KyPSC Case No. 2025-00125
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VERIFICATION

STATE OF NORTH CAROLINA)
) SS:
COUNTY OF MECKLENBURG)

The undersigned, Claire C. Hudson, Manager, Finance Forecasting, being duly sworn, deposes and says that she has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of her knowledge, information and belief.

Claire Hudson
Claire C. Hudson Affiant

Subscribed and sworn to before me by Claire C. Hudson on this 29th day of May, 2025.

Teresa Ray
NOTARY PUBLIC

TERESA RAY NOTARY PUBLIC UNION COUNTY, NC My Commission Expires 01-21-29

My Commission Expires: 01/21/29

VERIFICATION

STATE OF NORTH CAROLINA)
) **SS:**
COUNTY OF MECKLENBURG)

The undersigned, Linda L. Miller, Director, Gas and Fuel Accounting, being duly sworn, deposes and says that she has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of her knowledge, information and belief.

Linda L. Miller Affiant

Subscribed and sworn to before me by Linda L. Miller on this 3rd day of June, 2025.

HEATHER PAIGE BLUM NOTARY PUBLIC MECKLENBURG COUNTY, N.C.

Heather Paige Blum
NOTARY PUBLIC

My Commission Expires: 1/9/2028

VERIFICATION

STATE OF NORTH CAROLINA)
) SS:
COUNTY OF MECKLENBURG)

The undersigned, Brian R. Weisker, SVP and President, Natural Gas Business, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of his knowledge, information and belief.

B R. Weisker

Brian R. Weisker Affiant

Subscribed and sworn to before me by Brian R. Weisker on this 5th day of June, 2025.

JANET P CURETON
NOTARY PUBLIC
Mecklenburg County
State of North Carolina

Janet P. Cureton

NOTARY PUBLIC

My Commission Expires: March 1, 2030

VERIFICATION

STATE OF OHIO)
) **SS:**
COUNTY OF HAMILTON)

The undersigned, Jefferson "Jay" P. Brown, Director Rates & Regulatory Planning, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained there are true and correct to the best of his knowledge, information and belief.

Jefferson "Jay" P. Brown Affiant

Subscribed and sworn to before me by Jefferson "Jay" P. Brown on this 6th day of June, 2025.

NOTARY PUBLIC

My Commission Expires: July 8, 2027

EMILIE SUNDERMAN
Notary Public
State of Ohio
My Comm. Expires
July 8, 2027

VERIFICATION

STATE OF NORTH CAROLINA)
)
COUNTY OF MECKLENBURG)

SS:

The undersigned, Sharif S. Mitchell, Manager of Accounting II, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of his knowledge, information and belief.

Sharif S. Mitchell Affiant

Subscribed and sworn to before me by Sharif S. Mitchell on this 10th day of June, 2025.

NOTARY PUBLIC

My Commission Expires: 01/21/29

TERESA RAY
My Commission Expires
NOTARY
PUBLIC
01-21-29
UNION COUNTY, NC

VERIFICATION

STATE OF NORTH CAROLINA)
) **SS:**
COUNTY OF MECKLENBURG)

The undersigned, Rebekah E. Buck, Director of Allocations and Reporting, being duly sworn, deposes and says that she has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of her knowledge, information and belief.

Rebekah Buck
Rebekah E. Buck Affiant

Subscribed and sworn to before me by Rebekah E. Buck on this 11th day of June, 2025.

Teresa Ray
NOTARY PUBLIC



My Commission Expires: 01/21/29

VERIFICATION

STATE OF NORTH CAROLINA)
) SS:
COUNTY OF MECHLENBURG)

The undersigned, Shannon A. Caldwell, Director Compensation, being duly sworn, deposes and says that she has personal knowledge of the matters set forth in the foregoing responses and that it is true and correct to the best of her knowledge, information and belief.

Shannon A. Caldwell Affiant

Subscribed and sworn to before me by Shannon A. Caldwell on this 6th day of June, 2025.

NOTARY PUBLIC

My Commission Expires: 10-1-2028

FELICIA SUEANN RUTTY NOTARY PUBLIC MECKLENBURG COUNTY, NC

VERIFICATION

STATE OF NORTH CAROLINA)
)
COUNTY OF MECKLENBURG)

SS:

The undersigned, John R. Panizza, Director, Tax Operations, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of his knowledge, information and belief.

