supplies and continuous glucose monitors for the management and treatment of diabetes based upon your medical needs. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under the Plan's prescription drug benefit.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.

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 do not 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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits for dedicated speech generating 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.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

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 do not 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 two business days 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 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 two business days 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.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under *Fertility Services*. This Benefit limit also includes services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services*. Benefits are further limited to one cycle of fertility

preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan.

Fertility Services

Therapeutic services for the treatment of fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to InVitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection - ICSI.
  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- Insemination procedures artificial insemination (AI) and intrauterine insemination (IUI).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the *SPD*. Benefits for diagnostic tests are described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, *Physician's Office Services – Sickness and Injury.*

Enhanced Benefit Coverage

Donor Coverage: The Plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The Plan will not pay for donor charges associated with compensation or administrative services.

Criteria to be eligible for Benefits

- You do not need to have a diagnosis of Infertility in order to be eligible to receive services described above.

To be eligible for fertility services, you must meet the following:

- You are a female:
  - under age 44 and using own oocytes (eggs), or
  - under age 55 and using donor oocytes (eggs).

  Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Child Dependents are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

Any combination of Network Benefits and Non-Network Benefits are limited to $25,000 per Covered Person for medical Benefits during the entire period you are covered under the Plan. There is a separate prescription drug lifetime maximum under your CVS Caremark Prescription Drug Benefit. This limit includes Benefits as described under *Fertility Preservation for Iatrogenic Infertility* and for related services as described under *Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services.*

Charges for the following apply toward the Infertility lifetime maximum:

- Hospital outpatient facility.
- Surgeon's and assistant surgeon's fees.
- Anesthesia.
- Lab and x-ray.
- Diagnostic services.
- Physician's office visits.
- Consultations.
- Injections.

Fertility Solutions (FS) Program

Please see Section 6, *Clinical Programs & Resources* for details.

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 provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

For questions about your Gender Dysphoria Benefits under this Plan, please call the number on your ID card.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

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.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.

- A written prescription.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $2,500 as a single purchase (including repair/replacement) per hearing impaired ear every 36 months.

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 from the Claims Administrator five business days before receiving services ,including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you do not 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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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 under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

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 Genetic Testing, stress echocardiography and transthoracic echocardiogram, and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you do not obtain prior authorization from the Claims Administrator 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 CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received. If you do not 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

The AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

There are no Deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from or to provide notification to the Claims 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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before 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 Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you do not obtain prior authorization from or provide notification to the Claims 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 twelve individual sessions per calendar year for each medical condition.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 6*, Clinical Programs and Resources* for more information on the BRS program.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits under this section do not include medications for the treatment of Infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Inflammatory Injectable Medications (site of care). If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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*.

Please Note
Your Physician does not have a copy of your Benefit Booklet and is not responsible for knowing or communicating your Benefits.

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year.)

Benefit limits will be the same as, and combined with, those stated under *Fertility Services*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This Benefit limit also includes services as described under *Fertility Preservation for Iatrogenic Infertility*.

Benefits for Assisted Reproductive Technology (ART) for related services as described under *Fertility Services* do not include the Preimplantation genetic testing for the specific genetic disorder.

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.

The Plan does not provide coverage for:

- Doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Post-delivery – services/treatment for the newborn of a dependent daughter.

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 do not 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 Resources*, 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 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 your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 stroke;
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals 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 the following be provided:

- medical records,
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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, or Congenital Anomaly. Rehabilitation services will be reviewed after 40 visits for medical necessity.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Claims Administrator or search for a Network program on www.myuhc.com**.**

Prior Authorization Requirement
Please remember, for Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.

- A non-scheduled admission, you must provide notification to the Claims Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from or to provide notification to the Claims 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 cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization 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 do not 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, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you do not 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 including CAR-T cell therapy for malignancies 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 including CAR-T cell therapy for malignancies, 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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization 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 as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

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.

24/7 Virtual Visits

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

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).

- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility 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, bio microscopy, tonometry, visual acuity, subjective, refraction, accommodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to one wig/hair piece up to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including Complex Medical Conditions Programs & Services.

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.

Consumer Solutions and Self-Service Tools

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 your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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 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;
- Access all of the content and wellness topics from NurseLine℠;
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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**.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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 your ID card.

Complex Medical Conditions Programs & Services

Bariatric Resource Services (BRS)

Your Plan offers the Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Cancer Resource Services (CRS) Program

Your Plan offers a Cancer Resource Services (CRS) Program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

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 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).*

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD

surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Kidney Resource Services (KRS) Program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS Program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS Program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS Program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

Specialist Management Solutions Program

A Surgical Advocate is a surgical solution that opens the door to quality, affordable outpatient specialty and surgical care and is part of your UnitedHealthcare Duke Energy Team. A Surgical Advocate will work closely with you on every aspect of your surgery to ensure the highest quality of care. Services include connecting you with specialists/ surgeons to help you choose the most appropriate setting for your outpatient surgery/procedures.

Specialties may include, but are not limited to:

- Cardiovascular

- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine*
- Ophthalmology
- Orthopedic*
- Pain Management
- Podiatry
- Urology
- Women's Health

*For Orthopedic and Musculoskeletal care, surgical advocates partner with registered orthopedic nurses to help:

- Manage your pain; and
- Understand your treatment options.
- Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier. Available at no extra cost as part of your health plan. Visit: http://startkaia.com/uhc

If you are planning an inpatient knee, hip or spine procedure, you are required to enroll in the Specialist Management Solutions Program prior to surgery otherwise there is no coverage. You may also be required to use a center of excellence designated facility. The nurses can help you:

- Find a designated provider and facility for your surgery;
- Find other resources such as physical therapists and durable medical equipment;
- Coordinate your surgery with the designated facility; and
- Prepare for both your surgery and recovery.

For inpatient back, knee, hip or spine surgeries, if you live within **50** miles of a designated facility, use of the designated facility is also required. If you reside more than **50** miles from a designated provider and facility, a Travel & Lodging benefit is available for both inpatient and outpatient procedures.

If you or a family member will be having an upcoming surgery or want to enroll in the program, please call the number on your ID card and ask to speak to a surgical advocate.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions, you may be eligible to participate in a disease management program at no additional 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
- 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 your ID card.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

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 Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.

- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person 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 Specialist Management Solutions 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 Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Wellness Programs

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 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 your ID card.

Real Appeal

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no Deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through **www.realappeal.com**, or at the number shown on your ID card.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.

- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the Plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Fertility Solutions

Fertility Solutions is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on fertility treatment options.
- Access to specialized Network facilities and Physicians for fertility services.
- Education, specialized clinical counseling, treatment options and access to national Network of premier fertility treatment clinics.

The Plan pays Benefits for the fertility services described above when provided by Designated Providers participating in the Fertility Solutions program.

Covered Persons who do not live within a 60-mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment.

For fertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

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, animal-assisted 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 dedicated speech generating 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 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding.

8. Powered and non-powered exoskeleton devices.

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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

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.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

8. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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.
   - 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, except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.

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*.
- Urinary catheters for which Benefits are provided as described under *Urinary Catheters* 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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

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.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - 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 as described under *Wigs* in Section 5, *Additional Coverage Details*.

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 impairment 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. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

18. Intracellular micronutrient testing.

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.

Reproduction

1. The following fertility treatment-related services:

   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
   - Ovulation predictor kits.

2. The following services related to a Gestational Carrier or Surrogate:

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.

4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen
   - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. The reversal of voluntary sterilization.

6. Health care services and related expenses for 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) or medically necessary termination of pregnancy through the first 16 weeks of pregnancy.

7. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

8. Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

9. Fertility treatment following unsuccessful reversal of voluntary sterilization.

10. Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

11. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

12. Elective fertility preservation.

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 animal organs.

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 *Complex Medical Conditions Travel and Lodging Assistance Program* described in Section 6, *Clinical Programs and Resources*, and except as identified under *Travel and Lodging* in Section 2, *How the Plan Works.* Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 12, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

6. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*.

7. Rest cures.

8. Services of personal care attendants.

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3 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. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

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.

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*.

12. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible, Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes 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 Benefit.*

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the denial;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;

- if an internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If you would like paper copies of the EOBs, you may call the number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.

- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy, or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal,

so that you will have a reasonable opportunity to respond prior to that date. In addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action, and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**

If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance

with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice

of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care,

continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final decision on the claim under the internal appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.
- **Secondary Plan.** The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary plan and the plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the plan that covered the parent longest is the Primary plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the Custodial Parent.

b) The plan covering the Custodial Parent's spouse.

c) The plan covering the non-Custodial Parent.

d) The plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan, and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services 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, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Annual 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is **a**n Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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 Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.

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 an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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 carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- 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, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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 you that are payable under the Plan. If the refund is due from a person or organization other than you, 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 payment in connection with services provided to persons under other plans for which the Claims Administrator processes 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 either:

- 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

UnitedHealthcare has agreements in place that govern the relationships between it, the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 administer payment of 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 are not responsible 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination of or modifications to the Plan.

The Claims Administrator is not the Plan Administrator of the Plan, as that term is used in *ERISA*. The Claims Administrator is a named fiduciary of the Plan, as that term is used in *ERISA*, solely with respect to the Claims Administrator's authority to decide claims for Benefits under the Plan and appeals of denied claims for Benefits under the Plan. If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

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.

Interpretation of Benefits

Duke Energy and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Duke Energy and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims

Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Duke Energy may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Duke Energy does so in any particular case shall not in any way be deemed to require Duke Energy to do so in other similar cases.

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, including provider billing and provider payment records. 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 4, *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

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.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible). The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, 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 charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount, when applicable.

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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations.*

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6, *Clinical Programs and Resources*, "Covered Person" means all domestic Employees who are eligible for and enrolled in the Plan and their Dependents age 18 and over who are eligible for and enrolled 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.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Dispensing Entity - a pharmacy, provider, 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 Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services

provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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 – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical

transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 Service(s) – 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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.

Fertility Solutions (FS) – a Program administered by UnitedHealthcare or its affiliates made available to you by the Company. The FS Program provides:

- Specialized clinical consulting services to Covered Persons to educate on Infertility treatment options.
- Access to specialized Network facilities and Physicians for Infertility services.

Gender Dysphoria - A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;

- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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 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, service 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), service site 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. UHCprovider.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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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 – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a Program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS Program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The PPO Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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 a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Copayment, Coinsurance and applicable Annual Deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - 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**.**

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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 - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care – care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT III – NONDISCRIMINATION & 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 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 UnitedHealth**c**are Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The 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: 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the 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 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	¯(=™ ¬φ¯ xi ™Ɱ‹ ⌡ M å ®8 H ı; Ş≠é 8 } é µ+ñ" ⌂ µ Lâ MC: ∫ ™ ` Mɟ - ‹ Ωα(Ғ xĚ ®↓ +™8 å ÷b¯‹ é +· {(€ xât' 8 U8 MU- ¬ aě M· ¸ €) ®0™ ŀ ¶⌂ 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 nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	š ĂąĽ¯ð Ę š ĂœĘĽ đĽ ő¢, Ž ă ĂIJĘ - Ιў ě ăIJ¹ κ ĂIJĘ Ž ž lĆ ¹ IĆ=Ľ Þ č Ilę¹ IĎŇ – ¹ Ę Ι¯ õ˜ Í ő¡ ĂĽ Þd'Ă –Şlę ő Ą LĂ Ă› Œ Ę –Ą LĂ ¹ ⁄ Ă (Ű) ĚŇĚ ¾ã Ą TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	[illegible] TTY 711
10. Cherokee	¯ Šľě ýğ ŔŮą² Ŕ ŔľĽ Ŕ ŻþαŦ Đ Źź ğ ř ³ ýń Ŕ−þř Ŕ þŮĽ ř Ŕ Đ¯ⁿ Ľ ŔŽ, ¹ ŀďĽ Ň 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	p y t éá~ t ÜAgz éy r r T t ép y Ü¨ x ÜÅÜy ÜRy Ü¶Ép à y ¢ ~ ~ Ü ë T ás aÜ{ g é Jâx ÜÅz Üy Ükoá~ t pRà a {~ Ü p y Ü{ ÜÉgq Ē Ü ID aÜnu {t à Jfâ ày ÜRU u ¢ ké , □ y Éw { vë t wR{ Xu { aë a {ë ñ r wÜ ë TTY 600
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 निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल,फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti 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	နအိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒဉ်နဝဲလၢတလိဉ်ဟ့ဉ်အပ့ၤဘဉ်နူဉ်လီၤ.လၢတၢ်ကယ့နူၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘဉ်လီတဲစိအကျိၤလၢကရၢဖိအတလိဉ်ဟ့ဉ်အပ့ၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချ့အတၢ်ရဲဉ်တၢ်ကျဲအကးအလိၤဒီးဆီဉ်လီၤနီၢ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	□□□ □□□ □□□ □□□ □□□ □□ □□□□ □□ □ □□ □□□ □□□□.□□□□ □□□□ □□□□ □□□ □□ ID□□□ □□□ □□ □□ □□□□□ □□□□ 0□□ □□□□□. 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 پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ĪǣĔij ŵǣŴ♦ Ŵ♠ Ēĩ♦ǾĠųn ☻Ĕij ♣Ā♥ ĥǿĔĉ Ħ◦ ĒŴǾÅij ☼ǣĔĀā Ĕij Ŵĥ'ų ij ℓ Ĕā Ĕ☼ĉ ♂ĪǣĔij ŵǣŵ ♀ǣĔĨ ♣ǿǣĔ♥. ĥǣ ĉ ŵ☼Ǿĉ ♂ij Ĕ♥ ℓ Ĕā Ĕ,ħĲ□ ♠Ĉ ĔĈ ▪ Ĕ♥ ĥ◦ ☻ħĲ◦ Ēāųn ŵāĔ◦ųn ā Ē▪ ĔŴ☻Ŵĩ♦Ǿ Ēħ ĩ ǾĀij ňų♦ ā Ē▪ Ĕ♣ŵ☻☼ĉ ♂ĪǣĔij , ǣ♦ ĥ◦ ☻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.
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 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

Language	Translated Taglines
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 wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	kÇ-hÑ Ü S pj Ås-z ~Äyña {| ~T k~Rk Ñ-j \ ~v Åt Ç'k p•pk \ v o m~RÄn \ ~v | ÖmÇ-z ÅX wU kÇ-hÑ Ö l pw~o S Uh ÅÄmk Ñ ^ X f ~w ç•Åt r v ç Ü o r v f Å Å~U 711 kÑ ~w \ vÜ0 mr Ü
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
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

Language	Translated Taglines
	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] 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	Z| ºPj ≠a zæ | Î øPΘ†H !! ¢Å| l'Ï Ñ Pv º x ←∑ º Çx ºź †z ΏΩĆq Θ†OŰH ` øÉ ` ø┼VPε ∂] ` → q áv ¢←ÖŰÑ→Ñ Pj Ì H ↨ Ȿ ‖ΩÑь \ Θ™ŰÑ╬æH q g •Aα †ź å v1 ╝j ȩΓ _Ü Ᵽv zæ øΐ ĹЪ ź ⇕ ,Ö0 φ H ź ä Ĺ┼□TTY 711
55. Thai	•¥¬Ã∏∏Ë%µ¢"•»'¬´å√ÕÃÿË∆"£ç∈Ã,∫ ¡ 'À'£œ®¥%µçµ√%oå•å,´ ç√ Õ¢∂ç®'ƒ£œÃ¬ º ∆¡ 'À' ,º ƒµ,∏ƒ.ä∏∑Õ¬'√∆£,∏¿ƒ∏Ë∫ ª ∂ƒº ƒ'©∂»ÃÕƒ" · Ω Ã£¡ 'ø£œ®¥ · ∆ç¢µ 0 ÃÕƒ"Ω∏Ë»'¬ª ¢øƒå®∏®'ƒ%µ∫Õƒ¢'ƒø∈ ,º ƒµ,∏ƒ∑Õ¬'√∆£ 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

Language	Translated Taglines
	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 קארטל , דרוקט 0. TTY 711 ID
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 Active Medical Plan

TABLE OF CONTENTS

SECTION 1 – WELCOME

The Duke Energy Active Medical Plan ("Medical Plan") options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation ("Duke Energy") (individually or collectively referred to with its affiliated companies as the "Company," as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 66,000 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 66,000 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 by calling 800-378-5697.

- **Option 2:** Use the CVS Caremark mobile app on your smart phone to photograph and submit your prescription.

- **Option 3:** 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, deductible and coinsurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service Pharmacy 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 automatic refill service.

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. Coverage requires enrollment in the Fertility Solutions Program. Please call 877-214-2930 to enroll. Once enrollment is completed, infertility agents will be covered at 100% after the standard co-pay, coinsurance and/or deductible, as applicable, up to $10,000 per person per lifetime, then the participant pays 100% of the cost of the drug.
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime, 100% covered with no co-pay or coinsurance)
- Anti-obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)

- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Active Dental Plan)

Medical Plan and Health Care Spending Account

The prescription drug program co-pays and coinsurance amounts are not subject to or applied toward your Medical Plan annual deductibles or ***medical*** out-of-pocket maximums, if applicable. This means that the prescription drug program under the Medical Plan provides applicable benefits for covered prescription drug expenses even before you satisfy your annual deductible, if applicable.

The prescription drug program co-pays and coinsurance amounts are applied toward your Medical Plan annual ***prescription drug*** out-of-pocket maximums, if applicable. This means that once you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums, you do not have to pay any further co-pays or coinsurance amounts for covered prescription drugs. Please note that the Medical Plan has separate annual ***medical*** out-of-pocket maximums. If you satisfy the Medical Plan's separate annual ***medical*** out-of-pocket maximums, but have not yet satisfied your applicable annual ***prescription drug*** out-of-pocket maximums, you still have to pay any applicable co-pay or coinsurance amount for covered prescription drugs until you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums.

If you have enrolled in a Health Care Spending Account (HCSA) and are eligible to access HCSA funds, you may pay any prescription drug co-pays and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCSA or using your HCSA debit card.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your co-pay and/or coinsurance amounts for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at **www.Caremark.com** or call CVS Caremark Customer Service at 888-797-8912. This listing is also available for viewing by employees on the Duke Energy Portal.

Refer to the prescription drug benefit summary on page 21 for more information about applicable co-pays and/or coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and
- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- COVID-19
- Dengue Fever
- 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)
- RSV (Adult)
- 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.

Caremark Cost Saver® & GoodRx®

Beginning January 1, 2024, your prescription drug program coordinates with GoodRx. This means that when the GoodRx price for a generic, non-specialty drug is lower than the amount you would pay under the Medical Plan's prescription drug coverage, you will automatically pay the lower GoodRx price when you check out at your pharmacy, and 100% of the GoodRx price will apply to your applicable Medical Plan annual deductible. If you have any questions about GoodRx, contact CVS Caremark Customer Service at 888-797-8912.

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 certain participants. Please see the section titled "Medicare Part B Medications" below for more details.

Medicare Part B Medications

(*Applicable only to Medicare Part B enrollees*)

If you have Medicare Part B coverage, you will be able to fill prescriptions as described below:

Take your prescription to a Medicare Part B retail pharmacy. If you choose to use a Medicare Part B retail pharmacy for your Medicare Part B medication or supply needs, you will be asked to present your Medicare ID card.

- The participating Medicare Part B retail pharmacy will work with you to bill Medicare on your behalf.
- Most independent pharmacies and national chains are Medicare Part B providers. If you want to locate a retail pharmacy that is a Medicare Part B provider, visit the Medicare website at **www.medicare.gov**.