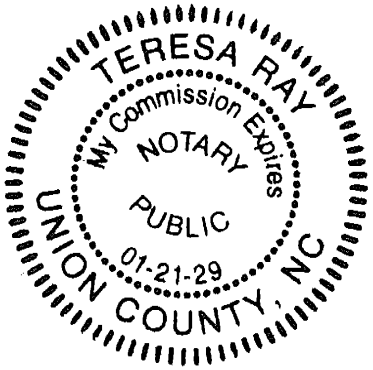
John R. Panizza

John R. Panizza Affiant

Subscribed and sworn to before me by John R. Panizza on this 29th day of May, 2025.

Teresa Ray

NOTARY PUBLIC



My Commission Expires: 01/21/29

VERIFICATION

STATE OF NORTH CAROLINA)
)
COUNTY OF MECKLENBURG)

SS:

The undersigned, Thomas J. Heath, Jr., Director Corporate Finance, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data request and that the answers contained therein are true and correct to the best of his knowledge, information and belief.

Thomas J. Heath, Jr. Affiant

Subscribed and sworn to before me by Thomas J. Heath, Jr. on this 5th day of June, 2025.

NOTARY PUBLIC



My Commission Expires: 01/21/29

VERIFICATION

COMMONWEALTH OF PENNSYLVANIA)
) SS:
COUNTY OF CUMBERLAND)

The undersigned, John J. Spanos, President of Gannett Fleming Valuation and Rate Consultants, LLC, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained there are true and correct to the best of his knowledge, information and belief.

John J. Spanos

John J. Spanos, Affiant

Subscribed and sworn to before me by John J. Spanos on this 2nd day of June, 2025.

NOTARY PUBLIC

Commonwealth of Pennsylvania - Notary Seal
Cheryl Ann Rutter, Notary Public
Cumberland County
My commission expires February 20, 2027
Commission number 1143028
Member, Pennsylvania Association of Notaries

My Commission Expires: February 20, 2027

VERIFICATION

STATE OF OHIO)
) **SS:**
COUNTY OF HAMILTON)

The undersigned, Bruce L. Sailers, Director Jurisdictional Rate Administration, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of his knowledge, information and belief.

Bruce L. Sailers

Bruce L. Sailers Affiant

Subscribed and sworn to before me by Bruce L. Sailers on this 10th day of June, 2025.

Emilie Sunderman

NOTARY PUBLIC

My Commission Expires: July 8, 2027

EMILIE SUNDERMAN
Notary Public
State of Ohio
My Comm. Expires
July 8, 2027

VERIFICATION

STATE OF OHIO)
) **SS:**
COUNTY OF HAMILTON)

The undersigned, Douglas J. Heitkamp, Manager, Rates & Regulatory Strategy, being duly sworn, deposes and says that he has personal knowledge of the matters set forth in the foregoing data requests and that the answers contained therein are true and correct to the best of his knowledge, information and belief.

Douglas J. Heitkamp Affiant

Subscribed and sworn to before me by Douglas J. Heitkamp on this 10th day of June, 2025.

NOTARY PUBLIC

My Commission Expires: July 8, 2027

EMILIE SUNDERMAN
Notary Public
State of Ohio
My Comm. Expires
July 8, 2027

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-001

REQUEST:

Provide the following expense account data:

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

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

RESPONSE:

a. Please see STAFF-DR-01-001(a) Attachment.

b. Since its last natural gas base rate case filed in 2021, Operation & Maintenance (O&M) costs for Duke Energy Kentucky have remained relatively flat, overcoming the cost of inflation, due to several initiatives the Company has executed on in order to minimize costs to customers.

As discussed in the direct testimony of Brian R. Weisker, Duke Energy Kentucky has aggressively investigated and, where justified, implemented new products, technologies, and work methods to increase our productivity. Duke Energy Kentucky and Ohio participate in the American Gas Association's (AGA) Gas Utility Operations Best

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

In addition to the AGA efforts to drive efficiency in operations, Duke Energy Kentucky has continued to utilize our Watch and Protect Program to reduce 3rd party damages which drives cost savings and efficiency. The Watch and Protect Program is a two-part program that aims to predict and prevent damages by utilizing data analytics of historic damages and their associated 811 tickets. Field inspectors are then tasked with visiting the excavations sites that are calculated to have the highest risk to inform the excavator of the dangers of excavating around a natural gas pipeline and reduce the probability of a damage occurring. Duke Energy Kentucky has also continued utilizing our Untonable Program with a goal to repair tonability to underground assets and confirm the location of these assets before a 3rd party excavation and potential damage occurs. The contractor awarded this work receives a notice of an untonable underground asset directly from our locate contractor and reports to the site to repair tonability as soon as possible. Like the Watch and Protect Program, the Untonable Program reduces 3rd party damages

and helps with reducing costs for repairs. Duke Energy also implemented a new Ticket Management System (TMS) in the fall of 2023. The TMS provides greatly improved visibility to our 811 tickets, provides efficiency with marking facilities, and provides data for developing performance metrics for our contract locators. The efficiencies gained with the TMS help with controlling O&M costs. Finally, Duke Energy Kentucky has driven efficiencies in our Designated Building Leak Survey Program, eliminating unnecessary inspections and helping to keep O&M costs flat.

PERSON RESPONSIBLE: Claire C. Hudson – a.
Linda L. Miller – a.
Brian R. Weisker – b.

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
COMPARISON OF EXPENSE ACCOUNT BALANCES
FOR THE BASE PERIOD
AND THE MOST RECENT THREE CALENDAR YEARS