Medicare Part B allows only 30 days worth of medication except for Diabetic Supplies. For Diabetic Supplies, you can receive up to a 90-day supply; however, you can only test up to 3 times a day. If you test more than 3 times a day, you will need to provide further documentation as to why it is necessary for you to test so often. Further documentation can include the results of blood tests conducted by your physician's office.

All prescriptions must be in writing; CVS Caremark cannot take a verbal prescription over the phone. However, CVS Caremark can accept a faxed copy.

Call CVS Caremark at 888-797-8912 to find out what types of drugs or supplies are covered by Medicare Part B.

CVS Caremark needs to have an original Assignment of Benefits (AOB) form filled out before your Medicare Part B prescriptions can 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, 2024, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2025 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 whose initial effective date with CVS Caremark is January 1, 2024 would have 45 days (until February 14, 2024) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims
In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CVS Caremark sends such a notice of missing information, and the determination period will resume on the date you respond to the notice. You will have at least 45 days to respond to the request for information.

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)
In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims
If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination
In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under section 502(a) of ERISA following any final internal adverse benefit determination on appeal and any time limits for filing such a civil action;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- a statement that a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim is available free of charge upon request;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims;

- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If the adverse benefit determination relates to an urgent care claim, the information described above may be provided to you orally within the required time frame, provided that a written or electronic notification is provided no later than 3 days after the oral notification.

When You Have a Complaint or an Appeal
If your claim is denied, you may request a full review by CVS Caremark within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and participant ID number;
- your doctor's name and telephone number;
- the name of the medication; and
- any additional information from your pharmacy or medical provider that will assist CVS Caremark in completing its review of your appeal, such as documents, records, questions or comments.

Documents, records, written comments, and other information in support of your appeal should accompany your request. This information will be considered by CVS Caremark in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. CVS Caremark will review your claim without granting any deference to the initial decision regarding your claim. Also, no reviewer may be a person that was involved in making the initial decision regarding your claim, or a subordinate to that person. If the claim was based, in whole or in part, on a medical judgment in reviewing the claim, CVS Caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person (or a subordinate of a person) consulted by CVS Caremark in deciding the initial claim. Your appeal should be mailed to:

Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark

at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

To the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;
- CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the prescription drug program (or at the direction of the prescription drug program) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and
- if the denial of your appeal is based on a new or additional rationale, CVS Caremark will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Appeal Notification for Post-Service Claims
In the case of a post-service claim, CVS Caremark will notify you of its decision on your appeal within 30 days of its receipt of your request for review.

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Timing of Appeal Notification for Urgent Care Claims
In the case of an urgent care claim, CVS Caremark will provide notification of its determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate the external appeals process;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final internal adverse benefit determination and any applicable time limits for bringing such an action;

- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge;
- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Second Level Appeal Process for Post-Service Claims
If your post-service claim is denied on appeal, you have a right to bring a second appeal within 30 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 30 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Second Level Appeal Process for Pre-Service Claims
If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Voluntary External Review Program
Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and is available only for certain types of adverse benefit determinations, as defined by federal regulations.

If you wish to file a request for external review, you must submit your request within 4 months of the date of your receipt of CVS Caremark's final internal adverse determination on your

appeal. Contact CVS Caremark at the telephone number shown on your CVS Caremark prescription ID card for more information on how to file a request for external review of your appeal.

CVS Caremark will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the 4-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If your claim is eligible for external review, CVS Caremark will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the prescription drug program;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If your request for external review relates to an urgent care claim, CVS Caremark will determine if the appeal is eligible for the voluntary external review program and will provide you with written notice of its determination immediately. If the urgent care claim is eligible for external review, CVS Caremark will assign the urgent care claim to an IRO as described above. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to you and the Medical Plan of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, the IRO will provide you and the Medical Plan with a written confirmation of its decision within 48 hours after the date of providing the notice.

Legal Action
You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the internal appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority
The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling, unless overturned through the voluntary external review program described above. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to CVS Caremark at the address listed above. Call CVS Caremark Customer Service for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. This guide contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable co-pays, coinsurance and plan limits, please call CVS Caremark Customer Service or visit ***www.Caremark.com****. For more detailed information on the Medical Plan, refer to the Duke Energy Active Medical Plan General Information Booklet and UnitedHealthcare® Benefits Booklet sections of this Summary Plan Description.*

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 **$150***	**50%** of the cost of the medication up to a maximum of **$300***
***Prescription Drug Out-of-Pocket Maximum** These amounts apply to only the prescription drug out-of-pocket maximum	$2,000 per year for individual coverage / $4,000 per year for family coverage	

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Teladoc Medical Experts' Services for the Duke Energy Active Medical Plan

January 1, 2024

Table of Contents

An Introduction to Teladoc Medical Experts Services

Duke Energy Corporation (Duke Energy) offers comprehensive coverage under the Duke Energy Active Medical Plan (Plan) that includes medical, surgical, hospitalization, prescription drug, wellness and disease management benefits, as well as expert medical opinions and certain onsite health care services. This booklet provides a summary of the expert medical opinion services available under the Plan through Teladoc Medical Experts, and is part of the summary plan description for the Plan.

Duke Energy is making the Teladoc Medical Experts services described in this booklet (Teladoc Medical Experts Services) available to you because it recognizes the challenges and stresses that can occur when you are uncertain about a medical diagnosis or treatment plan, and wants to provide resources to help you make medical decisions with confidence.

Teladoc Medical Experts provides medical information only and does not provide medical care, diagnosis or treatment. The information you receive from Teladoc Medical Experts is intended to supplement, not replace, the medical care provided by your treating physician, and to help you and your treating physician make informed decisions regarding your diagnosis and/or treatment plan. Many doctors find that collaboration with other experts is very helpful, especially in complex situations. Teladoc Medical Experts enables doctors to collaborate in a new way.

The Teladoc Medical Experts' Services

Eligibility to Use the Teladoc Medical Experts Services

You are eligible to use the Teladoc Medical Experts Services only if you are enrolled in the Plan, and your dependents are eligible to use the Teladoc Medical Experts Services only if they are enrolled in the Plan.

You are not eligible to use the Teladoc Medical Experts Services if you are not enrolled in the Plan, and your dependents are not eligible to use the Teladoc Medical Experts Services if they are not enrolled in the Plan.

See the Eligibility section of the Duke Energy Active Medical Plan General Information booklet for more information about the Plan's eligibility requirements.

Description of the Teladoc Medical Experts Services

You have access to the following Teladoc Medical Experts Services:

1. **"Expert Medical Opinion"** is a service whereby a Teladoc Medical Expert reviews your diagnosis and/or treatment plan and provides a detailed recommendation. Teladoc Medical Experts collects all of your records, images and test samples and provides them to a Teladoc Medical Expert for review. The Teladoc Medical Expert reviews everything in detail and creates a comprehensive report, either confirming what you've been told by your treating physician or recommending a change. You can share this report with your treating physician to help you and your treating physician make treatment decisions.

2. **"Critical Care Expert Review"** is an Expert Review as described above, but for individuals in an in-patient medical setting experiencing a traumatic or catastrophic event such as traumatic brain injury, spinal cord injury, multi-organ failure, serious burns or premature birth. With a Critical

Care Expert Review, Teladoc Medical Experts will address, in real time, your immediate and highly complex needs. Critical Care Expert Reviews are available 24 hours a day, 7 days a week, 365 days a year.

Cost for Teladoc Medical Experts Services

Teladoc Medical Experts Services are offered to you at no cost. The Plan covers all Teladoc Medical Experts costs. If you decide to obtain additional tests and/or services based on the information you obtain from Teladoc Medical Experts, these additional tests and/or services, as applicable, may be covered under the terms of the Plan, or you may have to pay for these additional tests and services out-of-pocket. Refer to the other portions of the Plan's Summary Plan Description for additional information regarding covered services and benefits under the Plan.

Do I Have to Travel or Collect My Own Medical Records?

No. You make a call to Teladoc Medical Experts and they handle everything for you. All of your contact with Teladoc Medical Experts is over the phone or the Internet. You do not need to travel or contact your doctor(s) to obtain records, images or other information related to your medical case. In rare situations, if you doctor(s) does not respond to Teladoc Medical Experts' requests for records we may ask you to contact your doctor(s) directly.

What Type of Information Does Teladoc Medical Experts Provide?

Teladoc Medical Experts provides medical information only and does not provide medical care, diagnosis or treatment. The information you receive from Teladoc Medical Experts is intended to help you and your treating physician make informed decisions regarding your diagnosis and/or treatment plan. You remain in full control of your healthcare decision making, and you can decide whether to share the report with your treating physician. Teladoc Medical Experts will not share your report with your treating physician without your authorization.

How Does Teladoc Medical Experts Expert Medical Opinion Process Work?

- You call 1-800-835-2362 or visit Teladoc.com/MedicalExperts.
- A dedicated Teladoc Medical Experts Physician will have an in-depth discussion with you about your medical condition and obtain a full health history.
- With your written approval, Teladoc Medical Experts will collect all appropriate medical records, images and test samples.
- The Teladoc Medical Experts clinical team will then conduct a comprehensive analysis of your case and select the most appropriate Teladoc Medical Expert(s).
- The Teladoc Medical Expert(s) will review your case and provide Teladoc Medical Experts with a detailed report that includes his or her recommendations.
- Teladoc Medical Experts will share the report with you, but will not share the report with your treating physician without your consent.

Throughout the process, the Teladoc Medical Experts Member Advocate is available to answer your questions. Depending on your case, your Teladoc Medical Experts Member Advocate also may follow up with you to see if you need any other help.

How Will Teladoc Medical Experts Work With My Treating Physician?

Teladoc Medical Experts share the Teladoc Medical Expert's findings with you – and only with you. Teladoc Medical Experts will not share the report with your treating physician without your consent. The goal is to provide useful information so that you and your treating physician can make more informed decisions together regarding treatment.

Can Teladoc Medical Experts Services be Used in Emergency Situations?

For urgent medical situations where immediate intervention is requested, Teladoc Medical Experts Services are not an option. In these situations, Teladoc Medical Experts may be able to provide you with appropriate questions to ask your provider before you proceed with treatment. However, you should seek immediate treatment as directed by your doctor. Once your condition has stabilized, Teladoc Medical Experts can evaluate your case for future treatment options.

Am I required to use Teladoc Medical Experts Services?

No. Participation is completely voluntary.

How Will Teladoc Medical Experts Maintain My Privacy?

Teladoc Medical Experts complies with all relevant state and federal laws and regulations regarding privacy and confidentiality, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To provide the Teladoc Medical Experts Services, Teladoc Medical Experts will need to collect, use and disclose your protected health information (PHI). When you initiate the Teladoc Medical Experts Services, you will be provided with more detailed information regarding the Teladoc Medical Experts Services and the confidentiality of your PHI.

How to File a Claim or an Appeal

Request

In order to initiate the Teladoc Medical Experts Services, you should call 1-800-835-2362 or visit Teladoc.com/MedicalExperts. A request to use the Teladoc Medical Experts Services is referred to throughout this document as a "Claim".

Teladoc Medical Experts has been given responsibility for reviewing initial Claims and reviewing all Claim denials. Neither Duke Energy nor the Duke Energy Benefits Committee has any discretionary authority with respect to the review of initial Claims or the review of Claim denials.

Denial

It is very unlikely that you would be denied the use of Teladoc Medical Experts Services. However, if your Claim is denied, you have the rights outlined in this section. The denial, reduction or termination of a service, supply, or benefit is called an "Adverse Benefit Determination". With respect to the Teladoc Medical Experts Services, reasons for such an Adverse Benefit Determination may include, but are not limited to:

- Your eligibility for the Teladoc Medical Experts Services, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit); or
- Your intention to use the Teladoc Medical Experts Services for litigation or legal reasons (*e.g.*, for purposes of a medical malpractice case); or
- Your request to use the Teladoc Medical Experts Services for an excluded diagnosis (*e.g.,* for a mental health condition); or
- Your request to use certain Teladoc Medical Experts Services when you do not have a sufficient or recent diagnostic history (with or without a diagnosis); or
- Your refusal to sign an authorization form for Teladoc Medical Experts to collect your medical information when such information is necessary for the type of service you requested.

In the event of an Adverse Benefit Determination, Teladoc Medical Experts will provide you or your representative with notice of such Adverse Benefit Determination (Notice of Adverse Benefit Determination) within 30 days after receiving your Claim. However, if more time is needed to make a determination as to whether to deny your Claim due to matters beyond Teladoc Medical Experts' control, Teladoc Medical Experts will notify you or your representative that an extension is needed (Extension Notice). Teladoc Medical Experts will provide you with this Extension Notice within 30 days of receiving your Claim. 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 your original Claim.

If an extension is needed because necessary information is missing from your Claim, the Extension Notice will specify what information is needed (Request for Information). The determination period will be suspended on the date Teladoc Medical Experts sends such a Request for Information, and the determination period will resume on the date you or your representative responds to the Request for Information. You will have at least 45 days to respond to the Request for Information.

Notice of Adverse Determination

In the event of an Adverse Benefit Determination, in whole or in part, you (or your authorized representative) will be notified of the Adverse Benefit Determination in writing or electronically. Your Notice of Adverse Benefit Determination will provide you or your representative with the following information:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific references to the pertinent Plan provisions on which the Adverse Benefit Determination is based;
- a description of any additional information or material necessary to process the Claim properly and an explanation of why such information or material is necessary;
- an explanation of the review procedures applicable to your request for Teladoc Medical Experts Services and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) following any final Adverse Benefit Determination on review and any time limits for filing such a civil action; and
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request.

Appeal of Adverse Determination

If your Claim is denied, upon receipt of your Notice of Adverse Benefit Determination you (or your authorized representative) have 180 calendar days to appeal the Adverse Benefit Determination. If you (or your authorized representative) do not file an appeal within 180 days after receipt of the Notice of Adverse Benefit Determination, your Claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue.

If you choose to submit an appeal of your Adverse Benefit Determination, you must send a written appeal (Notice of Appeal of Adverse Benefit Determination) to the following address:

Teladoc Medical Experts Medical Director
Teladoc Health, Inc.
1250 Hancock St., Suite 501N
Quincy, MA 02169

When reviewing your Notice of Appeal of Adverse Benefit Determination, Teladoc Medical Experts will consider any new information that you provide that was not available or utilized when the initial determination was made. Someone at Teladoc Medical Experts, other than an individual involved in the initial determination or a subordinate of such individual, will make the determination on appeal.

Teladoc Medical Experts will notify you of its decision on your appeal within 60 days of its receipt of your Notice of Appeal of Adverse Benefit Determination. Teladoc Medical Experts' decision is referred to as "Notice of Adverse Benefit Determination on Appeal."

Every Notice of Adverse Benefit Determination on Appeal will be provided in writing or electronically and will include Teladoc Medical Experts' ultimate determination and, if such determination is an adverse determination, will include:

- the specific reason or reasons for the Adverse Benefit Determination on appeal;
- specific references to the pertinent Plan provisions on which the Adverse Benefit 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 regarding your right to bring a civil action under Section 502(a) of ERISA following any final Adverse Benefit Determination on your appeal 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 Benefit Determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request; 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."

After completing all mandatory appeal levels, you have the right to bring a civil action under 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 and appeals process. You may not initiate a legal action against Teladoc Medical Experts, the Company, the Plan or the Plan Administrator until you have completed the appeal process. No legal action may be brought more than one year following a final decision on the Claim under the appeal process. 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 and denied Claims on review includes the full power and discretion to interpret the Teladoc Medical Experts Services and to make factual determinations, with Teladoc Medical Experts' decisions, interpretations and factual determinations controlling. Requests for information regarding individual Claims, or review of a denied Claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial Claim, or to decide the denied Claim on review, as applicable.

Retiree Medical Plan

Catastrophic option

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: UnitedHealthcare Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: CVS Caremark Prescription Drug Guide (includes Summary of Prescription Drug 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 1, 2024 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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.

Eligibility

Eligible Retirees

If your employment terminates on or after January 1, 2024, 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.

Other Retiree Eligibility Information

If your employment with Duke Energy and its affiliates terminated before January 1, 2024, your eligibility for retiree coverage is governed by the eligibility rules in effect at that time.

If you were previously employed with Duke Energy and its affiliates and you are rehired, you will be eligible for retiree coverage under the Medical Plan upon your subsequent termination of employment only if either (1) you satisfied the eligibility requirements for retiree coverage under the Medical Plan upon your previous termination of employment (i.e., you were at least age 50 and credited with at least 5 years of retiree eligibility service upon your previous termination of

employment) or (2) you satisfy the eligibility requirements for retiree coverage under the Medical Plan upon your subsequent termination of employment based solely on retiree eligibility service credited during your subsequent period of employment (i.e., you are at least age 50 at your subsequent termination of employment and are credited with at least 5 years of retiree eligibility service during your subsequent period of employment) and you timely enroll in retiree coverage under the Medical Plan following your subsequent period of employment. Your retiree eligibility service from your previous period of employment and your subsequent period of employment will not be aggregated for purposes of determining whether you are credited with at least 5 years of retiree eligibility service. Please refer to the section *Enrolling in the Medical Plan* for additional information about the Medical Plan's enrollment requirements.

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.

Please note: New enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage became effective on Jan. 1, 2024. Under these new enrollment requirements:

- if you became an eligible retiree on or before Jan. 1, 2024 (Pre-2024 Retiree) and you did not enroll in in the Medical Plan for the 2024 plan year, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Duke Energy Retiree Dental Plan (Dental Plan) or the Duke Energy Retiree Vision Plan (Vision Plan) at any future date; and

- if you become an eligible retiree after Jan. 1, 2024 (Post-2023 Retiree) and you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline (as defined below), you cannot enroll yourself or your eligible dependents in the Medical Plan, Dental Plan or Vision Plan at any future date.

For purposes of this booklet, your **Retiree Coverage Election Deadline** is the date that is 31 days after your retirement date (or 31 days after your COBRA continuation coverage under the Duke Energy Active Medical Plan (Active Medical Plan) ends). Please refer to the sections *Enrolling in the Medical Plan* and *Mid-Year Changes* for additional information.

Duke Energy Corporation reserves the right to amend, modify or terminate retiree coverage offered under the Medical Plan at any time, including termination of eligibility.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

In order to be eligible for coverage under the Medical Plan, your eligible dependent must be under age 65. Pre-65 eligible dependents of eligible retirees who are age 65 or older can elect to be covered under the Medical Plan. However, if you are a Pre-2024 Retiree and your pre-65 eligible dependents did not enroll in the Medical Plan effective as of Jan. 1, 2024, or if you are a Post-2023 Retiree and your pre-65 eligible dependents do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, your pre-65 eligible dependents cannot enroll in the Medical Plan, Dental Plan or Vision Plan at any future date. 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.

Generally, for medical coverage of a taxpayer's domestic partner to be tax-free to the taxpayer, the domestic partner must qualify as the taxpayer's tax dependent for federal income tax purposes, as

defined by Section 152 of the Internal Revenue Code. See *Cost of Coverage* below for additional information regarding the tax treatment of your domestic partner's medical coverage.

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, the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan) and the date that your spouse/domestic partner drops survivor medical coverage.

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 your spouse/domestic partner and/or dependent children elect survivor coverage, they may drop their survivor coverage at any time during the calendar year, regardless of whether they experience a work/life event for which mid-year changes are allowed. However, if your suriviving spouse/domestic partner and/or dependent children drop their survivor coverage at any time, they cannot enroll in survivor coverage under the Medical Plan at any future date. See *Mid-Year Changes* for additional information about work/life events for which mid-year changes are allowed.