	Line No.	Account No.	Account Title	2022	2023	2023 vs. 2022 Variance	2023 vs. 2022 % Change	2024	2024 vs. 2023 Variance	2024 vs. 2023 % Change	Base Period	2024 vs. Base Period Variance	2024 vs. Base Period % Change
403	1	403	Depreciation Expenses	16,298,381	17,492,023	1,193,642	7.32%	19,387,439	1,895,416	10.84%	20,402,714	1,015,275	5.24%
404	2	404	Amortization Expenses	4,318,843	4,221,608	(97,235)	(2.25)%	3,969,814	(251,794)	(5.96)%	3,371,804	(598,010)	(15.06)%
407	3	407	Regulatory Debits and Credits	1,136,574	1,274,382	137,808	12.12%	(1,599,759)	(2,874,141)	(225.53)%	(1,657,848)	(58,089)	(3.63)%
408	4	408	Taxes Other Than Income Taxes	4,955,559	3,707,509	(1,248,050)	(25.18)%	5,337,302	1,629,793	43.96%	3,840,159	(1,497,143)	(28.05)%
409	5	409	Current Income Taxes	(178,218)	(22,713,418)	(22,535,200)	(12644.74)%	1,489,064	24,202,482	106.56%	10,707,130	9,218,066	619.05%
410	6	410	Deferred Income Taxes - Deferrals	17,214,574	50,945,148	33,730,574	195.94%	23,673,477	(27,271,671)	(53.53)%	4,998,076	(18,675,401)	(78.89)%
411	7	411	Deferred Income Taxes - Writebacks	(12,959,045)	(22,023,854)	(9,064,809)	(69.95)%	(20,499,796)	1,524,058	6.92%	(8,473,848)	12,025,948	58.66%
426	8	426	Sale of AR	800,269	1,565,373	765,104	95.61%	328,961	(1,236,412)	(78.99)%	0	(328,961)	(100.00)%
711	9	711	Gas Boiler Labor	194,280	0	(194,280)	(100.00)%	0	0	-	0	0	-
712	10	712	Gas Production - Other Expense	33,088	0	(33,088)	(100.00)%	0	0	-	0	0	-
717	11	717	Liquid Petroleum Gas Expense	13,725	0	(13,725)	(100.00)%	0	0	-	0	0	-
728	12	728	Liquid Petroleum Gas	1,257,393	0	(1,257,393)	(100.00)%	0	0	-	0	0	-
735	13	735	Miscellaneous Prod Expense	93,080	81,146	(11,934)	(12.82)%	3,533	(77,613)	(95.65)%	1,627	(1,906)	(53.95)%
742	14	742	Production Equipment	28,804	0	(28,804)	(100.00)%	0	0	-	0	0	-
801	15	801	Natural Gas Field Line Purchase	72,478,022	46,247,463	(26,230,559)	(36.19)%	51,689,571	5,442,108	11.77%	61,096,460	9,406,889	18.20%
804	16	804	Natural Gas City Gate Purchase	493	516	23	4.67%	595	79	15.31%	295	(300)	(50.42)%
805	17	805	Unrecovered Purch Gas Adjustment	(1,771,471)	1,589,480	3,360,951	189.73%	(6,126,497)	(7,715,977)	(485.44)%	(4,117,429)	2,009,068	32.79%
807	18	807	Gas Purchased Expenses	631,584	433,945	(197,639)	(31.29)%	691,354	257,409	59.32%	640,605	(50,749)	(7.34)%
813	19	813	Other Gas Supply Expenses	0	0	0	-	0	0	-	0	0	-
844	20	844	LNG Ops Supv Eng Labor & Exp	0	0	0	-	0	0	-	0	0	-
850	21	850	Operation Supv & Eng-Tran	2,522	2,586	64	2.54%	8,228	5,642	218.17%	6,934	(1,294)	(15.73)%
856	22	856	Mains Expenses	0	0	0	-	(710,192)	(710,192)	-	(710,192)	0	-
859	23	859	Other Expenses	16,264	3,990	(12,274)	(75.47)%	5,554	1,564	39.20%	5,554	0	-
863	24	863	Transm-Maint of Mains	451,821	170,323	(281,498)	(62.30)%	402,082	231,759	136.07%	335,313	(66,769)	(16.61)%
871	25	871	Distribution Load Dispatching	298,962	337,062	38,100	12.74%	268,360	(68,702)	(20.38)%	211,693	(56,667)	(21.12)%
874	26	874	Mains And Services	1,449,168	1,147,902	(301,266)	(20.79)%	1,611,521	463,619	40.39%	2,237,797	626,276	38.86%
875	27	875	Measuring & Reg Stations - Gen	136,207	208,905	72,698	53.37%	157,100	(51,805)	(24.80)%	196,455	39,355	25.05%
876	28	876	Measuring & Reg Stations - Ind	32,836	48,235	15,399	46.90%	49,689	1,454	3.01%	48,456	(1,233)	(2.48)%
878	29	878	Meter And House Regulators	427,848	547,643	119,795	28.00%	470,838	(76,805)	(14.02)%	537,450	66,612	14.15%
879	30	879	Customer Installations	1,370,158	1,335,989	(34,169)	(2.49)%	1,376,384	40,395	3.02%	1,286,470	(89,914)	(6.53)%
880	31	880	Gas Distribution Other Expense	1,549,332	1,903,858	354,526	22.88%	1,379,989	(523,869)	(27.52)%	2,107,337	727,348	52.71%
885	32	885	Maint- Supervision & Engineeri	0	0	0	-	0	0	-	0	0	-
887	33	887	Maintenance Of Mains	715,212	842,393	127,181	17.78%	780,134	(62,259)	(7.39)%	854,678	74,544	9.56%
889	34	889	Maint- Measuring & Reg Stat -	33,839	62,499	28,660	84.70%	68,293	5,794	9.27%	59,806	(8,487)	(12.43)%
890	35	890	Maint - Meas/Reg Stn Eq-Indus	0	0	0	-	0	0	-	0	0	-
892	36	892	Maintenance Of Services	958,307	983,076	24,769	2.58%	1,028,361	45,285	4.61%	895,203	(133,158)	(12.95)%
893	37	893	Maintenance Of Meters & House	113,732	48,306	(65,426)	(57.53)%	43,414	(4,892)	(10.13)%	35,630	(7,784)	(17.93)%
894	38	894	Maint - Other Distribution Equipment	23,816	198,995	175,179	735.55%	54,123	(144,872)	(72.80)%	20,919	(33,204)	(61.35)%
901	39	901	Supervision & Engineering	167,421	138,170	(29,251)	(17.47)%	140,867	2,697	1.95%	66,945	(73,922)	(52.48)%
902	40	902	Meter Reading Expense	18,214	11,204	(7,010)	(38.49)%	28,502	17,298	154.39%	76,892	48,390	169.78%
903	41	903	Customer Records & Collections	2,635,087	2,695,533	60,446	2.29%	2,657,250	(38,283)	(1.42)%	2,753,785	96,535	3.63%
904	42	904	Uncollectible Accounts	43,338	295,003	251,665	580.70%	1,575,392	1,280,389	434.03%	1,531,800	(43,592)	(2.77)%
905	43	905	Miscellaneous Customers Accounts	114	89	(25)	(21.93)%	104	15	16.85%	74	(30)	(28.85)%
908	44	908	Customer Assistance Activities	170,461	169,117	(1,344)	(0.79)%	173,007	3,890	2.30%	200,074	27,067	15.65%
909	45	909	Informational & Instructional Adver.	4,324	4,106	(218)	(5.04)%	10,268	6,162	150.07%	2,750	(7,518)	(73.22)%
910	46	910	Misc. Cust. Serv. & Info.	377,066	632,875	255,809	67.84%	502,012	(130,863)	(20.68)%	510,043	8,031	1.60%
911	47	911	Supervision	0	0	0	-	0	0	-	0	0	-
912	48	912	Demonstrating & Selling Exp	342,661	73,217	(269,444)	(78.63)%	72,007	(1,210)	(1.65)%	65,498	(6,509)	(9.04)%
913	49	913	Advertising	7,097	810	(6,287)	(88.59)%	19	(791)	(97.65)%	338	319	1678.95%
920	50	920	Administrative & General Salaries	2,667,809	2,209,961	(457,848)	(17.16)%	2,113,272	(96,689)	(4.38)%	2,392,276	279,004	13.20%
921	51	921	Office Supplies & Expenses	1,552,765	1,495,522	(57,243)	(3.69)%	1,760,729	265,207	17.73%	1,727,128	(33,601)	(1.91)%
922	52	922	Administrative Expenses Transfer Cr.	0	0	0	-	0	0	-	0	0	-
923	53	923	Outside Services Employed	875,654	715,885	(159,769)	(18.25)%	681,230	(34,655)	(4.84)%	657,317	(23,913)	(3.51)%
924	54	924	Property Insurance	73,882	69,755	(4,127)	(5.59)%	14,708	(55,047)	(78.91)%	(1,957)	(16,665)	(113.31)%
925	55	925	Injuries & Damages	99,783	241,305	141,522	141.83%	226,102	(15,203)	(6.30)%	236,633	10,531	4.66%
926	56	926	Employee Pension & Benefits	2,348,909	1,296,914	(1,051,995)	(44.79)%	1,258,928	(37,986)	(2.93)%	1,511,748	252,820	20.08%
928	57	928	State Reg. Commission Expense	295,007	278,574	(16,433)	(5.57)%	252,621	(25,953)	(9.32)%	233,102	(19,519)	(7.73)%
929	58	929	Duplicate Charges-Credit	(1,079,826)	(602,115)	477,711	44.24%	(488,591)	113,524	18.85%	(489,206)	(615)	(0.13)%
930150	59	930.1	General Advertising Exp	59,570	47,886	(11,684)	(19.61)%	70,027	22,141	46.24%	104,777	34,750	49.62%
930	60	930.2	Miscellaneous General Expenses	281,152	194,932	(86,220)	(30.67)%	592,182	397,250	203.79%	659,813	67,631	11.42%
931	61	931	Rents	723,702	856,088	132,386	18.29%	941,275	85,187	9.95%	767,368	(173,907)	(18.48)%
932	62	932	Maintenance of General Plant - Gas	18,935	37,380	18,445	97.41%	(6,012)	(43,392)	(116.08)%	(1,945)	4,067	67.65%
935	63	935	Maintenence of General Plant	2,039	2,259	220	10.79%	501	(1,758)	(77.82)%	110	(391)	(78.04)%