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.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

If your spouse/domestic partner is a Duke Energy employee who is enrolled in the Active Medical Plan, you can elect to be covered as a dependent of your spouse/domestic partner under the Active Medical Plan, rather than electing coverage under the Medical Plan. However, if you are a Pre-2024 Retiree and you did not enroll in the Medical Plan effective as of Jan. 1, 2024, or if you are a Post-2023 Retiree and you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan at any future date. This means that by remaining covered as a dependent under the Active Medical Plan rather than electing coverage under the Medical Plan when you retire, you are permanently waiving your right to enroll in the Medical Plan, the Dental Plan and the Vision Plan.

Your spouse/domestic partner who is a Duke Energy employee cannot enroll in the Medical Plan as your dependent while an active employee. If your spouse/domestic partner becomes an eligible retiree upon retirement, you can enroll your spouse/domestic partner in the Medical Plan as your dependent at that time (or during any subsequent annual enrollment provided that you remain enrolled in the Medical Plan at that time, as described in *Enrolling in the Medical Plan* below), or your spouse/domestic partner can elect retiree coverage under the Medical Plan by the Retiree Coverage Election Deadline. If your spouse/domestic partner does not elect retiree coverage under the Medical Plan by the Retiree Coverage Election Deadline, your spouse/domestic partner cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan as a retiree at any future date.

If you are a Pre-2024 Retiree, your spouse/domestic partner died while a Duke Energy employee, you were enrolled in survivor coverage under the Active Medical Plan in 2023 and you did not enroll in the Medical Plan for the 2024 plan year, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. If you are an eligible Post-2023 Retiree but you have not yet retired, your spouse/domestic partner dies while a Duke Energy Employee and you enroll in survivor coverage under the Active Medical Plan, when you retire you can elect to either retain your survivor coverage under the Active Medical Plan or enroll in the Medical Plan. However, if you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll yourself or your dependents in the Medical Plan at any future date.

See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

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

Pre-2024 Retirees

New enrollment requirements for the Duke Energy-sponsored pre-65 retiree health coverage became effective on Jan. 1, 2024. Under these new enrollment requirements, if you are a Pre-2024 Retiree and you did not enroll in the Medical Plan for the 2024 plan year, you cannot enroll

yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

If you enrolled in the Medical Plan for the 2024 plan year, your Medical Plan coverage will continue in accordance with Medical Plan terms and provisions. However, if you drop your Medical Plan coverage at any time after Jan. 1, 2024, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

Post-2023 Retirees

If you are a Post-2023 Retiree, you may elect retiree coverage under the Medical Plan when you retire. However, if you do not elect retiree coverage under the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. See *Other Retiree Eligibility Information* above for additional information about your Retiree Coverage Election Deadline.

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))

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 enrolling in the Medical Plan, 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.

During Annual Enrollment

Each fall you will have the opportunity to change your coverage option under the Medical Plan for the following plan year, drop or add eligible dependents or drop Medical Plan coverage altogether. This process is referred to as “annual enrollment.” However, if you drop Medical Plan coverage altogether during annual enrollment, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. 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. See *Other Retiree Eligibility Information* above for additional information.

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 your employment with Duke Energy and its affiliates ends on or after January 1, 2024 and you are eligible for a Company contribution toward the cost of retiree medical coverage, the Company contribution will be provided in the form of Health Reimbursement Account benefits (i.e., either the Subsidy Health Reimbursement Account or the Modified Cinergy Health Reimbursement Account). Refer to the applicable Health Reimbursement Account summary plan description for additional information about eligibility for Health Reimbursement Account benefits.

If your employment with Duke Energy and its affiliates ended prior to January 1, 2024, your eligibility for a Company contribution toward the cost of retiree medical coverage and the form of your Company contribution toward the cost of retiree medical coverage are governed by the eligibility rules in effect at that time.

If you are an eligible retiree and you are rehired, 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 towards 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 (i.e., your prior period of employment with Duke Energy and its affiliates will not be considered in determining whether you satisfy any applicable service requirements for a Company contribution toward the cost of retiree medical coverage), and you will be responsible for paying

the full cost of any retiree medical coverage you elect upon your subsequent termination of employment.

If you have questions about 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 myHR website.

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, you will need to confirm whether your covered domestic partner is your tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code.

If your covered domestic partner is not your tax dependent for federal income tax purposes 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. The Company is obligated to collect the applicable taxes on the imputed income created by the election of benefits for a domestic partner who is not your tax dependent for federal income tax purposes. 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.

If your domestic partner is your tax dependent for federal income tax purposes 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 <u>not</u> considered taxable (or imputed) income to you, and the tax and reporting obligations described above with respect to imputed income do not apply. As a result, please make sure to indicate your domestic partner's tax dependent status when you enroll to ensure proper tax treatment for your coverage. 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.

Termination of Coverage for Non-Payment

Your coverage under the Medical Plan (and all other Duke Energy-sponsored plans in which you are enrolled and for which payments are required) 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 for your coverage under the Medical Plan (and any other Duke Energy-sponsored plans under which you want to continue coverage) must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If your coverage under the Medical Plan is reinstated under this provision and then subsequently terminated again for non-payment, you will not be entitled to reinstatement of your coverage under the Medical Plan, or under any other Duke Energy-sponsored plan for which payments are required, at any later date. 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 by your Retiree Coverage Election Deadline). Payments for your coverage begin as soon as administratively practicable following the date that you make your election. See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

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

If you are a Pre-2024 Retiree and you did not enroll in Medical Plan coverage for the 2024 plan year, or you are a Post-2023 Retiree and you do not enroll in Medical Plan coverage by the Retiree Coverage Election Deadline as described in *Enrolling in the Medical Plan* above, you cannot enroll

yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date, even if you experience a work or life event for which a mid-year enrollment change would otherwise be permitted. See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

If you are a Pre-2024 Retiree and you enroll in Medical Plan coverage for the 2024 plan year, or you are a Post-2023 Retiree and you enroll in Medical Plan coverage by the Retiree Coverage Election Deadline, but you do not enroll your eligible dependents, you may not change your election during the year to enroll your eligible dependents in coverage 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 your eligible dependents in coverage occurs, you cannot elect to enroll 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 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[1]
- 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 dependent's COBRA coverage from another employer expires
- Your dependent loses Medicare or Medicaid
- Your dependent loses coverage under a group health plan

[1]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.

- There is a significant increase in the cost of coverage under the employer plan in which your dependent participates

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.

If you drop coverage for yourself under the Medical Plan, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. However, if you drop Medical Plan coverage for your eligible dependents under the Medical Plan mid-year, you may be able to re-enroll your eligible dependents in the Medical Plan if you remain enrolled and experience a work/life event for which mid-year enrollment changes are allowed, or during a future annual enrollment period.

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 enroll an eligible dependent 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).

- **Enroll Eligible Dependent**. If you enroll an eligible dependent 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

Regardless of whether you are enrolled in the Medical Plan, 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. However, if you terminate your coverage under the Medical Plan, you cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

If you and/or a covered dependent enroll in a Medicare prescription drug plan, you and/or your covered dependent will not be eligible for coverage under the Medical. If you drop your Medical Plan coverage to enroll in a Medicare prescription drug plan, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. If you remain enrolled in the Medical Plan but drop your eligible dependents' Medical Plan coverage to enroll them in a Medicare prescription drug plan, you may be able to re-enroll your eligible dependents in Medical Plan coverage if their Medicare prescription drug plan coverage subsequently ends (e.g., during a subsequent annual enrollment period or due to a mid-year work/life event for which mid-year enrollment changes are allowed).

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;
- the end of the month in which you elect to drop Medical Plan coverage; 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 your coverage under the Medical Plan ends, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

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. For example, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a 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.

COBRA notices, elections and premium payments generally must be submitted by certain deadlines, as further described below.

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
525 South Tryon Street
Charlotte, NC 28202
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 and the Piedmont 501(c)(9) Trusts is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (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 (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
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
525 South Tryon Street – DEP14C
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
525 South Tryon Street – DEP14C
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
525 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan…Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity, or (v) requests to enroll in the Medical Plan due to your failure to enroll for the 2024 plan year, if you are a Pre-2024 Retiree, or by your Retiree Coverage Election Deadline, if you are a Post-2023 Retiree.

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.

In the case of an Eligibility or Enrollment Claim relating to your failure to enroll your newborn or newly adopted child in Medical Plan coverage within 31 calendar days of your child's date of birth or adoption, Claims and Appeals Management will approve the Eligibility or Enrollment Claim notwithstanding your failure to timely enroll your child in Medical Plan coverage, but only if (1) you contact the Duke Energy myHR Service Center within 60 calendar days of your child's date of birth or adoption to enroll your child in Medical Plan coverage and (2) you submit a claim initiation form and all other required documentation, in accordance with the instructions specified

on the claim initiation form, within 75 calendar days of your child's date of birth or adoption. If Claims and Appeals Management approves your Eligibility or Enrollment Claim, your child's Medical Plan coverage will be effective retroactive to your child's date of birth if a newborn or date of adoption for a newly adopted child. If Claims and Appeals Management denies your Eligibility or Enrollment Claim, you (or your authorized representative) will be notified of the adverse determination in writing as described below.

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
525 South Tryon Street – DEP14C
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, 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/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[2] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the Medical Plan. The people who operate your Medical Plan, called "fiduciaries" of the Medical Plan, have a duty to do so prudently and in the interest of you and other Medical Plan participants and beneficiaries. No one, including the Company, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's claims procedures.

[2] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Medical Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

Benefit Booklet

Duke Energy Retiree Medical Plan
Catastrophic Option

Effective: January 1, 2024
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Retiree Medical Plan's Catastrophic Option. It includes summaries of:

- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions and Limitations;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Duke Energy is solely responsible for paying Benefits described in this Benefit Booklet.

IMPORTANT
The healthcare service, supply or pharmaceutical product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 12, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Retiree Medical Plan's Catastrophic Option works. If you have questions call the number on your ID card.

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's Catastrophic Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://digital.alight.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.

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Plan does not provide a Network benefit level or a Non-Network benefit level.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section

UnitedHealthcare arranges for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the amount that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, in certain circumstances if you are currently receiving treatment for Covered Health Services from a provider or health care facility whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's or health care facility's contract, you may be eligible to request continued care from your current provider or health care facility at the Network Benefit level for specified conditions and timeframes up to 90 days. This provision applies if you are undergoing a course of treatment for a serious and complex condition from the provider or health care facility, undergoing a course of institutional or in-patient care from the provider or health care facility, scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or health care facility with respect to such a surgery, pregnant and undergoing a course of treatment for pregnancy from the provider or determined to be terminally ill (as defined in *section 1861(dd)(3)(A) of the Social Security Act)* and receiving treatment for such illness from the provider or health care facility. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at Network provider rates if you do not have access to a Network provider within a 30 mile radius of your home zip code.

You can check a provider's Network status by visiting **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, UnitedHealthcare may require you to select a single Network Physician to provide and coordinate all future Covered Health Services. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Eligible Expenses

Duke Energy has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expense and the amount the provider bills.
- For Covered Health Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians***, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Services that are non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Services that are ***Emergency Health Services provided by a non-Network provider***, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Services that are ***Air Ambulance services provided by a non-Network provider***, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Provider or Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law.

Please contact the Claims Administrator 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.

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of Section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.
- **IMPORTANT NOTICE:** For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
- **For Emergency Health Services provided by a non-Network provider,** the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.
- **For Air Ambulance transportation provided by a non-Network provider,** the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.

- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  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 non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment, or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment and Deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable Coinsurance, Copayment or Deductible.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Covered Persons (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- Ancillary Services received at certain Network facilities on a non-Emergency basis;
- non-Ancillary Services received at certain Network facilities on a non-Emergency basis;
- Emergency Health Services;
- Air Ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or its designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, Copayment, and Deductible.

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, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits (other than Benefits for preventive care services and Benefits for which you must pay a Copay). The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to almost all Covered Health Services under the Plan including Covered Health Services provided through the prescription drug program. The only Covered Health Services under the Plan to which the Annual Deductible does not apply are Benefits for which you must pay a Copay and preventive care services and certain preventive medications and vaccines which the Plan covers at 100% even before you satisfy your Annual Deductible. This means that the prescription drug program under the Plan provides applicable benefits for covered prescription drug expenses even before you satisfy your Annual Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible, but Copays do count toward the Out-of-Pocket-Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay. Copay applies to Emergency Health Services only.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of- Pocket Maximum?
Copays	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	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.

Travel and Lodging (For Travel and Lodging related to complex medical conditions see Section 7: *Clinical Programs And Resources)*

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service provided by a Network provider that is not available in the Covered

Person's state of residence due to law or regulation when such Covered Health Services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their home address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year, will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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. You are responsible for obtaining authorization before you receive the services. 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 all Covered Health Services have been prior authorized 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.

To obtain prior authorization, call the number on 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.

The Plan requires prior authorization for certain Covered Health Services.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. 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 requirement.

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.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

Payment Terms & Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network
Copays[1] ■ Emergency Health Services	100% after you pay a $75 Copay
Annual Deductible[1] ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person)	$5,900 $17,700
Lifetime Maximum Benefit[2] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited
Annual Out-of-Pocket Maximum[2] ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person)	$5,900 $17,700

[1]Copays do not apply toward the Annual Deductible. Copays do apply toward the Out-of-Pocket Maximum.

[2]Generally, the following are considered to be essential Benefits: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for certain Covered Health Services, are based on n the Recognized Amount as defined in Section 12, *Glossary*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	100% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 100% after you meet the Annual Deductible *Air Ambulance* 100% after you meet the Annual Deductible
■ Non-Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 100% after you meet the Annual Deductible *Air Ambulance* 100% after you meet the Annual Deductible
Cellular and Gene Therapy	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.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Clinical Trials Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section.	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.
Congenital Heart Disease (CHD) Surgery Services See Section 5, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible
Dental Services - Accident Only	100% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition	100% after you meet the Annual Deductible
Dental Treatment Covered under Plan	100% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	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	100% after you meet the Annual Deductible
Emergency Health Services – Outpatient	100% after you pay a $75 Copay and after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
(Copay is per visit) If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 2: *How the Plan Works*.	
Foot Care	100% after you meet the Annual Deductible
Home Health Care	100% after you meet the Annual Deductible
Hospice Care	100% after you meet the Annual Deductible
Hospital - Inpatient Stay	100% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	100% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% after you meet the Annual Deductible
Mental Health Services ■ Inpatient ■ Outpatient, including Partial Hospitalization/Intensive Outpatient Treatment ■ Virtual Behavioral Health Therapy & Coaching	100% after you meet the Annual Deductible 100% after you meet the Annual Deductible **Designated Network** **(AbleTo Therapy 360)** 100%

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient ■ Outpatient, including Partial Hospitalization/Intensive Outpatient Treatment	100% after you meet the Annual Deductible 100% after you meet the Annual Deductible
Nutritional Counseling Up to 12 visits per condition per calendar year	100% after you meet the Annual Deductible
Obesity Surgery (The Plan pays Benefits only for Covered Health Services provided through Bariatric Resource Services) See *Obesity Surgery* in Section 5, *Additional Coverage Details*.)	100% after you meet the Annual Deductible
Orthotic Devices	100% after you meet the Annual Deductible
Ostomy Supplies	100% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	100% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable Annual Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	100% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	100% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps. ■ Colonoscopy	 100% 100% 100% 100%
Private Duty Nursing - Outpatient	100% after you meet the Annual Deductible
Prosthetic Devices	100% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.	 100% after you meet the Annual Deductible 100% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	100% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Up to 150 days per Covered Person per calendar year	
Substance-Related and Addictive Disorders Services ■ Inpatient Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Administrator or search for a Network program on www.myuhc.com. ■ Outpatient, including Partial Hospitalization/Intensive Outpatient Treatment	100% 100% after you meet the Annual Deductible
Surgery - Outpatient	100% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	100% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	100% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Provider) See *Transplantation Services* in Section 5, *Additional Coverage Details*.	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.
Urinary Catheters	100% after you meet the Annual Deductible
Urgent Care Center Services	100% after you meet the Annual Deductible
24/7 Virtual Visits Benefits are available only when services are delivered through a Designated Virtual	100% after you meet the Annual Deductible Non-Network Benefits are not available

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
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.	
Vision Examinations	100% after you meet the Annual Deductible
Wigs Up to a $500 maximum per Covered Person per lifetime	100% after you meet the Annual Deductible

[1]Please obtain prior authorization before receiving Covered Health Services, as described in Section 5, Additional Coverage Details.

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Acupuncture services will be reviewed after 20 visits for medical necessity.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed services or if goals have previously been met.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 12, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of a Cellular or Gene Therapy arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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 do not 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 UnitedHealthcare 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 facility participating in the CHD Resource Services Program. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD surgery services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD surgery services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD Program, you should contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD Program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* are Covered Health Services only in connection with CHD surgery services received at a Congenital Heart Disease Resource Services Program.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items	Insulin pumps and pump supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under the Plan's prescription drug benefit.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you do not 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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every five calendar years.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the five year timeline for replacement.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you do not 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. If you are admitted to a Hospital as a result of an Emergency, you must notify the Claims Administrator as soon as is reasonably possible.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Foot Care

The Plan covers hygienic and preventive maintenance foot care; cutting or removal of corns and calluses, nail trimming, cutting, or debriding only if the treatment is a Covered Health Service and related to a medical condition.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 12, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement
You must obtain prior authorization, from the Claims Administrator five business days before receiving services, including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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 Benefits for:
- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Kaia Health

A mobile app for on-demand, personalized support to help relieve pain and live healthier. Connect with Kaia: http://startkaia.com/uhc.

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 under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Benefits are limited to 18 Presumptive Drug Tests per calendar year.

Benefits are limited to 18 Definitive Drug Tests per calendar year.

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 Genetic Testing, stress echocardiography and transthoracic echocardiogram, and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you do not 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 CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received. If you do not 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Prior Authorization Requirement
Please remember for Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from or to provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

The AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

There are no Deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Prior Authorization Requirement
Please remember for Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, you must obtain prior authorization for Benefits from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing, and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization from or to provide notification to the Claims 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 twelve individual sessions per calendar year for each medical condition.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under the Plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 6*, Clinical Programs and Resources* for more information on the BRS program.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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.

You must obtain prior authorization as soon as the possibility of obesity surgery arises. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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.

Prior Authorization Requirement
For Benefits, you must obtain prior authorization from the Claims Administrator for Inflammatory Injectable Medications (site of care). If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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*.

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.

The Plan does not provide coverage for:

- Doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Post-delivery – services/treatment for the newborn of a dependent daughter.

Prior Authorization Requirement

You must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

If you do not 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 Resources*, 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 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 your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the

appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 stroke;
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals 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 the following be provided

- medical records,
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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, or Congenital Anomaly. Rehabilitation services will be reviewed after 40 visits for medical necessity.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
Please remember, for Benefits for:

- A scheduled admission, you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.

- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Claims Administrator or search for a Network program on www.myuhc.com.

Prior Authorization Requirement
Please remember, for Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification to the Claims Administrator as soon as is reasonably possible.
- In addition, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from or to provide notification to the Claims 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 cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization 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 do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, dialysis, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you do not 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 including CAR-T cell therapy for malignancies 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 including CAR-T cell therapy for malignancies, 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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

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.

24/7 Virtual Visits

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in

real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

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.
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every calendar year. and
- Non routine vision exam and refraction eye exam – (*Vision Exam* - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. *Refractive eye exam* – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accomodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Benefits are limited to one wig/hair piece up to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including Complex Medical Conditions Programs & Services.

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.

Consumer Solutions and Self-Service Tools

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 your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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 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;
- Access all of the content and wellness topics from NurseLine℠;
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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**.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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 your ID card.