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-002

REQUEST:

Provide, in the format provided in Schedule A, schedules showing a comparison of the balance in the revenue accounts for each month of the base period to the same month of the immediately preceding 12-month period for each revenue account or subaccount included in Duke Kentucky's chart of accounts. Include appropriate footnotes to show the month each rate change was approved and the month the full impact of the change was recorded in the accounts.

RESPONSE:

Please see STAFF-DR-01-002 Attachment.

PERSON RESPONSIBLE: Linda L. Miller

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

		Total			
Account	Description	Prior 12 Months	Base Period	Variance	% Change
450100	Late Payment	0	188,560	(188,560)	(100.00)%
480000	Residential Sales-Gas	83,458,459	95,252,839	(11,794,380)	(12.38)%
480990	Gas Residential Sales-Unbilled	(103,670)	(665,107)	561,437	84.41%
481000	Industrial Sales-Gas	1,720,301	1,866,323	(146,022)	(7.82)%
481090	Gas Industrial Sales Unbilled	(53,666)	9,984	(63,650)	(637.52)%
481200	Gas Commercial Sales	32,583,414	34,646,279	(2,062,865)	(5.95)%
481290	Gas Commercial Sales Unbilled	(353,981)	163,598	(517,579)	(316.37)%
482000	Other Sales to Public Auth-Gas	1,878,940	2,249,421	(370,481)	(16.47)%
482090	Gas OPA Unbilled	(221,355)	28,826	(250,181)	(867.90)%
482200	Gas Public St Hwy Ltng	0	0	0	-
484000	Interdepartmental Sales	19,097	30,845	(11,748)	(38.09)%
487001	Discounts Earn/Lost-Gas	170,862	213,643	(42,781)	(20.02)%
488000	Misc Service Revenue-Gas	24,015	35,744	(11,729)	(32.81)%
488100	IC Misc Svc Reg Gas Reg	0	0	0	-
489000	Transp Gas of Others	1,362,299	3,418,230	(2,055,931)	(60.15)%
489010	IC Gas Transp Rev Reg	1,795,608	1,795,608	0	-
489020	Comm Gas Transp Only	3,086,970	3,676,608	(589,638)	(16.04)%
489025	Comm Gas Transp Unbilled	(21,712)	64,271	(85,983)	(133.78)%
489030	Indust Gas Transp Only	4,480,541	5,717,662	(1,237,121)	(21.64)%
489035	Indust Gas Transp Unbilled	(84,497)	8,837	(93,334)	(1056.17)%
489040	OPA Gas Transp Only	770,419	832,124	(61,705)	(7.42)%
489045	OPA Gas Transp Unbilled	(54,059)	28,930	(82,989)	(286.86)%
489200	Transportation Fees	222	(149)	371	248.99%
495031	Gas Losses Damaged Lines	13,964	2,581	11,383	441.03%
496020	Provision for Rate Refund	17,190	0	17,190	-
	TOTAL	130,489,361	149,565,657		

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

Account	Description	September			October		
		2023	2024	Variance	2023	2024	Variance
450100	Late Payment	0	0	0	0	0	0
480000	Residential Sales-Gas	2,900,964	2,893,633	7,331	3,448,916	3,314,392	134,524
480990	Gas Residential Sales-Unbilled	(77,418)	(351,322)	273,904	908,111	260,259	647,852
481000	Industrial Sales-Gas	29,374	30,601	(1,227)	35,140	39,664	(4,524)
481090	Gas Industrial Sales Unbilled	(6,016)	(3,564)	(2,452)	14,894	10,345	4,549
481200	Gas Commercial Sales	1,539,462	1,057,525	481,937	648,255	1,618,682	(970,427)
481290	Gas Commercial Sales Unbilled	(360,856)	72,302	(433,158)	428,295	(82,749)	511,044
482000	Other Sales to Public Auth-Gas	83,814	51,375	32,439	65,831	59,464	6,367
482090	Gas OPA Unbilled	(204,797)	(25,037)	(179,760)	37,712	19,288	18,424
482200	Gas Public St Hwy Ltng	0	0	0	0	0	0
484000	Interdepartmental Sales	9	35	(26)	18	36	(18)
487001	Discounts Earn/Lost-Gas	0	13,960	(13,960)	0	12,764	(12,764)
488000	Misc Service Revenue-Gas	1,700	1,042	658	1,290	2,323	(1,033)
488100	IC Misc Svc Reg Gas Reg	0	0	0	0	0	0
489000	Transp Gas of Others	181,875	102,686	79,189	127,887	124,928	2,959
489010	IC Gas Transp Rev Reg	149,634	149,634	0	149,634	149,634	0
489020	Comm Gas Transp Only	193,922	411,974	(218,052)	132,435	114,799	17,636
489025	Comm Gas Transp Unbilled	(23,646)	22,356	(46,002)	22,740	(8,763)	31,503
489030	Indust Gas Transp Only	323,928	313,668	10,260	330,764	373,625	(42,861)
489035	Indust Gas Transp Unbilled	(12,402)	(9,527)	(2,875)	35,823	30,427	5,396
489040	OPA Gas Transp Only	30,354	31,881	(1,527)	51,191	49,897	1,294
489045	OPA Gas Transp Unbilled	(54,594)	(7,533)	(47,061)	8,652	12,353	(3,701)
489200	Transportation Fees	0	(170)	170	0	0	0
495031	Gas Losses Damaged Lines	(231)	1,561	(1,792)	12	215	(203)
496020	Provision for Rate Refund	2,865	0	2,865	2,865	0	2,865
	TOTAL	4,697,941	4,757,080		6,450,465	6,101,583	