Complex Medical Conditions Programs & Services

Bariatric Resource Services (BRS)

Your Plan offers the Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Cancer Resource Services (CRS) Program

Your Plan offers a Cancer Resource Services (CRS) Program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this program.

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 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).*

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD

surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Kidney Resource Services (KRS) Program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) Program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS Program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS Program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Specialist Management Solutions Program

A Surgical Advocate is a surgical solution that opens the door to quality, affordable outpatient specialty and surgical care and is part of your UnitedHealthcare Duke Energy Team. A Surgical Advocate will work closely with you on every aspect of your surgery to ensure the highest quality of care. Services include connecting you with specialists/ surgeons to help you choose the most appropriate setting for your outpatient surgery/procedures.

Specialties may include, but are not limited to:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine*
- Ophthalmology
- Orthopedic*
- Pain Management

- Podiatry
- Urology
- Women's Health

*For Orthopedic and Musculoskeletal care, surgical advocates partner with registered orthopedic nurses to help:

- Manage your pain; and
- Understand your treatment options.
- Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier. Available at no extra cost as part of your health plan. Visit: http://startkaia.com/uhc.

If you are planning an inpatient knee, hip or spine procedure, you are required to enroll in the Specialist Management Solutions Program prior to surgery otherwise there is no coverage. You may also be required to use a center of excellence designated facility. The nurses can help you:

- Find a designated provider and facility for your surgery;
- Find other resources such as physical therapists and durable medical equipment;
- Coordinate your surgery with the designated facility; and
- Prepare for both your surgery and recovery.

For inpatient back, knee, hip or spine surgeries, if you live within **50** miles of a designated facility, use of the designated facility is also required. If you reside more than **50** miles from a designated provider and facility, a Travel & Lodging benefit is available for both inpatient and outpatient procedures.

If you or a family member will be having an upcoming surgery or want to enroll in the program, please call the number on your ID card and ask to speak to a surgical advocate.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional 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
- 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 your ID card.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

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 Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person 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 Specialist Management Solutions 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 Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Wellness Programs

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 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 your ID card.

Real Appeal

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no Deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the Plan.

- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

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, animal-assisted 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 dedicated speech generating 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 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding.

8. Powered and non-powered exoskeleton devices.

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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

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.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

8. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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.

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*.
   - Urinary catheters for which Benefits are provided as described under *Urinary Catheters* 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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

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.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins.
    - 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 as described under *Wigs* in Section 5, *Additional Coverage Details*.

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 impairment 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. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

18. Intracellular micronutrient testing.

19. Sex transformation operations and related services.

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.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
    - Fees for the use of a Gestational Carrier or Surrogate.
    - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.

- Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
    - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
    - Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
    - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
5. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
6. The reversal of voluntary sterilization.
7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, missed abortion (commonly known as a miscarriage or medically necessary termination of pregnancy through the first 16 weeks of pregnancy.
8. InVitro fertilization regardless of the reason for treatment.
9. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

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 animal organs;

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 *Complex Medical Conditions Travel and Lodging Assistance Program* described in Section 6, *Clinical Programs and Resources*, and except as identified under *Travel and Lodging* in Section 2, *How the Plan Works*. Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 12, *Glossary;*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services;

5. Private Duty Nursing received on an inpatient basis;

6. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details;*

7. Rest cures;

8. Services of personal care attendants; 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.

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*.

12. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

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 your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the 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

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes

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 Benefit.*

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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 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 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy, or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

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.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the 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)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.
- **Secondary Plan.** The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary plan and the plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(2) If both parents have the same birthday, the plan that covered the parent longest is the Primary plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the Custodial Parent.

b) The plan covering the Custodial Parent's spouse.

c) The plan covering the non-Custodial Parent.

d) The plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan, and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on

the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services 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, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Annual 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is **a**n Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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 Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.

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 an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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 carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- 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, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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 you that are payable under the Plan. If the refund is due from a person or organization other than you, 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 payment in connection with services provided to persons under other plans for which the Claims Administrator processes 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 either:

- 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

UnitedHealthcare has agreements in place that govern the relationships between it, the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 administer payment of 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 are not responsible 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination of or modifications to the Plan.

The Claims Administrator is not the Plan Administrator of the Plan, as that term is used in ERISA. The Claims Administrator is a named fiduciary of the Plan, as that term is used in ERISA, solely with respect to the Claims Administrator's authority to decide claims for Benefits under the Plan and appeals of denied claims for Benefits under the Plan. If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

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.

Interpretation of Benefits

Duke Energy and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Duke Energy and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Duke Energy may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Duke Energy does so in any particular case shall not in any way be deemed to require Duke Energy to do so in other similar cases.

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, including provider billing and provider payment records. 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 4, *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

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.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, 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 charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense, or the Recognized Amount when applicable.

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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- 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 Resources*, "Covered Person" means all domestic Retired Employees who are eligible for and enrolled in the Plan, and their Dependents age 18 and over who are eligible for and enrolled 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.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Dispensing Entity - a pharmacy, provider, 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 Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

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 the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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 – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 Service(s) – 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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 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, service 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), service site 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. UHCprovider.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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of*

Diseases section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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 – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 medications or products administered in connection with a Covered Health Service by a Physician.

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.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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 a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Copayment, Coinsurance and applicable Annual Deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - 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.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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 & 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 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 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: 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 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 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 պահանջէլու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամնէրի հէռախոսահամարով, 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 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၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꭰ ᏏᏢ ᏗCZᏢᏗ Ꮧ4ᏅᎫᏗ ᏂᎪᎯᏳW ᎥᏆ GᏙᏢ VᎭ ᏏR ᏗJJAVᏗ ACᏅᎫVᏗ ᎢΘᏂᏅᎫᏗT, ᏅᏤ0ᵐᏅᎫᏓ 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 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	နအိဉ်ဒီးတါခွဲးတါယာ်လၢနကဒီးနူဉ်ဘဉ်တါမၤစၢးဒီးတါဂ့ၢ်တါကျိုၤလၢနကိုဉ်ဒဉ်နဲ့ဝလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါကယ့နူ်ပုၤကတိၤကျိုးထံတါတကၤအဂီၢ်ကိုးဘဉ်လီတဲစိအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတ်အိဉ်ဆူဉ်အိဉ်ချအတ်ခဲဉ်တါကဲ အကးအလိၤဒီးဆိဉ်လီၤနီၢ်ဂ်ၢ် 0 တကွ်ၤ.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 ئەوت 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 پیناسەیی 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.
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 yínikeedgo, ninaaltsoos nit ‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77

Language	Translated Taglines
	bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíilchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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

Language	Translated Taglines
	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	ܢ̇ܣܝܬܘܢ ܐܝܬܠܘܟܘܢ ܢܩܘܬ̈ܐ ܕܦܠܛܬܘܢ ܩ̇ܒ̈ܝܬܐ ܘܡܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡ̣ܓ̈ܢܐܝܬ ܠܡܫܟܚܬܐ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܠ̣ ܡܢܝ̈ܢܐ ܕܛܠܦܘܢ ܕܐܝܬܠܗ ܡܟܬܒܐ ܥܠ ܦܬܩܐ ܕܣܘܟܠܬܐ ܘܕܘܫ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang 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
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

Language	Translated Taglines
	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 קארטל , דרוקט 0. TTY 711 ID
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

TABLE OF CONTENTS

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 66,000 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 66,000 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 by calling 800-378-5697.

- **Option 2:** Use the CVS Caremark mobile app on your smart phone to photograph and submit your prescription.

- **Option 3:** 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, deductible and coinsurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service Pharmacy 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 automatic refill service.

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
- 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)
- Fertility Agents

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:

- COVID-19
- Dengue Fever
- 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)
- RSV (Adult)
- 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.

Caremark Cost Saver® & GoodRx®

Beginning January 1, 2024, your prescription drug program coordinates with GoodRx. This means that when the GoodRx price for a generic, non-specialty drug is lower than the amount you would pay under the Medical Plan's prescription drug coverage, you will automatically pay the lower GoodRx price when you check out at your pharmacy, and 100% of the GoodRx price will apply to your applicable Medical Plan annual deductible. If you have any questions about GoodRx, contact CVS Caremark Customer Service at 888-797-8912.

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, 2024, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2025 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 whose initial effective date with CVS Caremark is January 1, 2024 would have 45 days (until February 14, 2024) 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.*

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

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: UnitedHealthcare Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: CVS Caremark Prescription Drug Guide (includes Summary of Prescription Drug 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 1, 2024 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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.

Eligibility

Eligible Retirees

If your employment terminates on or after January 1, 2024, 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.

Other Retiree Eligibility Information

If your employment with Duke Energy and its affiliates terminated before January 1, 2024, your eligibility for retiree coverage is governed by the eligibility rules in effect at that time.

If you were previously employed with Duke Energy and its affiliates and you are rehired, you will be eligible for retiree coverage under the Medical Plan upon your subsequent termination of employment only if either (1) you satisfied the eligibility requirements for retiree coverage under the Medical Plan upon your previous termination of employment (i.e., you were at least age 50 and credited with at least 5 years of retiree eligibility service upon your previous termination of

employment) or (2) you satisfy the eligibility requirements for retiree coverage under the Medical Plan upon your subsequent termination of employment based solely on retiree eligibility service credited during your subsequent period of employment (i.e., you are at least age 50 at your subsequent termination of employment and are credited with at least 5 years of retiree eligibility service during your subsequent period of employment) and you timely enroll in retiree coverage under the Medical Plan following your subsequent period of employment. Your retiree eligibility service from your previous period of employment and your subsequent period of employment will not be aggregated for purposes of determining whether you are credited with at least 5 years of retiree eligibility service. Please refer to the section *Enrolling in the Medical Plan* for additional information about the Medical Plan's enrollment requirements.

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.

Please note: New enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage became effective on Jan. 1, 2024. Under these new enrollment requirements:

- if you became an eligible retiree on or before Jan. 1, 2024 (Pre-2024 Retiree) and you did not enroll in in the Medical Plan for the 2024 plan year, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Duke Energy Retiree Dental Plan (Dental Plan) or the Duke Energy Retiree Vision Plan (Vision Plan) at any future date; and

- if you become an eligible retiree after Jan. 1, 2024 (Post-2023 Retiree) and you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline (as defined below), you cannot enroll yourself or your eligible dependents in the Medical Plan, Dental Plan or Vision Plan at any future date.

For purposes of this booklet, your **Retiree Coverage Election Deadline** is the date that is 31 days after your retirement date (or 31 days after your COBRA continuation coverage under the Duke Energy Active Medical Plan (Active Medical Plan) ends). Please refer to the sections *Enrolling in the Medical Plan* and *Mid-Year Changes* for additional information.

Duke Energy Corporation reserves the right to amend, modify or terminate retiree coverage offered under the Medical Plan at any time, including termination of eligibility.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

In order to be eligible for coverage under the Medical Plan, your eligible dependent must be under age 65. Pre-65 eligible dependents of eligible retirees who are age 65 or older can elect to be covered under the Medical Plan. However, if you are a Pre-2024 Retiree and your pre-65 eligible dependents did not enroll in the Medical Plan effective as of Jan. 1, 2024, or if you are a Post-2023 Retiree and your pre-65 eligible dependents do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, your pre-65 eligible dependents cannot enroll in the Medical Plan, Dental Plan or Vision Plan at any future date. 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.

Generally, for medical coverage of a taxpayer's domestic partner to be tax-free to the taxpayer, the domestic partner must qualify as the taxpayer's tax dependent for federal income tax purposes, as

defined by Section 152 of the Internal Revenue Code. See *Cost of Coverage* below for additional information regarding the tax treatment of your domestic partner's medical coverage.

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, the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan) and the date that your spouse/domestic partner drops survivor medical coverage.

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 your spouse/domestic partner and/or dependent children elect survivor coverage, they may drop their survivor coverage at any time during the calendar year, regardless of whether they experience a work/life event for which mid-year changes are allowed. However, if your suriviving spouse/domestic partner and/or dependent children drop their survivor coverage at any time, they cannot enroll in survivor coverage under the Medical Plan at any future date. See *Mid-Year Changes* for additional information about work/life events for which mid-year changes are allowed.

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.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

If your spouse/domestic partner is a Duke Energy employee who is enrolled in the Active Medical Plan, you can elect to be covered as a dependent of your spouse/domestic partner under the Active Medical Plan, rather than electing coverage under the Medical Plan. However, if you are a Pre-2024 Retiree and you did not enroll in the Medical Plan effective as of Jan. 1, 2024, or if you are a Post-2023 Retiree and you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan at any future date. This means that by remaining covered as a dependent under the Active Medical Plan rather than electing coverage under the Medical Plan when you retire, you are permanently waiving your right to enroll in the Medical Plan, the Dental Plan and the Vision Plan.

Your spouse/domestic partner who is a Duke Energy employee cannot enroll in the Medical Plan as your dependent while an active employee. If your spouse/domestic partner becomes an eligible retiree upon retirement, you can enroll your spouse/domestic partner in the Medical Plan as your dependent at that time (or during any subsequent annual enrollment provided that you remain enrolled in the Medical Plan at that time, as described in *Enrolling in the Medical Plan* below), or your spouse/domestic partner can elect retiree coverage under the Medical Plan by the Retiree Coverage Election Deadline. If your spouse/domestic partner does not elect retiree coverage under the Medical Plan by the Retiree Coverage Election Deadline, your spouse/domestic partner cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan as a retiree at any future date.

If you are a Pre-2024 Retiree, your spouse/domestic partner died while a Duke Energy employee, you were enrolled in survivor coverage under the Active Medical Plan in 2023 and you did not enroll in the Medical Plan for the 2024 plan year, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. If you are an eligible Post-2023 Retiree but you have not yet retired, your spouse/domestic partner dies while a Duke Energy Employee and you enroll in survivor coverage under the Active Medical Plan, when you retire you can elect to either retain your survivor coverage under the Active Medical Plan or enroll in the Medical Plan. However, if you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll yourself or your dependents in the Medical Plan at any future date.

See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

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

Pre-2024 Retirees

New enrollment requirements for the Duke Energy-sponsored pre-65 retiree health coverage became effective on Jan. 1, 2024. Under these new enrollment requirements, if you are a Pre-2024 Retiree and you did not enroll in the Medical Plan for the 2024 plan year, you cannot enroll

yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

If you enrolled in the Medical Plan for the 2024 plan year, your Medical Plan coverage will continue in accordance with Medical Plan terms and provisions. However, if you drop your Medical Plan coverage at any time after Jan. 1, 2024, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

Post-2023 Retirees

If you are a Post-2023 Retiree, you may elect retiree coverage under the Medical Plan when you retire. However, if you do not elect retiree coverage under the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. See *Other Retiree Eligibility Information* above for additional information about your Retiree Coverage Election Deadline.

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))

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 enrolling in the Medical Plan, 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.

During Annual Enrollment

Each fall you will have the opportunity to change your coverage option under the Medical Plan for the following plan year, drop or add eligible dependents or drop Medical Plan coverage altogether. This process is referred to as "annual enrollment." However, if you drop Medical Plan coverage altogether during annual enrollment, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. 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. See *Other Retiree Eligibility Information* above for additional information.

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 your employment with Duke Energy and its affiliates ends on or after January 1, 2024 and you are eligible for a Company contribution toward the cost of retiree medical coverage, the Company contribution will be provided in the form of Health Reimbursement Account benefits (i.e., either the Subsidy Health Reimbursement Account or the Modified Cinergy Health Reimbursement Account). Refer to the applicable Health Reimbursement Account summary plan description for additional information about eligibility for Health Reimbursement Account benefits.

If your employment with Duke Energy and its affiliates ended prior to January 1, 2024, your eligibility for a Company contribution toward the cost of retiree medical coverage and the form of your Company contribution toward the cost of retiree medical coverage are governed by the eligibility rules in effect at that time.

If you are an eligible retiree and you are rehired, 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 towards 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 (i.e., your prior period of employment with Duke Energy and its affiliates will not be considered in determining whether you satisfy any applicable service requirements for a Company contribution toward the cost of retiree medical coverage), and you will be responsible for paying

the full cost of any retiree medical coverage you elect upon your subsequent termination of employment.

If you have questions about 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 myHR website.

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, you will need to confirm whether your covered domestic partner is your tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code.

If your covered domestic partner is not your tax dependent for federal income tax purposes 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. The Company is obligated to collect the applicable taxes on the imputed income created by the election of benefits for a domestic partner who is not your tax dependent for federal income tax purposes. 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.

If your domestic partner is your tax dependent for federal income tax purposes 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 <u>not</u> considered taxable (or imputed) income to you, and the tax and reporting obligations described above with respect to imputed income do not apply. As a result, please make sure to indicate your domestic partner's tax dependent status when you enroll to ensure proper tax treatment for your coverage. 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.

Termination of Coverage for Non-Payment

Your coverage under the Medical Plan (and all other Duke Energy-sponsored plans in which you are enrolled and for which payments are required) 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 for your coverage under the Medical Plan (and any other Duke Energy-sponsored plans under which you want to continue coverage) must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If your coverage under the Medical Plan is reinstated under this provision and then subsequently terminated again for non-payment, you will not be entitled to reinstatement of your coverage under the Medical Plan, or under any other Duke Energy-sponsored plan for which payments are required, at any later date. 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 by your Retiree Coverage Election Deadline). Payments for your coverage begin as soon as administratively practicable following the date that you make your election. See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

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

If you are a Pre-2024 Retiree and you did not enroll in Medical Plan coverage for the 2024 plan year, or you are a Post-2023 Retiree and you do not enroll in Medical Plan coverage by the Retiree Coverage Election Deadline as described in *Enrolling in the Medical Plan* above, you cannot enroll

yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date, even if you experience a work or life event for which a mid-year enrollment change would otherwise be permitted. See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

If you are a Pre-2024 Retiree and you enroll in Medical Plan coverage for the 2024 plan year, or you are a Post-2023 Retiree and you enroll in Medical Plan coverage by the Retiree Coverage Election Deadline, but you do not enroll your eligible dependents, you may not change your election during the year to enroll your eligible dependents in coverage 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 your eligible dependents in coverage occurs, you cannot elect to enroll 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 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[1]
- 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 dependent's COBRA coverage from another employer expires
- Your dependent loses Medicare or Medicaid
- Your dependent loses coverage under a group health plan

[1]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.

- There is a significant increase in the cost of coverage under the employer plan in which your dependent participates

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.

If you drop coverage for yourself under the Medical Plan, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. However, if you drop Medical Plan coverage for your eligible dependents under the Medical Plan mid-year, you may be able to re-enroll your eligible dependents in the Medical Plan if you remain enrolled and experience a work/life event for which mid-year enrollment changes are allowed, or during a future annual enrollment period.

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 enroll an eligible dependent 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).

- **Enroll Eligible Dependent**. If you enroll an eligible dependent 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

Regardless of whether you are enrolled in the Medical Plan, 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. However, if you terminate your coverage under the Medical Plan, you cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

If you and/or a covered dependent enroll in a Medicare prescription drug plan, you and/or your covered dependent will not be eligible for coverage under the Medical. If you drop your Medical Plan coverage to enroll in a Medicare prescription drug plan, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. If you remain enrolled in the Medical Plan but drop your eligible dependents' Medical Plan coverage to enroll them in a Medicare prescription drug plan, you may be able to re-enroll your eligible dependents in Medical Plan coverage if their Medicare prescription drug plan coverage subsequently ends (e.g., during a subsequent annual enrollment period or due to a mid-year work/life event for which mid-year enrollment changes are allowed).

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;
- the end of the month in which you elect to drop Medical Plan coverage; 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 your coverage under the Medical Plan ends, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

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. For example, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a 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.

COBRA notices, elections and premium payments generally must be submitted by certain deadlines, as further described below.

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
525 South Tryon Street
Charlotte, NC 28202
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 and the Piedmont 501(c)(9) Trusts is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (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 (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
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
525 South Tryon Street – DEP14C
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
525 South Tryon Street – DEP14C
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
525 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan…Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity, or (v) requests to enroll in the Medical Plan due to your failure to enroll for the 2024 plan year, if you are a Pre-2024 Retiree, or by your Retiree Coverage Election Deadline, if you are a Post-2023 Retiree.

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.

In the case of an Eligibility or Enrollment Claim relating to your failure to enroll your newborn or newly adopted child in Medical Plan coverage within 31 calendar days of your child's date of birth or adoption, Claims and Appeals Management will approve the Eligibility or Enrollment Claim notwithstanding your failure to timely enroll your child in Medical Plan coverage, but only if (1) you contact the Duke Energy myHR Service Center within 60 calendar days of your child's date of birth or adoption to enroll your child in Medical Plan coverage and (2) you submit a claim initiation form and all other required documentation, in accordance with the instructions specified

on the claim initiation form, within 75 calendar days of your child's date of birth or adoption. If Claims and Appeals Management approves your Eligibility or Enrollment Claim, your child's Medical Plan coverage will be effective retroactive to your child's date of birth if a newborn or date of adoption for a newly adopted child. If Claims and Appeals Management denies your Eligibility or Enrollment Claim, you (or your authorized representative) will be notified of the adverse determination in writing as described below.

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
525 South Tryon Street – DEP14C
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, 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/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[2] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the Medical Plan. The people who operate your Medical Plan, called "fiduciaries" of the Medical Plan, have a duty to do so prudently and in the interest of you and other Medical Plan participants and beneficiaries. No one, including the Company, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's claims procedures.

[2] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Medical Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

Benefit Booklet

Duke Energy Retiree Medical Plan
Health Savings Plan 1 Option

Effective: January 1, 2024
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy 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 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://digital.alight.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 5, *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. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

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. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

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.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, in certain circumstances if you are currently receiving treatment for Covered Health Services from a provider or health care facility whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's or health care facility's contract, you may be eligible to request continued care from your current provider or health care facility at the Network Benefit level for specified conditions and timeframes up to 90 days. This provision applies if you are undergoing a course of treatment for a serious and complex condition from the provider or health care facility, undergoing a course of institutional or in-patient care from the provider or health care facility, scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or health care facility with respect to such a surgery, pregnant and undergoing a course of treatment for pregnancy from the provider or determined to be terminally ill (as defined in Section *1861(dd)(3)(A) of the Social Security Act*) and receiving treatment for such illness from the provider or health care facility. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 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

Duke Energy has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

  Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Provider or Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, or any Annual Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of Section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Coinsurance, or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.

- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.
- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  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 non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, and Deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-Network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable Coinsurance, or Deductible.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Covered Persons (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- Ancillary Services received at certain Network facilities on a non-Emergency basis;
- non-Ancillary Services received at certain Network facilities on a non-Emergency basis;
- Emergency Health Services;
- Air Ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or it's designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, and Deductible.

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, or the Recognized Amount when applicable, 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.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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, or the Recognized Amount when applicable.	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.

Travel and Lodging (For Travel and Lodging related to complex medical conditions see Section 7: *Clinical Programs And Resources)*

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such Covered Health Services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their home address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year, will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services 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 your ID card.

To obtain prior authorization, call the number on 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

Payment Terms & Features

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 (not to exceed the applicable Individual amount per Covered Person)	$10,000	$20,000
Lifetime Maximum Benefit[3]		
There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]Amounts you pay out-of-pocket that are counted toward the Annual Deductible also apply toward the Out-of-Pocket Maximum.

[2]If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits (other than Benefits for Network preventive care services and certain preventive medications and vaccines) until the family Deductible is satisfied.

[3]Generally the following are considered to be essential Benefits: 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.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for certain Covered Health Services are based on the Recognized Amount as defined in Section 12, *Glossary*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services ■ Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 80% after you meet the Network Annual Deductible *Air Ambulance* 80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 60% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible
Cellular and Gene Therapy	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under	Non-Network Benefits are not available.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	each Covered Health Service category in this section.	
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	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.	
Congenital Heart Disease (CHD) Surgery Services Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	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.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 2: *How the Plan Works*.	*True Emergency* 80% after you meet the Annual Deductible *Non-True Emergency* 80% after you meet the Annual Deductible	*True Emergency* 80% after you meet the Network Annual Deductible *Non-True Emergency* 80% after you meet the Network Annual Deductible
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment. ■ Virtual Behavioral Health Therapy & Coaching	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible **Designated Network (AbleTo Therapy 360)** 100% after you meet the Annual Deductible; Benefits for the Initial Consultation will be paid at 100%	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible Not Covered
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling Up to 12 visits per condition 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**
Obesity Surgery (The Plan pays Benefits only for Covered Health Services provided through *Bariatric Resource Services*) See *Obesity Surgery* in Section 5, *Additional Coverage Details*.	80% after you meet the Annual Deductible	Non-Network Benefits are not available.
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 Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (, Coinsurance and applicable Annual Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 2, *How the Plan Works*, under *Eligible Expenses*.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Preventive Care Services		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
■ 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	100%	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.	
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	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
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
Substance-Related and Addictive Disorders Services ■ Inpatient Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Administrator or search for a Network program on myuhc.com.	100% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient including Partial Hospitalization/Intensive Outpatient Treatment.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible For Dialysis services, Non-Network Benefits are not available
Transplantation Services		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Non-Network Benefits include services provided at a facility that is not a Designated Provider and services provided at a non-Network facility. See *Transplantation Services* in Section 5, *Additional Coverage Details*.	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.	
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
24/7 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	Non-Network Benefits are not available.
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] Please obtain prior authorization before receiving Covered Health Services as described in Section 5, *Additional Coverage Details*.

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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. For Non-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

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
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you do not 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 UnitedHealthcare 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 facility participating in the CHD Resource Services Program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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 the *Complex Medical Conditions Travel and Lodging* Assistance Program in Section 6, *Clinical Programs & Resources* 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items	■ Insulin pumps and pump supplies and continuous glucose monitors for the management and treatment of diabetes based upon your medical needs. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under the Plan's prescription drug benefit.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.

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 do not 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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits for dedicated speech generating 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.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

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 do not 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 two business days 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 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 two business days 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.

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 from the Claims Administrator five business days before receiving services, ,including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you do not 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Kaia Health

A mobile app for on-demand, personalized support to help relieve pain and live healthier. Connect with Kaia: http://startkaia.com/uhc.

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 under Physician Fees for Surgical and Medical Services.)

- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

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 Genetic Testing, stress echocardiography and transthoracic echocardiogram, and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you do not obtain prior authorization from the Claims Administrator 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 CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received. If you do not 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from or to provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

The AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you do not obtain prior authorization from or to provide notification to the Claims 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 twelve individual sessions per calendar year for each medical condition.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under the Plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 6*, Clinical Programs and Resources* for more information on the BRS program.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6*, Clinical Programs & Resources* 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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Inflammatory Injectable Medications (site of care). If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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*.

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.

The Plan does not provide coverage for:

- Doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Post-delivery – services/treatment for the newborn of a dependent daughter.

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 do not 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 Resources*, 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 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 your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 stroke;
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals 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 the following be provided:

- medical records,
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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 or Congenital Anomaly. Rehabilitation services will be reviewed after 40 visits for medical necessity.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- 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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Claims Administrator or search for a Network program on www.myuhc.com**.**

Prior Authorization Requirement
Please remember, for Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator prior to the admission.
- A non-scheduled admission, you must provide notification to the Claims Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from or to provide notification to the Claims 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 cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization 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 do not 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, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you do not 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 including CAR-T cell therapy for malignancies 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 including CAR-T cell therapy for malignancies, 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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

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.

24/7 Virtual Visits

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.
- Non routine vision exam and refraction eye exam (*Vision Exam* - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. *Refractive eye exam* – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accommodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to one wig/hair piece up to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including Complex Medical Conditions Programs & Services.

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.

Consumer Solutions and Self-Service Tools

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 your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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 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;
- Access all of the content and wellness topics from NurseLine℠;
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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**.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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 your ID card.

Complex Medical Conditions Programs & Services

Bariatric Resource Services (BRS)

Your Plan offers the Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Cancer Resource Services (CRS) Program

Your Plan offers a Cancer Resource Services (CRS) Program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

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 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).*

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD

surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Kidney Resource Services (KRS) Program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS Program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS Program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Specialist Management Solutions Program

A Surgical Advocate is a surgical solution that opens the door to quality, affordable outpatient specialty and surgical care and is part of your UnitedHealthcare Duke Energy Team. A Surgical Advocate will work closely with you on every aspect of your surgery to ensure the highest quality of care. Services include connecting you with specialists/ surgeons to help you choose the most appropriate setting for your outpatient surgery/procedures.

Specialties may include, but are not limited to:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine*
- Ophthalmology
- Orthopedic*
- Pain Management
- Podiatry

- Urology
- Women's Health

*For Orthopedic and Musculoskeletal care, surgical advocates partner with registered orthopedic nurses to help:

- Manage your pain; and
- Understand your treatment options.
- Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier. Available at no extra cost as part of your health plan. Visit: http://startkaia.com/uhc.

If you are planning an inpatient knee, hip or spine procedure, you are required to enroll in the Specialist Management Solutions Program prior to surgery otherwise there is no coverage. You may also be required to use a center of excellence designated facility. The nurses can help you:

- Find a designated provider and facility for your surgery;
- Find other resources such as physical therapists and durable medical equipment;
- Coordinate your surgery with the designated facility; and
- Prepare for both your surgery and recovery.

For inpatient back, knee, hip or spine surgeries, if you live within **50** miles of a designated facility, use of the designated facility is also required. If you reside more than **50** miles from a designated provider and facility, a Travel & Lodging benefit is available for both inpatient and outpatient procedures.

If you or a family member will be having an upcoming surgery or want to enroll in the program, please call the number on your ID card and ask to speak to a surgical advocate.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional 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
- 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 your ID card.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

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 Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person 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 Specialist Management Solutions 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 Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Wellness Programs

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 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 your ID card.

Real Appeal

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no Deductibles, s or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the Plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information

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, animal-assisted 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 dedicated speech generating 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 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding.

8. Powered and non-powered exoskeleton devices.

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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion;

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.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

8. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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. Arch supports;

4. Treatment of subluxation of the foot.

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;*
   - Urinary catheters for which Benefits are provided as described under *Urinary Catheters* 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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

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.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - 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 as described under *Wigs* in Section 5, *Additional Coverage Details*.

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 impairment 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. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

18. Intracellular micronutrient testing.

19. Sex transformation operations and related services.

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.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.

- Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
    - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
    - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
    - Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
    - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
5. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
6. The reversal of voluntary sterilization.
7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, missed abortion (commonly known as a miscarriage) or medically necessary termination of pregnancy through the first 16 weeks of pregnancy.
8. InVitro fertilization regardless of the reason for treatment.
9. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

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 animal organs;

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 *Complex Medical Conditions Travel and Lodging Assistance Program* described in Section 6, *Clinical Programs and Resources*, and except as identified under *Travel and Lodging* in Section 2, *How the Plan Works*. Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 12, *Glossary;*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services;

5. Private Duty Nursing received on an inpatient basis;

6. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details;*

7. Rest cures;

8. Services of personal care attendants;

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants);

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;

4. Eye exercise or vision therapy;

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse;

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing;

3. Charges prohibited by federal anti-kickback or self-referral statutes;

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.

- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
- That exceed Eligible Expenses or any specified limitation in this Benefit Booklet.

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*.

12. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

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 your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the 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

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes 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 Benefit.*

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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 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 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy, or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

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.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may

request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external

review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;

- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the 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)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.

- **Secondary Plan.** The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary plan and the plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
      (2) If both parents have the same birthday, the plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the Custodial Parent.
b) The plan covering the Custodial Parent's spouse.
c) The plan covering the non-Custodial Parent.
d) The plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan, and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services 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, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary plan paid, the plan will pay the difference.

You will be responsible for any applicable Coinsurance or Annual 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is **a**n Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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 Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.

- Individuals with end-stage renal disease, for a limited period of time.

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 an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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 carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- 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, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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 you that are payable under the Plan. If the refund is due from a person or organization other than you, 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 payment in connection with services provided to persons under other plans for which the Claims Administrator processes 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 either:

- 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

UnitedHealthcare has agreements in place that govern the relationships between it, the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 administer payment of 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 are not responsible 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination of or modifications to the Plan.

The Claims Administrator is not the Plan Administrator of the Plan, as that term is used in *ERISA*. The Claims Administrator is a named fiduciary of the Plan, as that term is used in *ERISA,* solely with respect to the Claims Administrator's authority to decide claims for Benefits under the Plan and appeals of denied claims for Benefits under the Plan. If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

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.

Interpretation of Benefits

Duke Energy and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Duke Energy and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Duke Energy may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Duke Energy does so in any particular case shall not in any way be deemed to require Duke Energy to do so in other similar cases.

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, including provider billing and provider payment records. 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable and/or Coinsurance as described in Section 4, *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

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.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer

available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, 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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- 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 Resources*, "Covered Person" means all domestic Retired Employees who are eligible for and enrolled in the Plan, and their Dependents age 18 and over who are eligible for and enrolled 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.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Dispensing Entity - a pharmacy, provider, 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 Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 the Claims Administrator, or with an organization contracting on the Claims

Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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 – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
    b. The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
    c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
    d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
    e. Any other conditions as specified by the Secretary.

    The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 Service(s) – 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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 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, service 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), service site 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. UHCprovider.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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of*

Diseases section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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 – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 medications or products administered in connection with a Covered Health Service by a Physician.

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.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Coinsurance and applicable Annual Deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - 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.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living

arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care – care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a

hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

ATTACHMENT I - 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 & 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 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 UnitedHealth**c**are Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The 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: 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 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 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	¯(=™ ¬φ¯ xi ™ ‹ ⌡ M å ®8 H ı; Ş≠é 8 } é µ+ñ" ⌂ µ Ů â M Ć: ∫ ™ ` Ɱ - ‹ Ωα(₣ xĚ ®↓ +™8 å ÷b¯ ‹ é +˙ {(€ xâ ť 8 Ů8 MŮ ¬ aě M˙ ¸ €) ®0™ ł· ¶⌂ 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 nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	š Ăą Ľ ð Ę š ĂđĘĽ đĽ ő, Ž ă ĂĽĘ - Ły ě ă ĺĘ¹ ĸ ĂĽĘ Ž ž ĺĆ ¹ ĺĆ Þ č Ĺę¹ ĺĎŇ – ¹ Ę Ĺ ő Í ą ĂĽ Þđ Ă –Şĺę ő ĄĽĂ Ă ŕ ŒĘ –ĄĽĂ ¹ ˝ Ă (Ű) ĚŇĚ ¾ ă Ą TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	[illegible] TTY 711
10. Cherokee	¯ Šľě ýğ ŔŮą² Ŕ ŔľĽ Ŕ ŻþαŦ Đ Źź ğ ř ³ ýń Ŕ−þř Ŕ þŮĽ ř Ŕ Đ¯ⁿ Ľ ŔŽ, ¹ ŀďĽ Ň 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	p y t éá~ t ÜAgz éy r r T t ép y Ü¨ x ÜÅÜy ÜRy ÜÉp à y ~ ~ Ü ë T ás aÜ g éJâx ÜÅz Üy Ükoá~ t pRà a {~ Ü p y ÜÜÉgq Ē Ü ID aÜnu {t à Jfâ ày ÜRU u é kë , □ y Éw { vët t wx { Xu { aë a {ë ñ r wÜ ë TTY 600
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 निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल,फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti 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	နအိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒဉ်နဝဲလၢတလိဉ်ဟ့ဉ်အပ္ၤဘဉ်နူဉ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘဉ်လီတဲစိအကျိၤလၢကရၢဖိအတလိဉ်ဟ့ဉ်အပှ့ၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချ့အတၢ်ရဲဉ်တၢ်ကဲအကးအလီၤဒီးဆိဉ်လီၤနီၢ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	□□□ □□□ □□□ □□□ □□□ □□ □□□□ □□ □□ □□□ □□□□. □□□□ □□□□ □□□□ □□□ □□ ID□□□ □□□ □□ □□ □□□□□ □□□□ 0□□ □□□□□. 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 پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	IæĔij ŵâŴ♦ Ŵ♠ Ēĩ♦ǾĠųn ☻Ĕij ♣æĀ♥ĥǿĔĉ Ħ◦ ĒŴǾÅij ☼æĔĀā Ĕij Ŵĥ'ų ij ℓ Ĕā Ĕ☼ĉ ♂IæĔij ŵǽŵ ♀æĔĪ ♣ǿæĔ♥. ĥǽ ĉ ŵ☼Ǿĉ ♂ij Ĕ♥ ℓ Ĕā Ĕ,ħIJ□ ♠Ĉ ĔĈ ▪ Ĕ♥ĥ◦ ☻ħIJ◦ Ēąʼn āŵĔ◦ųʼn ā Ē▪ ĔŴ♣☻ŴĩǾ♦ Ēħ ĩǾĀ ij ʼnų♦ ā Ē▪ ĔŴ♣☻☼ĉ ♂IæĔij , ǽ♦ ĥ◦ ☻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 wōņāān. 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.
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 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

Language	Translated Taglines
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 wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	k Ç-h Ñ Ü S p j Ås-z ~Äyã {| ~T k ~Rk Ñ ~j \ ~v Åt Ç k p • p k \ v o m~RÄ \ ~v | Öm Ç-z ÅX wU k Ç-h Ñ Ö l p w~o S Uh ÅÄm k Ñ ^ X f ~ã ç • Åt r v ç Ü œ r v f Å Å y ~U 711 k Ñ ~ã \ v Ü 0 m r Ü
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
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

Language	Translated Taglines
	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] 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	Z| ºPj ≠a zæ| Î øPΘ†H !! ¢Å| l’Ï Ñ Pv º x ←∑ º Çx ºź †z ΏΏq Θ†OŰH ` øÉ ` ø┼VPε ∂] ` →} q áv ¢←ÖŰÑ→Ñ Pj Ì H ↕ ₣ ║ΩÑЬ \ Θ™ŰÑæH q g •Aα †ź å v l ╝j ȩΓ _Ü Ᵽv zæ ø ï ĹЬ ź ⇕ Ö0 φ H ź ä Ĺ┼□TTY 711
55. Thai	•¥¬Ã∏∏Ë%µ¢”•»‘¬´å√ÕŸË∆“£ç€,∫ ¡ ‘À‘£œ®¥%µçµ√%åˆå,´ ç√ Õ¢∂ç®‘ ƒ£œÅ¬ º ∆¡ ‘À‘ ,º ƒµ,∏ƒ. ä∏∑Õ¬‘√∆£,∏¿ƒ∏Ëå∫ ª ∂ƒº ƒ‘Ì∂”ÃÕƒ”· Ω Ã£¡ ‘ø£œ®¥ · ∆ç¢µ 0 ÃÕƒ”Ω∏Ë»‘¬ª ¢øƒå®∏®‘ ƒ%µ∫Õƒ‘ ƒø€ ,º ƒµ,∏ƒ∑Õ¬‘√∆£ 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

Language	Translated Taglines
	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 קארטל , דרוקט 0. TTY 711 ID
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

TABLE OF CONTENTS

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 66,000 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 66,000 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. 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 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 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 by calling 800-378-5697.