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

		November			December		
Account	Description	2023	2024	Variance	2023	2024	Variance
450100	Late Payment	0	0	0	0	0	0
480000	Residential Sales-Gas	6,112,941	5,749,944	362,997	11,047,903	12,783,406	(1,735,503)
480990	Gas Residential Sales-Unbilled	2,019,280	961,974	1,057,306	2,766,562	1,401,522	1,365,040
481000	Industrial Sales-Gas	95,933	65,524	30,409	256,363	234,919	21,444
481090	Gas Industrial Sales Unbilled	52,130	26,485	25,645	6,914	3,918	2,996
481200	Gas Commercial Sales	2,182,779	1,925,013	257,766	4,212,287	4,399,860	(187,573)
481290	Gas Commercial Sales Unbilled	1,072,070	629,826	442,244	692,906	494,814	198,092
482000	Other Sales to Public Auth-Gas	120,356	115,543	4,813	223,620	223,139	481
482090	Gas OPA Unbilled	113,197	49,551	63,646	25,385	22,164	3,221
482200	Gas Public St Hwy Ltng	0	0	0	0	0	0
484000	Interdepartmental Sales	55	402	(347)	660	1,413	(753)
487001	Discounts Earn/Lost-Gas	0	16,164	(16,164)	0	27,558	(27,558)
488000	Misc Service Revenue-Gas	1,520	1,715	(195)	1,446	1,686	(240)
488100	IC Misc Svc Reg Gas Reg	0	0	0	0	0	0
489000	Transp Gas of Others	120,394	112,915	7,479	110,149	111,067	(918)
489010	IC Gas Transp Rev Reg	149,634	149,634	0	149,634	149,634	0
489020	Comm Gas Transp Only	153,440	196,998	(43,558)	680,045	612,457	67,588
489025	Comm Gas Transp Unbilled	58,568	49,624	8,944	27,949	48,559	(20,610)
489030	Indust Gas Transp Only	375,560	378,361	(2,801)	388,063	437,765	(49,702)
489035	Indust Gas Transp Unbilled	100,601	61,943	38,658	23,131	16,579	6,552
489040	OPA Gas Transp Only	81,527	76,554	4,973	95,751	119,510	(23,759)
489045	OPA Gas Transp Unbilled	30,067	26,626	3,441	3,468	12,439	(8,971)
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	0	161	(161)	0	16	(16)
496020	Provision for Rate Refund	2,865	0	2,865	2,865	0	2,865
	TOTAL	12,842,917	10,594,957		20,715,101	21,102,425	