- **Option 2:** Use the CVS Caremark mobile app on your smart phone to photograph and submit your prescription.

- **Option 3:** 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 coinsurance 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 Pharmacy 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 automatic refill service.

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
- 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)
- Fertility Agents

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 benefit summary 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 coinsurance 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. Note: the Preventive Therapy Drug List excludes brand medications except in circumstances where there is no generic equivalent available.

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:

- COVID-19
- Dengue Fever
- 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)
- RSV (Adult)
- 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.

Caremark Cost Saver® & GoodRx®

Beginning January 1, 2024, your prescription drug program coordinates with GoodRx. This means that when the GoodRx price for a generic, non-specialty drug is lower than the amount you would pay under the Medical Plan's prescription drug coverage, you will automatically pay the lower GoodRx price when you check out at your pharmacy, and 100% of the GoodRx price will apply to your applicable Medical Plan annual deductible. If you have any questions about GoodRx, contact CVS Caremark Customer Service at 888-797-8912.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30- or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they

are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a higher deductible and coinsurance amount, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable deductible or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required deductible and coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2024, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2025 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 whose initial effective date with CVS Caremark is January 1, 2024 would have 45 days (until February 14, 2024) 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.*

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 Excludes brand medications if there is a generic available.	**$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

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: UnitedHealthcare Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: CVS Caremark Prescription Drug Guide (includes Summary of Prescription Drug 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 1, 2024 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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.

Eligibility

Eligible Retirees

If your employment terminates on or after January 1, 2024, 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.

Other Retiree Eligibility Information

If your employment with Duke Energy and its affiliates terminated before January 1, 2024, your eligibility for retiree coverage is governed by the eligibility rules in effect at that time.

If you were previously employed with Duke Energy and its affiliates and you are rehired, you will be eligible for retiree coverage under the Medical Plan upon your subsequent termination of employment only if either (1) you satisfied the eligibility requirements for retiree coverage under the Medical Plan upon your previous termination of employment (i.e., you were at least age 50 and credited with at least 5 years of retiree eligibility service upon your previous termination of

employment) or (2) you satisfy the eligibility requirements for retiree coverage under the Medical Plan upon your subsequent termination of employment based solely on retiree eligibility service credited during your subsequent period of employment (i.e., you are at least age 50 at your subsequent termination of employment and are credited with at least 5 years of retiree eligibility service during your subsequent period of employment) and you timely enroll in retiree coverage under the Medical Plan following your subsequent period of employment. Your retiree eligibility service from your previous period of employment and your subsequent period of employment will not be aggregated for purposes of determining whether you are credited with at least 5 years of retiree eligibility service. Please refer to the section *Enrolling in the Medical Plan* for additional information about the Medical Plan's enrollment requirements.

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.

Please note: New enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage became effective on Jan. 1, 2024. Under these new enrollment requirements:

- if you became an eligible retiree on or before Jan. 1, 2024 (Pre-2024 Retiree) and you did not enroll in in the Medical Plan for the 2024 plan year, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Duke Energy Retiree Dental Plan (Dental Plan) or the Duke Energy Retiree Vision Plan (Vision Plan) at any future date; and

- if you become an eligible retiree after Jan. 1, 2024 (Post-2023 Retiree) and you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline (as defined below), you cannot enroll yourself or your eligible dependents in the Medical Plan, Dental Plan or Vision Plan at any future date.

For purposes of this booklet, your **Retiree Coverage Election Deadline** is the date that is 31 days after your retirement date (or 31 days after your COBRA continuation coverage under the Duke Energy Active Medical Plan (Active Medical Plan) ends). Please refer to the sections *Enrolling in the Medical Plan* and *Mid-Year Changes* for additional information.

Duke Energy Corporation reserves the right to amend, modify or terminate retiree coverage offered under the Medical Plan at any time, including termination of eligibility.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

In order to be eligible for coverage under the Medical Plan, your eligible dependent must be under age 65. Pre-65 eligible dependents of eligible retirees who are age 65 or older can elect to be covered under the Medical Plan. However, if you are a Pre-2024 Retiree and your pre-65 eligible dependents did not enroll in the Medical Plan effective as of Jan. 1, 2024, or if you are a Post-2023 Retiree and your pre-65 eligible dependents do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, your pre-65 eligible dependents cannot enroll in the Medical Plan, Dental Plan or Vision Plan at any future date. 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.

Generally, for medical coverage of a taxpayer's domestic partner to be tax-free to the taxpayer, the domestic partner must qualify as the taxpayer's tax dependent for federal income tax purposes, as

defined by Section 152 of the Internal Revenue Code. See *Cost of Coverage* below for additional information regarding the tax treatment of your domestic partner's medical coverage.

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, the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan) and the date that your spouse/domestic partner drops survivor medical coverage.

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 your spouse/domestic partner and/or dependent children elect survivor coverage, they may drop their survivor coverage at any time during the calendar year, regardless of whether they experience a work/life event for which mid-year changes are allowed. However, if your suriviving spouse/domestic partner and/or dependent children drop their survivor coverage at any time, they cannot enroll in survivor coverage under the Medical Plan at any future date. See *Mid-Year Changes* for additional information about work/life events for which mid-year changes are allowed.

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.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

If your spouse/domestic partner is a Duke Energy employee who is enrolled in the Active Medical Plan, you can elect to be covered as a dependent of your spouse/domestic partner under the Active Medical Plan, rather than electing coverage under the Medical Plan. However, if you are a Pre-2024 Retiree and you did not enroll in the Medical Plan effective as of Jan. 1, 2024, or if you are a Post-2023 Retiree and you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan at any future date. This means that by remaining covered as a dependent under the Active Medical Plan rather than electing coverage under the Medical Plan when you retire, you are permanently waiving your right to enroll in the Medical Plan, the Dental Plan and the Vision Plan.

Your spouse/domestic partner who is a Duke Energy employee cannot enroll in the Medical Plan as your dependent while an active employee. If your spouse/domestic partner becomes an eligible retiree upon retirement, you can enroll your spouse/domestic partner in the Medical Plan as your dependent at that time (or during any subsequent annual enrollment provided that you remain enrolled in the Medical Plan at that time, as described in *Enrolling in the Medical Plan* below), or your spouse/domestic partner can elect retiree coverage under the Medical Plan by the Retiree Coverage Election Deadline. If your spouse/domestic partner does not elect retiree coverage under the Medical Plan by the Retiree Coverage Election Deadline, your spouse/domestic partner cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan as a retiree at any future date.

If you are a Pre-2024 Retiree, your spouse/domestic partner died while a Duke Energy employee, you were enrolled in survivor coverage under the Active Medical Plan in 2023 and you did not enroll in the Medical Plan for the 2024 plan year, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. If you are an eligible Post-2023 Retiree but you have not yet retired, your spouse/domestic partner dies while a Duke Energy Employee and you enroll in survivor coverage under the Active Medical Plan, when you retire you can elect to either retain your survivor coverage under the Active Medical Plan or enroll in the Medical Plan. However, if you do not enroll in the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll yourself or your dependents in the Medical Plan at any future date.

See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

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

Pre-2024 Retirees

New enrollment requirements for the Duke Energy-sponsored pre-65 retiree health coverage became effective on Jan. 1, 2024. Under these new enrollment requirements, if you are a Pre-2024 Retiree and you did not enroll in the Medical Plan for the 2024 plan year, you cannot enroll

yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

If you enrolled in the Medical Plan for the 2024 plan year, your Medical Plan coverage will continue in accordance with Medical Plan terms and provisions. However, if you drop your Medical Plan coverage at any time after Jan. 1, 2024, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

Post-2023 Retirees

If you are a Post-2023 Retiree, you may elect retiree coverage under the Medical Plan when you retire. However, if you do not elect retiree coverage under the Medical Plan by your Retiree Coverage Election Deadline, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. See *Other Retiree Eligibility Information* above for additional information about your Retiree Coverage Election Deadline.

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))

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 enrolling in the Medical Plan, 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.

During Annual Enrollment

Each fall you will have the opportunity to change your coverage option under the Medical Plan for the following plan year, drop or add eligible dependents or drop Medical Plan coverage altogether. This process is referred to as “annual enrollment.” However, if you drop Medical Plan coverage altogether during annual enrollment, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. 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. See *Other Retiree Eligibility Information* above for additional information.

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 your employment with Duke Energy and its affiliates ends on or after January 1, 2024 and you are eligible for a Company contribution toward the cost of retiree medical coverage, the Company contribution will be provided in the form of Health Reimbursement Account benefits (i.e., either the Subsidy Health Reimbursement Account or the Modified Cinergy Health Reimbursement Account). Refer to the applicable Health Reimbursement Account summary plan description for additional information about eligibility for Health Reimbursement Account benefits.

If your employment with Duke Energy and its affiliates ended prior to January 1, 2024, your eligibility for a Company contribution toward the cost of retiree medical coverage and the form of your Company contribution toward the cost of retiree medical coverage are governed by the eligibility rules in effect at that time.

If you are an eligible retiree and you are rehired, 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 towards 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 (i.e., your prior period of employment with Duke Energy and its affiliates will not be considered in determining whether you satisfy any applicable service requirements for a Company contribution toward the cost of retiree medical coverage), and you will be responsible for paying

the full cost of any retiree medical coverage you elect upon your subsequent termination of employment.

If you have questions about 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 myHR website.

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, you will need to confirm whether your covered domestic partner is your tax dependent for federal income tax purposes, as defined by Section 152 of the Internal Revenue Code.

If your covered domestic partner is not your tax dependent for federal income tax purposes 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. The Company is obligated to collect the applicable taxes on the imputed income created by the election of benefits for a domestic partner who is not your tax dependent for federal income tax purposes. 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.

If your domestic partner is your tax dependent for federal income tax purposes 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 <u>not</u> considered taxable (or imputed) income to you, and the tax and reporting obligations described above with respect to imputed income do not apply. As a result, please make sure to indicate your domestic partner's tax dependent status when you enroll to ensure proper tax treatment for your coverage. 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.

Termination of Coverage for Non-Payment

Your coverage under the Medical Plan (and all other Duke Energy-sponsored plans in which you are enrolled and for which payments are required) 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 for your coverage under the Medical Plan (and any other Duke Energy-sponsored plans under which you want to continue coverage) must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If your coverage under the Medical Plan is reinstated under this provision and then subsequently terminated again for non-payment, you will not be entitled to reinstatement of your coverage under the Medical Plan, or under any other Duke Energy-sponsored plan for which payments are required, at any later date. 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 by your Retiree Coverage Election Deadline). Payments for your coverage begin as soon as administratively practicable following the date that you make your election. See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

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

If you are a Pre-2024 Retiree and you did not enroll in Medical Plan coverage for the 2024 plan year, or you are a Post-2023 Retiree and you do not enroll in Medical Plan coverage by the Retiree Coverage Election Deadline as described in *Enrolling in the Medical Plan* above, you cannot enroll

yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date, even if you experience a work or life event for which a mid-year enrollment change would otherwise be permitted. See *Other Retiree Eligibility Information* above for additional information about the Retiree Coverage Election Deadline.

If you are a Pre-2024 Retiree and you enroll in Medical Plan coverage for the 2024 plan year, or you are a Post-2023 Retiree and you enroll in Medical Plan coverage by the Retiree Coverage Election Deadline, but you do not enroll your eligible dependents, you may not change your election during the year to enroll your eligible dependents in coverage 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 your eligible dependents in coverage occurs, you cannot elect to enroll 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 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[1]
- 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 dependent's COBRA coverage from another employer expires
- Your dependent loses Medicare or Medicaid
- Your dependent loses coverage under a group health plan

[1]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.

- There is a significant increase in the cost of coverage under the employer plan in which your dependent participates

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.

If you drop coverage for yourself under the Medical Plan, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. However, if you drop Medical Plan coverage for your eligible dependents under the Medical Plan mid-year, you may be able to re-enroll your eligible dependents in the Medical Plan if you remain enrolled and experience a work/life event for which mid-year enrollment changes are allowed, or during a future annual enrollment period.

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 enroll an eligible dependent 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).

- **Enroll Eligible Dependent**. If you enroll an eligible dependent 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

Regardless of whether you are enrolled in the Medical Plan, 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. However, if you terminate your coverage under the Medical Plan, you cannot enroll in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

If you and/or a covered dependent enroll in a Medicare prescription drug plan, you and/or your covered dependent will not be eligible for coverage under the Medical. If you drop your Medical Plan coverage to enroll in a Medicare prescription drug plan, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date. If you remain enrolled in the Medical Plan but drop your eligible dependents' Medical Plan coverage to enroll them in a Medicare prescription drug plan, you may be able to re-enroll your eligible dependents in Medical Plan coverage if their Medicare prescription drug plan coverage subsequently ends (e.g., during a subsequent annual enrollment period or due to a mid-year work/life event for which mid-year enrollment changes are allowed).

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;
- the end of the month in which you elect to drop Medical Plan coverage; 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 your coverage under the Medical Plan ends, you cannot enroll yourself or your eligible dependents in the Medical Plan, the Dental Plan or the Vision Plan at any future date.

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. For example, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a 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.

COBRA notices, elections and premium payments generally must be submitted by certain deadlines, as further described below.

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
525 South Tryon Street
Charlotte, NC 28202
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 and the Piedmont 501(c)(9) Trusts is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (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 (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
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
525 South Tryon Street – DEP14C
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
525 South Tryon Street – DEP14C
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
525 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan…Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity, or (v) requests to enroll in the Medical Plan due to your failure to enroll for the 2024 plan year, if you are a Pre-2024 Retiree, or by your Retiree Coverage Election Deadline, if you are a Post-2023 Retiree.

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.

In the case of an Eligibility or Enrollment Claim relating to your failure to enroll your newborn or newly adopted child in Medical Plan coverage within 31 calendar days of your child's date of birth or adoption, Claims and Appeals Management will approve the Eligibility or Enrollment Claim notwithstanding your failure to timely enroll your child in Medical Plan coverage, but only if (1) you contact the Duke Energy myHR Service Center within 60 calendar days of your child's date of birth or adoption to enroll your child in Medical Plan coverage and (2) you submit a claim initiation form and all other required documentation, in accordance with the instructions specified

on the claim initiation form, within 75 calendar days of your child's date of birth or adoption. If Claims and Appeals Management approves your Eligibility or Enrollment Claim, your child's Medical Plan coverage will be effective retroactive to your child's date of birth if a newborn or date of adoption for a newly adopted child. If Claims and Appeals Management denies your Eligibility or Enrollment Claim, you (or your authorized representative) will be notified of the adverse determination in writing as described below.

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
525 South Tryon Street – DEP14C
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, 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/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[2] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the Medical Plan. The people who operate your Medical Plan, called "fiduciaries" of the Medical Plan, have a duty to do so prudently and in the interest of you and other Medical Plan participants and beneficiaries. No one, including the Company, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's claims procedures.

[2] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Medical Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

Benefit Booklet

Duke Energy Retiree Medical Plan
Standard PPO Option

Effective: January 1, 2024
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy 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 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://digital.alight.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 5, *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. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

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. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, in certain circumstances if you are currently receiving treatment for Covered Health Services from a provider or health care facility whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's or health care facility's contract, you may be eligible to request continued care from your current provider or health care facility at the Network Benefit level for specified conditions and timeframes up to 90 days. This provision applies if you are undergoing a course of treatment for a serious and complex condition from the provider or health care facility, undergoing a course of institutional or in-patient care from the provider or health care facility, scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or health care facility with respect to such a surgery, pregnant and undergoing a course of treatment for pregnancy from the provider or determined to be terminally ill (as defined in Section *1861(dd)(3)(A) of the Social Security Act*) and receiving treatment for such illness from the provider or health care facility. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 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

Duke Energy has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

  Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

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 our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any Annual Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of Section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in Section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in Section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in Section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Annual Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.

- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Annual Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  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 non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and Deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable Coinsurance, Copayment, or Deductible.

When Covered Health Services are received from a non-network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification

for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- Ancillary Services received at certain Network facilities on a non-Emergency basis;
- non-Ancillary Services received at certain Network facilities on a non-Emergency basis;
- Emergency Health Services;
- Air Ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or it's designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, Copayment, and Deductible.

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, or the Recognized Amount when applicable, 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.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual Deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

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

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	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.

Travel and Lodging (For Travel and Lodging related to complex medical conditions see Section 7: *Clinical Programs And Resources)*

The Plan provides a Covered Person with a travel and lodging allowance related to the Covered Health Service provided by a Network provider that is not available in the Covered Person's state of residence due to law or regulation when such Covered Health Services are received in another state, as legally permissible.

Travel and Lodging provides support for the Covered Person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a Covered Person and travel companion when the Covered Person must travel at least 50 miles from their home address, as reflected in our records, to receive the Covered Health Services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the Covered Person. An allowance of up to $2,000 per Covered Person per year, will be provided for travel and lodging expenses incurred as a part of the Covered Health Service. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact us at www.myuhc.com or the telephone number on your ID card.

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 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

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services 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 your ID card.

To obtain prior authorization, call the number on 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 5, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

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

Payment Terms & Features

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
■ 24/7 Virtual Visits	$40	Not Applicable
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.

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for certain Covered Health Services are based on the Recognized Amount as defined in Section 12, *Glossary*.

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 Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance* 80% after you meet the Annual Deductible	*Ground Ambulance* 80% after you meet the Network Annual Deductible *Air Ambulance* 80% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance	*Ground Ambulance* 80% after you meet the Annual Deductible *Air Ambulance*	*Ground Ambulance* 60% after you meet the Annual Deductible *Air Ambulance*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 2, *How the Plan Works*.	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
Cellular and Gene Therapy	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.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	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.	
Congenital Heart Disease (CHD) Surgery Services Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
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
Emergency Health Services – Outpatient (Copay is per visit) If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	*True Emergency* 100% after you pay a $150 Copay *Non-True Emergency* 100% after you pay a $150 Copay	*True Emergency* 100% after you pay a $150 Copay *Non-True Emergency* 100% after you pay a $150 Copay

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital – Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient	*Physician's office* 100% *All other locations* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services ■ Inpatient ■ Outpatient, including Partial Hospitalization/Intensive Outpatient Treatment ■ Virtual Behavioral Health Therapy & Coaching	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible **Designated Network (AbleTo Therapy 360)** 100%	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible Not Covered
Neurobiological Disorders – Autism Spectrum Disorder Services		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient, including Partial Hospitalization/Intensive Outpatient Treatment	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Nutritional Counseling (Copay is per visit) Up to 12 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 (The Plan pays Benefits only for Covered Health Services provided through *Bariatric Resource Services*) See *Obesity Surgery* in Section 5, *Additional Coverage Details*.		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $50 Copay	Non-Network Benefits are not available
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	
■ Hospital – Inpatient Stay	80% after you meet the Annual Deductible	
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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Pharmaceutical Products – Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable Annual Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services – Sickness and Injury (Copay is per visit)		
■ Primary Physician	100% after you pay a $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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Breast Pumps.	100%	60% after you meet the Annual Deductible
■ Colonoscopy	100%	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.	
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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
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
Substance-Related and Addictive Disorders Services ■ Inpatient Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Administrator or search for a Network program on www.myuhc.com.	100%	60% after you meet the Annual Deductible
■ Outpatient, including Partial Hospitalization/Intensive Outpatient Treatment	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services (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 For Dialysis Services, Non-Network Benefits are not available.
Transplantation Services Non-Network Benefits include services provided at a facility that is not a	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Designated Provider and services provided at a non-Network facility. See *Transplantation Services* in Section 5, *Additional Coverage Details*.	Covered Health Service category in this section.	
Urinary Catheters	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services (Copay is per visit)	100% after you pay a $50 Copay	100% after you pay a $50 Copay
24/7 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.	100% after you pay a $40 Copay	Non-Network Benefits are not available
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
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]Please obtain prior authorization before receiving Covered Health Services as described in Section 5, *Additional Coverage Details*.

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*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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. For Non-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cellular and Gene Therapy

The Plan covers Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

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
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you do not 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 UnitedHealthcare 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 facility participating in the CHD Resource Services Program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic Self-Management Items	Insulin pumps and pump supplies and continuous glucose monitors for the management and treatment of diabetes based upon your medical needs. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under the Plan's prescription drug benefit.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.

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 do not 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. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. 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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

Benefits for dedicated speech generating 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.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

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 do not 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 two business days 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 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 two business days 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.

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 from the Claims Administrator five business days before receiving services ,including nutritional foods and Private Duty Nursing or as soon as is reasonably possible. If you do not 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 do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Kaia Health

A mobile app for on-demand, personalized support to help relieve pain and live healthier. Connect with Kaia: http://startkaia.com/uhc.

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 under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

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 Genetic Testing, stress echocardiography and transthoracic echocardiogram, and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you do not obtain prior authorization from the Claims Administrator 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 CT, PET scans, MRI, MRA and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received. If you do not 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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider 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 admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from or to provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy360 Program") for Covered Persons with certain co-occurring behavioral and medical conditions.

The AbleTo Therapy360 Program provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your

specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

There are no Deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider 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 admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you do not obtain prior authorization from or to provide notification to the Claims 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 twelve individual sessions per calendar year for each medical condition.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under the Plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 6*, Clinical Programs and Resources* for more information on the BRS program.

Note: The services described under the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* 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.

Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Inflammatory Injectable Medications (site of care). If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

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.

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.

The Plan does not provide coverage for:

- Doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Post-delivery – services/treatment for the newborn of a dependent daughter.

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 do not 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 Resources,* 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 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 your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

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 available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 stroke;
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals 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 the following be provided:

- medical records
- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

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, or Congenital Anomaly. Rehabilitation services will be reviewed after 40 visits for medical necessity.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- 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 from the Claims Administrator five business days before admission.
- A non-scheduled admission, 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.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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 behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- 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 assistance in locating a provider and coordination of care.

Use of a Network program will result in enhanced benefits and waiver of cost share, where applicable. Contact the Claims Administrator or search for a Network program on www.myuhc.com**.**

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission, you must provide notification to the Claims Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from or to provide notification to the Claims 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 cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization 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 do not 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, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you do not 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 including CAR-T cell therapy for malignancies 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 including CAR-T cell therapy for malignancies, 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 the *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs & Resources* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

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.

Urinary Catheters

Benefits for external. indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

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.

24/7 Virtual Visits

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

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 one wig/hairpiece up to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including Complex Medical Conditions Programs & Services.

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.

Consumer Solutions and Self-Service Tools

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 your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

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 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;
- Access all of the content and wellness topics from NurseLine℠;
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources;
- 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**.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. 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 your ID card.

Complex Medical Conditions Programs & Services

Bariatric Resource Services (BRS)

Your Plan offers the Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

See *Obesity Surgery* in Section 5, *Additional Coverage Details* for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Cancer Resource Services (CRS) Program

Your Plan offers a Cancer Resource Services (CRS) Program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

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 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).*

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on the Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD

surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* in this section.

Kidney Resource Services (KRS) Program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services (KRS) program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS Program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS Program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your Plan's terms, exclusions, limitations and conditions, including the Plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Specialist Management Solutions Program

A Surgical Advocate is a surgical solution that opens the door to quality, affordable outpatient specialty and surgical care and is part of your UnitedHealthcare Duke Energy Team. A Surgical Advocate will work closely with you on every aspect of your surgery to ensure the highest quality of care. Services include connecting you with specialists/ surgeons to help you choose the most appropriate setting for your outpatient surgery/procedures.

Specialties may include, but are not limited to:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine*
- Ophthalmology
- Orthopedic*
- Pain Management
- Podiatry

- Urology
- Women's Health

*For Orthopedic and Musculoskeletal care, surgical advocates partner with registered orthopedic nurses to help:

- Manage your pain; and
- Understand treatment options.
- Download the Kaia app for on-demand, personalized support to help relieve pain and live healthier. Available at no extra cost as part of your health plan. Visit: http://startkaia.com/uhc

If you are planning an inpatient knee, hip or spine procedure, you are required to enroll in the Specialist Management Solutions Program prior to surgery otherwise there is no coverage. You may also be required to use a center of excellence designated facility. The nurses can help you:

- Find a designated provider and facility for your surgery;
- Find other resources such as physical therapists and durable medical equipment;
- Coordinate your surgery with the designated facility; and
- Prepare for both your surgery and recovery.

For inpatient back, knee, hip or spine surgeries, if you live within **50** miles of a designated facility, use of the designated facility is also required. If you reside more than **50** miles from a designated provider and facility, a Travel & Lodging benefit is available for both inpatient and outpatient procedures.

If you or a family member will be having an upcoming surgery or want to enroll in the program, please call the number on your ID card and ask to speak to a surgical advocate.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional 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
- 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 your ID card.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below

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 Covered Person, provided the Covered Person is not covered by Medicare, and a companion as follows:

- Transportation of the Covered Person 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 care related to one of the programs listed below.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the Covered Person resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the Covered Person 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 Specialist Management Solutions 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 Covered Person or the caregiver if the Covered Person is in the Hospital.
- A per diem rate, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

Wellness Programs

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 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 your ID card.

Real Appeal

The Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no Deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the Plan.

- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

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, animal-assisted 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 dedicated speech generating 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*. This exclusion does not apply to cranial molding helmets and cranial banding.

8. Powered and non-powered exoskeleton devices.

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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

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.

7. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.
   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

8. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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.

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*.
   - Urinary catheters for which Benefits are provided as described under *Urinary Catheters* 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 *International Classification of Diseases section on Mental and Behavioral Disorders* or *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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

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.

8. Non-Medical 24-Hour Withdrawal Management.

9. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins.
    - 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 as described under *Wigs* in Section 5, *Additional Coverage Details*.

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 impairment 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. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

18. Intracellular micronutrient testing.

19. Sex transformation operations and related services.

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.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

- Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
- Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
- Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
- Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
6. The reversal of voluntary sterilization.
7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, missed abortion (commonly known as a miscarriage), or medically necessary termination of pregnancy through the first 16 weeks of pregnancy.
8. InVitro fertilization regardless of the reason for treatment.
9. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

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 animal organs;

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 *Complex Medical Conditions Travel and Lodging Assistance Program* described in Section 6, *Clinical Programs and Resources*, and except as identified under *Travel and Lodging* in Section 2, *How the Plan Works*. Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 12, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

6. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*.

7. Rest cures.

8. Services of personal care attendants.

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3 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.

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*.

12. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

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 your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the 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

You may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes 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 Benefit.*

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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 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 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy, or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

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.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.

- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare's determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company,

the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the 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)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary plan and the plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(2) If both parents have the same birthday, the plan that covered the parent longest is the Primary plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the Custodial Parent.

b) The plan covering the Custodial Parent's spouse.

c) The plan covering the non-Custodial Parent.

d) The plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan, and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Services 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, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Annual 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.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is **a**n Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that meets the definition of a Covered Health Services under this Plan.

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 Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.

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 an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, 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, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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 carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on 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. The Claims Administrator 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.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- 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, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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 you that are payable under the Plan. If the refund is due from a person or organization other than you, 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 payment in connection with services provided to persons under other plans for which the Claims Administrator processes 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 either:

- 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

UnitedHealthcare has agreements in place that govern the relationships between it, the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

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 administer payment of 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 are not responsible 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 the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination of or modifications to the Plan.

The Claims Administrator is not the Plan Administrator of the Plan, as that term is used in ERISA. The Claims Administrator is a named fiduciary of the Plan, as that term is used in ERISA, solely with respect to the Claims Administrator's authority to decide claims for Benefits under the Plan and appeals of denied claims for Benefits under the Plan. If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

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.

Interpretation of Benefits

Duke Energy and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Duke Energy and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims

Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Duke Energy may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Duke Energy does so in any particular case shall not in any way be deemed to require Duke Energy to do so in other similar cases.

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, including provider billing and provider payment records. 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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 4, *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

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, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

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.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to Emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

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 or the Recognized Amount when applicable, 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 charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

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:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- 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 Resources*, "Covered Person" means all domestic Retired Employees who are eligible for the and enrolled in the Plan, and their Dependents age 18 and over who are eligible for and enrolled 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.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Dispensing Entity - a pharmacy, provider, 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 Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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 the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

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 – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
    b. The provider or facility furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
    c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
    d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
    e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 Service(s) – 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 as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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 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, service 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), service site 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.UHCprovider.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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *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 – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the

date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 medications or products administered in connection with a Covered Health Service by a Physician.

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.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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 a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- 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 a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Copayment, Coinsurance and applicable Annual Deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in section *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - 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.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care – care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

ATTACHMENT I - 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 & 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 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 UnitedHealth**c**are Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The 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: 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 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 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	¯(=™ ¬φ¯ xi ™Ɱ‹ ⌡ M å ®8 H ı; Ş≠é 8 } é µ+ñ" ⌂ µ Lâ MC: ∫ ™ ` Mⱬ - ‹ Ωα(Ŧ xĚ ®↓ +™8 å ÷b¯‹ é +· {(€ xât' 8 U8 MU- ¬ aě M· ¸ €) ®0™ ŀ ¶⌂ 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 nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	š ĂąĽ¯ð Ę š ĂœĘĽ đĽ¹ ő¢, Ž ă ĂIJĘ - Ιÿ ě ăIJ¹ κ ĂIJĘ Ž ž lĆ ¹ IĆ=Ľ Þ č Ilę¹ IĎŇ – ¹ Ę I¯ő Í ő¡ ĂĽ Þd'Ă –Şlę ő ĄLĂ Ă›Œ –ĄLĂ ¹ ⁄ Ă (Ű) ĚŇĚ ¾ã Ă TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	[illegible] TTY 711
10. Cherokee	¯ Šľě ýğ ŔŮą² Ŕ ŔľĽ Ŕ ŻþαŦ Đ Źź ğ ř ³ ýń Ŕ−þř Ŕ þŮĽ ř Ŕ Đ¯ⁿ Ľ ŔŽ, ¹ ŀďĽ Ň 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	p y t éá~ t ÜAgz éy r r T t ép y Ü¨ x ÜÅÜy ÜRy ÜÉp à y ~ ~ Ü ë T ás aÜ g éJâx ÜÅz Üy Ükoá~ t pRà a {~ Ü p y ÜÜÉgq Ē Ü ID aÜnu {t à Jfâ ày ÜRU u é kë , □ y Éw { vët t wx { Xu { aë a {ë ñ r wÜ ë TTY 600
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 निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल,फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti 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	နအိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒဉ်နဝဲလၢတလိဉ်ဟ့ဉ်အပ္၊ဘဉ်နဉ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘဉ်လီတဲစိအကျိၤလၢကရၢဖိအတလိဉ်ဟ့ဉ်အပ္၊လၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချ့အတၢ်ရဲဉ်တၢ်ကျ အကားအလိၤဒီးဆီဉ်လီၤနီၢ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	□ . □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ ID□ 0□ □ □ □ □ □ □ . 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 پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	IæĔij ŵâŴ♦ Ŵ♠ Ēĩ♦ǾĠųn ☻Ĕij ♣æĀ♥ ĥǿĒĉ Ħ◦ ĒŴǾÁij ☼æĔĀā Ĕij Ŵĥųij ℓ Ĕā Ĕ☼ĉ ♂IæĔij ŵŵ■ŵ æĔĨ ♣Ǿ♠æĔ♥. ĥǿé ĉ ŵ☼Ǿĉ ♂ij Ĕ♥ ℓ Ĕā Ĕ,ħIJ□ ♠ŵĈ ĔĈ ▪ Ĕ♥ ĥ◦ ☻ħIJ◦ Ēąųn ŵāĔ◦ųn ā Ē▪ Ĕ♣ŵ☻Ŵĩ♦Ǿ◦ Ēnĩ ĀǾij ’nų♦ ā Ē▪ Ĕ♣ŵ☻☼ĉ ♂IæĔij , æ☻♦ ĥ◦ ☻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 wōņāān. 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.
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 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

Language	Translated Taglines
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 wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	kÇ-hÑ Ü S pj Ås-z ~Äyña {| ~T k ~Rk Ñ-j \ ~v Åt Ç'k p•pk \ v o m~RÄn \ ~v | ÖmÇ-z ÅX wU kÇ-hÑ Öl pw~o S Uh ÅÄmk Ñ ^ X f ~w ç•Åt r v çÜ o r v f Å Å~U 711 kÑ ~w \ vÜ0 mr Ü
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
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

Language	Translated Taglines
	faʻatalosagaina se tagata faʻaliliu, 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	ܐܚܬܘܢ ܐܝܬܠܘܟܘܢ ܢܡܘܣܐ ܕܡܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܛܠܝܦܘܢ ܕܐܝܬܠܗ ܒܟܪܛܝܣܐ ܕܝܠܝ ܦܠܩܐ ܕܣܘܠܚܢܐ ܘܕܘܫ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	Z| ºPj ≠a zæ | Î øPΘ†H !! ¢Å| l’Ï Ñ Pv º x ←∑ º Çx ºź †z ΏΦq Θ†OŰH ` øÉ ` ø┼VPε ∂] ` →} q áv ¢←ÖŰÑ→Ñ Pj Ì H ↨ F ║ΩÑЬ \ Θ™ŰÑ╧æH q g •Aα †ź å v l ╧j ę Γ _ Ü Ᵽv zæ øï ĹЬ ź ↨ ÖO φ H ź ï å Ĺ┼□TTY 711
55. Thai	•¥¬ÃÆ∏∏Ë©%µç”•»‘¬´å√ÕÀŸ∆“£çe€,∫ ¡ ‘À‘£œ®¥%µçµ√%oå•å,´ ça√ Õ¢∂ç®‘ƒ£œÅ¬ º ∆¡ ‘À‘ ,º ƒµ,∏ƒ.”ä∏∑ÕÕ¬‘√∆£,∏¿ƒ∏Ëè∫ ª ∂ƒº ƒ“©ì∂”ÃÕƒ”· Ω∫ Ã£¡ ‘ø£œ®¥ · ∆ç¢µ 0 ÃÕƒ”Ω∏Ë•»‘¬ª ¢øƒå®∏®‘ƒ%µç÷Õƒè‘ƒøe ,º ƒµ,∏ƒ∑ÕÕ¬‘√∆£ 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

Language	Translated Taglines
	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 קארטל , דרוקט 0. TTY 711 ID
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

TABLE OF CONTENTS

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 66,000 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 66,000 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 by calling 800-378-5697.

- **Option 2:** Use the CVS Caremark mobile app on your smart phone to photograph and submit your prescription.

- **Option 3:** 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, deductible and coinsurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service Pharmacy 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 automatic refill service.

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
- 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)
- Fertility Agents

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:

- COVID-19
- Dengue Fever
- 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)
- RSV (Adult)
- 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.

Caremark Cost Saver® & GoodRx®

Beginning January 1, 2024, your prescription drug program coordinates with GoodRx. This means that when the GoodRx price for a generic, non-specialty drug is lower than the amount you would pay under the Medical Plan's prescription drug coverage, you will automatically pay the lower GoodRx price when you check out at your pharmacy, and 100% of the GoodRx price will apply to your applicable Medical Plan annual deductible. If you have any questions about GoodRx, contact CVS Caremark Customer Service at 888-797-8912.

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, 2024, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2025 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 whose initial effective date with CVS Caremark is January 1, 2024 would have 45 days (until February 14, 2024) 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.*

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 **$150***	**50%** of the cost of the medication up to a maximum of **$300***
***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. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-045

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:

Please see table on following page.

<table>
<tr><th>Plan</th><th>Coverage Category</th><th>Employee Contribution Rates</th><th>Employer Contributions Rates</th></tr>
<tr><td>Basic Life</td><td>• 1 x annual base pay
• $50,000</td><td>N/A
(100% employer paid)</td><td><table><tr><th>Per $1,000 of Coverage
Monthly Premium</th></tr><tr><td>$0.134</td></tr></table></td></tr>
<tr><td>Supplemental Life</td><td>• 1 x annual base pay
• 2 x annual base pay
• 3 x annual base pay
• 4 x annual base pay
• 5 x annual base pay
• 6 x annual base pay
• 7 x annual base pay
• 8 x annual base pay</td><td><table><tr><th colspan="3">Per $1,000 Coverage</th></tr><tr><th>Age</th><th>Non- Tobacco User Monthly Premium</th><th>Tobacco User Monthly Premium</th></tr><tr><td>0-24</td><td>$0.029</td><td>$0.056</td></tr><tr><td>25-29</td><td>$0.029</td><td>$0.068</td></tr><tr><td>30-34</td><td>$0.032</td><td>$0.097</td></tr><tr><td>35-39</td><td>$0.052</td><td>$0.099</td></tr><tr><td>40-44</td><td>$0.067</td><td>$0.143</td></tr><tr><td>45-49</td><td>$0.104</td><td>$0.217</td></tr><tr><td>50-54</td><td>$0.166</td><td>$0.417</td></tr><tr><td>55-59</td><td>$0.306</td><td>$0.654</td></tr><tr><td>60-64</td><td>$0.461</td><td>$0.979</td></tr><tr><td>65-69</td><td>$0.839</td><td>$2.427</td></tr><tr><td>70+</td><td>$1.373</td><td>$4.348</td></tr></table></td><td>N/A
(100% employee paid)</td></tr>
<tr><td>Spouse/ Domestic Partner Life</td><td>• $5,000
• $8,000
• $10,000
• $15,000
• $25,000
• $50,000
• $75,000
• $100,000
• $200,000
• $250,000</td><td><table><tr><th colspan="3">Per $1,000 Coverage</th></tr><tr><th>Age</th><th>Non- Tobacco User Monthly Premium</th><th>Tobacco User Monthly Premium</th></tr><tr><td>0-24</td><td>$0.033</td><td>$0.068</td></tr><tr><td>25-29</td><td>$0.034</td><td>$0.077</td></tr><tr><td>30-34</td><td>$0.035</td><td>$0.106</td></tr><tr><td>35-39</td><td>$0.058</td><td>$0.107</td></tr><tr><td>40-44</td><td>$0.077</td><td>$0.164</td></tr><tr><td>45-49</td><td>$0.124</td><td>$0.257</td></tr><tr><td>50-54</td><td>$0.192</td><td>$0.490</td></tr><tr><td>55-59</td><td>$0.353</td><td>$0.753</td></tr><tr><td>60-64</td><td>$0.541</td><td>$1.147</td></tr><tr><td>65-69</td><td>$0.938</td><td>$1.874</td></tr><tr><td>70+</td><td>$1.709</td><td>$3.738</td></tr></table></td><td>N/A
(100% employee paid)</td></tr>
<tr><td>Child Life</td><td>• $3,000
• $5,000
• $10,000
• $20,000</td><td><table><tr><th>Coverage</th><th>Monthly Premium</th></tr><tr><td>$3,000</td><td>$0.243</td></tr><tr><td>$5,000</td><td>$0.405</td></tr><tr><td>$10,000</td><td>$0.810</td></tr><tr><td>$20,000</td><td>$1.620</td></tr></table></td><td>N/A
(100% employee paid)</td></tr>
</table>

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-046

REQUEST:

Provide a listing of all retirement plans 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:

2024 retiree medical options and full monthly cost rates:

	Individual Only	Individual + Spouse	Indiv + Child(ren)	Individual +Family
Catastrophic	$1,552	$2,842	$1,912	$3,204
Health Savings Plan 1	$1,743	$3,186	$2,235	$3,677
Standard PPO	$2,020	$3,691	$2,540	$4,217

Employees who newly retire from Duke Energy and enroll in Duke Energy's coverage pay the full cost of coverage. The 2024 full monthly cost rates are in the chart above. When the employee retires, if he is part of a closed group eligible for a subsidy, the retiree may be eligible for credits to an HRA until attainment of age 65. Amounts credited to the HRA can be used to help pay for the cost of retiree healthcare coverage through Duke Energy or otherwise. These monthly pre-65 company contributions to the HRA are $250 per month (and $125 for spouses/domestic partners) or $350 per month (and $175 for spouses/domestic partners) depending on the employee's age as of January 1, 2015. This HRA benefit also has been negotiated with each of our unions, resulting in effective dates beyond January 1, 2015, for certain unions.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-047

REQUEST:

Concerning employee fringe benefits:

a. Provide a detailed list of all fringe benefits available to Duke Kentucky's employees. Indicate any fringe benefits that 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:

Please see STAFF-DR-01-047 Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky - Electric

		12 Month Preceding 3/1/23 – 2/29/24	Base Period 3/1/24 – 2/28/25	Variance
1B110	Qualified Pension	459,936	453,722	(6,214)
1B112	Employee Savings Active	947,598	1,081,140	133,541
1B114	OPEB Active	25,272	19,947	(5,325)
1B210	Medical Active	1,117,694	1,483,802	366,108
1B212	Dental Active	46,482	57,532	11,050
1B214	Misc Other Fees	22	-	(22)
1B216	Long Term Disability	42,346	41,728	(618)
1B218	FAS112 Offset	(172,504)	571,900	744,404
1B310	Service/Safety Awards	11,373	10,533	(841)
1B312	Other Work/Family Benefits	-	-	-
1B410	Tuition Refund	6,092	7,939	1,848
1B510	Basic Life	14,816	15,444	628
1B512	Accidental Death & Dismember.	1,350	1,399	49
Total		2,500,478	3,745,087	1,244,609

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 variance for the 24 month period in question are:

(1) Higher 'Employee Savings Active' (401(k)) - the base period includes merit increases and new hires not eligible for pension but eligible for the 4% new hire credit;

(2) Higher 'Medical Active' due to medical claims;

(3) Higher 'FAS112 Offset' due to LTD medical expense.

Duke Energy Kentucky - Gas

		12 Month Preceding 3/1/23 – 2/29/24	Base Period 3/1/24 – 2/28/25	Variance
1B110	Qualified Pension	165,994	174,173	8,180
1B112	Employee Savings Active	341,896	426,976	85,079
1B114	OPEB Active	9,083	7,656	(1,428)
1B210	Medical Active	403,308	568,737	165,429
1B212	Dental Active	16,828	22,029	5,201
1B214	Misc Other Fees	8	-	(8)
1B216	Long Term Disability	15,279	16,011	732
1B218	FAS112 Offset	(61,115)	219,879	280,994
1B310	Service/Safety Awards	4,020	4,034	15
1B312	Other Work/Family Benefits	-	-	-
1B410	Tuition Refund	2,183	3,032	849
1B510	Basic Life	5,345	5,925	580
1B512	Accidental Death & Dismember.	487	537	49
Total		903,317	1,448,989	545,672

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 variance for the 24 month period in question are:

(1) Higher 'Employee Savings Active' (401(k)) - the base period includes merit increases and new hires not eligible for pension but eligible for the 4% new hire credit;

(2) Higher 'Medical Active' due to medical claims;

(3) Higher 'FAS112 Offset' due to LTD medical expense.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-048

REQUEST:

State whether 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 the results of the study or survey, including all workpapers and discuss the results of such comparisons. State whether any adjustments to wages, salaries, benefits, and other compensation in the rate application are consistent with the results of such comparisons.

b. If comparisons were not performed, explain why such comparisons were not performed.

RESPONSE:

As discussed throughout the Direct Testimony of Company witness Shannon A. Caldwell, 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 compensation strategy by using 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. Duke Energy participates in a variety of third-party salary surveys on an annual basis and data from these

surveys is analyzed to determine overall competitiveness of pay for jobs throughout the Company. In Section III and the first question of Section IV of the Direct Testimony provided by Ms. Caldwell, the application of the salary survey data is described and how it directly relates to ensuring the competitiveness of the Company's compensation programs. 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.

In Section VI of the Direct Testimony provided by Ms. Caldwell, benefit program benchmarking is described. 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. This ensures 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. Based on Duke Energy's reviews of the competitiveness and reasonableness of its benefit programs and employee costs, Duke Energy routinely determines if any changes should be made.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

PUBLIC STAFF-DR-01-049
(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.

e. 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:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment (c) only)

a. The Compensation and People Development Committee of the Board of Directors (Committee) establishes and reviews the overall compensation philosophy of Duke Energy, 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. Please see STAFF-DR-01-049(a) Attachment to reference the Committee Charter.

b. Our compensation philosophy is described on pages 7-9 of Shannon A. Caldwell's direct testimony.

c. The 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 Committee and is not permitted to provide any services to Duke Energy other than at the direction of the Committee. Please see STAFF-DR-01-049(c) Confidential Attachment for an annual study conducted by FW Cook in 2023.

d. Annually, our compensation philosophy is described in detail in the Compensation Discussion and Analysis (CD&A) of the proxy statement. The 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.

e. The utility's expenses for wages, salaries, benefits, and other compensation included in the base period and any adjustments to the base period, are components of the Board of Director's compensation program and the Company's Total Rewards compensation program which includes: (1) the establishment of a fair market value for all jobs; (2) annual pay reviews to recognize individual performance; (3) annual short-term cash incentive awards that reward eligible employees with cash bonuses when pre-

established goals are achieved; (4) long-term incentive (LTI) opportunities to attract and retain high-performing leaders; and (5) recognition awards given when employees make significant contributions to business operations due to exceptional personal initiative, dedication, perseverance or a uniquely effective approach to work.

PERSON RESPONSIBLE: Shannon A. Caldwell

CHARTER OF THE COMPENSATION AND PEOPLE DEVELOPMENT COMMITTEE OF THE BOARD OF DIRECTORS OF DUKE ENERGY CORPORATION

(Amended and Restated as of September 19, 2024)

I. General Focus

The Compensation and People Development Committee (the "Committee") shall (a) discharge the responsibilities of the Board of Directors (the "Board") of Duke Energy Corporation (the "Corporation") with respect to the compensation of the Corporation's executive officers and directors, and (b) provide general oversight of the Corporation's compensation philosophy and practices and human capital initiatives.

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. 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. Review and approve periodically, but no less frequently than annually, the Corporation's goals and objectives relevant to the compensation of the Chief Executive Officer and the other executive officers and evaluate the performance of the Chief Executive Officer (based on input from the Corporate Governance Committee) and other executive officers in light of those goals and objectives.

3. Review periodically, but no less frequently than annually, the compensation level (including base salary, short-term incentive opportunity, long-term incentive opportunity and other benefits) of the Chief Executive Officer and make recommendations regarding the Chief Executive Officer's compensation level to the independent members of the Board.

4. Review and approve periodically, but no less frequently than annually, the compensation level (including base salary, short-term incentive opportunity, long-term incentive opportunity and other benefits) of the executive officers other than the Chief Executive Officer.

5. In connection with executive compensation programs:

   (i) Review and recommend to the 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;

   (iv) Take steps to modify any executive compensation program that yields payments and benefits that are not reasonably related to executive and corporate performance; and

   (v) Consider the results of shareholder advisory votes regarding named executive officer compensation when evaluating and determining executive compensation (and recommend the frequency with which the Corporation shall conduct future shareholder advisory votes regarding executive compensation).

6. Review and recommend to the Board the compensation program for non-employee directors.

7. Review and recommend to the Board, or approve, any contracts or other transactions with executive officers of the Corporation, including consulting arrangements, employment contracts, nonqualified deferred compensation plans, perquisite arrangements and severance or termination arrangements, or any revisions thereto. Notwithstanding any other provision of this Charter, the Committee shall review and recommend to the independent members of the Board for approval any consulting arrangement, employment contract, severance or termination arrangement with the Chief Executive Officer, or any revision thereto.

<u>Monitoring Incentive and Equity-Based Compensation Plans</u>

8. 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.

9. 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.

10. 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.

11. Review and make recommendations to the Board, or approve, all awards of shares, 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.

Human Capital

12. Review the Corporation's strategies and policies related to human capital management, including with respect to matters such as diversity and inclusion, employee engagement and talent development.

Reports

13. 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.

14. 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.

15. Maintain minutes or other records of meetings and activities of the Committee.

Advisors

16. 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 have oversight to 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.

VI. Committee References

The Board approved a change in the Committee's name on December 17, 2020 from the "Compensation Committee" to the "Compensation and People Development Committee". Any reference to the Compensation Committee, or words of similar import, in any plans, agreements, arrangements or policies maintained by the Corporation or any subsidiary or affiliate are hereby deemed to be references to the Compensation and People Development Committee, in each case except where the context clearly dictates otherwise.

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-049(c)
CONFIDENTIAL ATTACHMENT

FILED UNDER SEAL

STAFF-DR-01-050

REQUEST:

To the extent not provided in the responses above, provide all wage, compensation, or employee benefits studies, analyses, or surveys conducted since Duke Kentucky's last rate case or that are currently utilized by Duke Kentucky.

RESPONSE:

While Duke Energy does not conduct actual surveys or studies, we participate in and utilize a variety of salary and benefit surveys and ad hoc analyses conducted by third parties on an annual basis. As noted in the response to STAFF-DR-01-048, the documents are voluminous in nature and are considered to be proprietary by the vendor and subject to licensing agreements. As a result, to the extent permitted by these vendors, the Company will make available for the Commission's review, any of the surveys at a time and place that is convenient to the Commission and the Company.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-051

REQUEST:

Provide the average number of customers on Duke Kentucky's system (actual and projected), by rate schedule, for the base period and the three most recent calendar years.

RESPONSE:

Please see STAFF-DR-01-051 Attachment.

PERSON RESPONSIBLE: Bruce L. Sailers

Duke Energy Kentucky, Inc.
Average Monthly Customer Bills[4]
2021 - 2023 and Base Period

Rate Schedule	2021[2]	2022[2]	2023	Actual Mar 24 - Aug 24	Forecast Sep 24 - Feb 25	Base Period Mar 24 - Feb 25
RS	133,093	134,165	136,748	139,200	139,689	139,445
DS	13,230	13,367	13,475	13,588	13,042	13,315
EH	62	60	90	57	104	80
GSFL[1]	41	40	24	24	23	24
SP	13	13	14	14	14	14
DP	10	34	11	10	10	10
DT	171	149	148	151	149	150
TT	13	12	13	13	13	13
WS	8	1	1	1	1	1
SL[5]	11,273	8,342	7,580	8,908	7,631	8,269
TL[3]	8,221	8,104	128	131	130	131
UOLS[3]	7,571	9,947	2,533	2,562	2,544	2,553
NSU[5]	765	681	622	753	673	713
SC[5]	172	172	172	172	172	172
SE[5]	2,073	1,970	1,845	1,777	1,711	1,744
LED[5]	9	127	144	172	161	166

[1] GSFL count is the average number of Fixed Load Locations that were charged the minimum bill.

[2] 2021 - 2022 Data sourced from Case No. 2022-00372 files.

[3] These lighting schedule values were changed from average monthly number of fixtures in 2021 and 2022 to the average monthly bills in 2023 and 2024. Neither of the values are billing determinants for the rates.

[4] Unless otherwise noted, these counts represent the average monthly number of bills for service provided in the months of the year referenced.

[5] These lighting schedule values represent average monthly number of fixtures. Forecast values are set equal to average fixture counts from the 12 month period Sept 2023 - Aug 2024.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-052

REQUEST:

Provide a schedule, in the format provided in Schedule L, of electric operations net income, per kWh sold, per company books for the base period and the three calendar years preceding the base period.

RESPONSE:

Refer to Schedule I-1, page 2 of 2, of Duke Energy Kentucky's Application in this proceeding [Vol. 10, Tab 52].

PERSON RESPONSIBLE: Danielle L. Weatherston

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

STAFF-DR-01-053

REQUEST:

Provide, in the format provided in Schedule M, comparative operating statistics for electric operations.

RESPONSE:

Please see STAFF-DR-01-053 Attachment.

PERSON RESPONSIBLE: Danielle L. Weatherston

DUKE ENERGY KENTUCKY, INC.
Case No. 2024-00354
Comparative Operating Statistics - Electric Operations
For the Calendar Years 2021 through 2023
(Total Company)

Line No.	Item	Three Most Recent Calendar Years 2021 Cost	2021 % Inc.	2022 Cost	2022 % Inc.	2023 Cost	2023 % Inc.
	(a)	(b)	(c)	(d)	(e)	(f)	(g)
1	Cost per KWH of Electricity Generated	$0.042	(2.33)%	$0.049	16.67%	$0.058	18.37%
	Cost (Total Production Expense)	$108,079,150.00	8.95%	$139,711,377.00	29.27%	$140,033,887.00	0.23%
	KWH - Net Generation	2,600,462,000	11.89%	2,878,964,000	10.71%	2,403,788,000	(16.51)%
2	Cost per KWH of Electricity Purchased	$0.046	119.05%	$0.076	65.22%	$0.030	(60.53)%
	Cost	$96,616,963.00	106.83%	$142,594,801.00	47.59%	$61,373,449	(56.96)%
	KWH	2,101,545,000	(3.43)%	1,879,092,000	(10.59)%	2,032,077,000	8.14%
3	Cost per KWH of Electricity Sold	$0.052	36.84%	$0.073	40.38%	$0.052	(28.77)%
	Cost	$204,696,113.00	40.29%	$282,306,178.00	37.91%	$201,407,336.00	(28.66)%
	KWH	3,969,343,604	3.31%	3,887,328,000	(2.07)%	3,869,885,000	(0.45)%
4	Transmission Maintenance Cost	$638,436	(55.39)%	$952,521	49.20%	$1,004,236	5.43%
	per transmission mile	$5,951.23	(55.08)%	$8,752.38	47.07%	$9,536.00	8.95%
5	Distribution Maintenance Cost	$7,547,744	(4.46)%	$10,585,379	40.25%	$8,044,924	(24.00)%
	per distribution mile	$2,558.24	(5.47)%	$3,572.67	39.65%	$2,692.41	(24.64)%
6	Sales Promotion Expense	$1,451,143	13.67%	$1,392,054	(4.07)%	$192,348	(86.18)%
	per Customer	$9.90	13.23%	$9.35	(5.60)%	$1.27	(86.38)%
7	Administration & General Expense	$22,907,236	(3.25)%	$24,512,081	7.01%	$24,047,481	(1.90)%
	per Customer	$156.35	(3.62)%	$164.62	5.29%	$159.12	(3.34)%
8	Wages and Salaries - Charged Expense - per Average Employee	N/A	N/A	N/A	N/A	N/A	N/A
9	Depreciation Expense:	$48,640,753	3.77%	$49,783,713	2.35%	$53,729,352	7.93%
10	per $100 of Average Gross Depreciable Plant in Service	$2.34	(1.27)%	$2.32	(0.85)%	$2.43	4.74%
11	Rents:	$934,529	(1.48)%	$948,735	1.52%	$2,574,965	171.41%
12	per $100 of Average Gross Plant in Service	$0.05	(6.12)%	$0.05	(2.17)%	$0.12	162.22%
13	Property taxes:	$14,497,979	27.43%	$15,509,813	6.98%	$10,140,464	(34.62)%
14	per $100 of Average Net Plant in Service	1.08	20.00%	1.09	0.93%	0.69	(36.70)%
15	Payroll taxes:	N/A	N/A	N/A	N/A	N/A	N/A
16	per Average Employee Whose Salary is Charged to Expense	N/A	N/A	N/A	N/A	N/A	N/A
17	Interest Expense:	$ 20,614,692		$ 22,400,616		$ 27,472,818	
18	per $100 of Average Debt Outstanding	N/A	N/A	N/A	N/A	N/A	N/A
19	per $100 of Average Plant Investment	1.53	N/A	1.57	N/A	1.86	N/A
20	per KWH sold	$0.005	(3.70)%	$0.006	11.54%	$0.007	22.41%
21	Meter reading expense:	$294,899	(21.94)%	$225,910	(23.39)%	$188,725	(16.46)%
22	per Meter	$2.01	(22.22)%	$1.52	(24.64)%	$1.25	(17.67)%

(1) Duke Energy Kentucky does not allocate interest expense between gas and electric operations.
Therefore, interest expense per $100 was not calculated.

Duke Energy Kentucky
Case No. 2024-00354
STAFF First Set Data Requests
Date Received: November 22, 2024

PUBLIC STAFF-DR-01-054
(As to Attachments BLS-3 and BLS-4 only)

REQUEST:

To the extent not already provided, provide a copy of each cost of service study, billing analysis, and all exhibits and schedules that were prepared in Duke Kentucky's rate application in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET
(As to Attachments BLS-3 and BLS-4 only)

1. Please see STAFF-DR-01-054 Attachment - KPSC Electric SFRs-2024 which is an electronic copy of the Company's application, Volume 11, that satisfies 807 KAR 5:001 Section 16(8)(a) through (k).

2. Electronic versions of Schedules M and N are provided in files STAFF-DR-01-054 Attachment - SCH M-N – Test Period and STAFF-DR-01-054 Attachment - SCH M-N – Base Period. In addition, STAFF-DR-01-054 Confidential Attachment BLS-3 and STAFF-DR-01-054 Confidential Attachment BLS-4, are confidential, electronic versions of the schedules provided in the Direct Testimony of Company witness Bruce L. Sailers.

3. Please see STAFF-DR-01-054 Attachment – DEK Electric COSS 2024 Production Stacking Macros Disabled, STAFF-DR-01-054 Attachment – DEK Electric

COSS 2024 Average & Excess Macros Disabled, and STAFF-DR-01-054 Attachment – DEK Electric COSS 2024 Macros Disabled.

PERSON RESPONSIBLE: Lisa D. Steinkuhl
Bruce L. Sailers
James E. Ziolkowski

STAFF-DR-01-054 ATTACHMENT – DEK ELECTRIC COSS 2024 AVERAGE AND EXCESS MACROS DISABLED

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

STAFF-DR-01-054 ATTACHMENT – DEK ELECTRIC COSS 2024 MACROS DISABLED

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

STAFF-DR-01-054 ATTACHMENT – DEK ELECTRIC COSS 2024 PRODUCTION STACKING MACROS DISABLED

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

STAFF-DR-01-054 ATTACHMENT – SCH M-N – BASE PERIOD

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

STAFF-DR-01-054 ATTACHMENT – SCH M-N – TEST PERIOD

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

STAFF-DR-01-054 ATTACHMENT – KPSC ELECTRIC SFRS-2024

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

CONFIDENTIAL PROPRIETARY TRADE SECRET

DUKE ENERGY KENTUCKY, INC

DEK Levelized Fixed Charge Rates by Service Life

		Annual
1	**Service Life**	**LFCR**
2	10	16.60%
3	15	13.41%
4	20	11.95%
5	30	10.74%

2024 Rates

Stores, Freight Handling	**11.00%**
Design and Project Mgmt Adder	**16.40%**
Mgmt and Supervison Adder	**24.40%**
Crew Hourly Rate w Burden	**$82.14**