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

		January			February		
Account	Description	2024	2025	Variance	2024	2025	Variance
450100	Late Payment	0	0	0	0	0	0
480000	Residential Sales-Gas	15,590,171	18,073,378	(2,483,207)	15,259,039	18,139,309	(2,880,270)
480990	Gas Residential Sales-Unbilled	(96,664)	835,523	(932,187)	(1,912,089)	518,722	(2,430,811)
481000	Industrial Sales-Gas	335,153	358,370	(23,217)	452,521	451,459	1,062
481090	Gas Industrial Sales Unbilled	(39,575)	10,357	(49,932)	(60,350)	(7,485)	(52,865)
481200	Gas Commercial Sales	5,900,910	6,614,331	(713,421)	6,562,192	6,971,591	(409,399)
481290	Gas Commercial Sales Unbilled	276,254	299,717	(23,463)	(1,090,741)	285,147	(1,375,888)
482000	Other Sales to Public Auth-Gas	322,245	361,313	(39,068)	399,317	394,988	4,329
482090	Gas OPA Unbilled	14,246	13,941	305	(111,556)	12,969	(124,525)
482200	Gas Public St Hwy Ltng	0	0	0	0	0	0
484000	Interdepartmental Sales	2,871	5,179	(2,308)	8,573	8,822	(249)
487001	Discounts Earn/Lost-Gas	0	63,998	(63,998)	0	79,199	(79,199)
488000	Misc Service Revenue-Gas	1,816	1,183	633	(1,734)	1,797	(3,531)
488100	IC Misc Svc Reg Gas Reg	0	0	0	0	0	0
489000	Transp Gas of Others	122,650	123,169	(519)	108,104	86,495	21,609
489010	IC Gas Transp Rev Reg	149,634	149,634	0	149,634	149,634	0
489020	Comm Gas Transp Only	292,460	375,948	(83,488)	228,504	316,449	(87,945)
489025	Comm Gas Transp Unbilled	21,245	32,779	(11,534)	(42,752)	(24,865)	(17,887)
489030	Indust Gas Transp Only	471,554	522,086	(50,532)	462,357	451,290	11,067
489035	Indust Gas Transp Unbilled	(52,319)	32,517	(84,836)	(112,813)	(73,222)	(39,591)
489040	OPA Gas Transp Only	142,149	154,533	(12,384)	94,044	117,297	(23,253)
489045	OPA Gas Transp Unbilled	9,789	9,893	(104)	(20,001)	(13,787)	(6,214)
489200	Transportation Fees	0	0	0	52	21	31
495031	Gas Losses Damaged Lines	0	333	(333)	0	295	(295)
496020	Provision for Rate Refund	2,865	0	2,865	2,865	0	2,865
	TOTAL	23,467,454	28,038,182		20,375,166	27,866,125	

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

		March			April		
Account	Description	2024	2025	Variance	2024	2025	Variance
450100	Late Payment	0	54,860	(54,860)	0	40,120	(40,120)
480000	Residential Sales-Gas	9,908,866	11,018,707	(1,109,841)	6,657,317	7,284,941	(627,624)
480990	Gas Residential Sales-Unbilled	(1,361,974)	(1,684,910)	322,936	(1,058,532)	(1,115,509)	56,977
481000	Industrial Sales-Gas	239,521	281,894	(42,373)	137,269	158,436	(21,167)
481090	Gas Industrial Sales Unbilled	7,307	(9,354)	16,661	32,948	(20,283)	53,231
481200	Gas Commercial Sales	4,064,747	4,189,121	(124,374)	2,859,168	2,340,267	518,901
481290	Gas Commercial Sales Unbilled	(343,914)	(621,649)	277,735	(546,747)	(397,804)	(148,943)
482000	Other Sales to Public Auth-Gas	251,077	318,272	(67,195)	147,533	194,780	(47,247)
482090	Gas OPA Unbilled	(22,350)	(6,060)	(16,290)	(44,328)	(65,194)	20,866
482200	Gas Public St Hwy Ltng	0	0	0	0	0	0
484000	Interdepartmental Sales	4,009	3,656	353	1,480	2,246	(766)
487001	Discounts Earn/Lost-Gas	54,860	0	54,860	40,120	0	40,120
488000	Misc Service Revenue-Gas	11,681	4,333	7,348	1,218	4,333	(3,115)
488100	IC Misc Svc Reg Gas Reg	0	0	0	0	0	0
489000	Transp Gas of Others	85,646	348,658	(263,012)	97,801	375,216	(277,415)
489010	IC Gas Transp Rev Reg	149,634	149,634	0	149,634	149,634	0
489020	Comm Gas Transp Only	213,839	370,599	(156,760)	144,638	257,053	(112,415)
489025	Comm Gas Transp Unbilled	(17,744)	(24,544)	6,800	(36,388)	(16,172)	(20,216)
489030	Indust Gas Transp Only	423,754	562,983	(139,229)	355,409	492,870	(137,461)
489035	Indust Gas Transp Unbilled	5,521	(10,009)	15,530	113,016	(41,948)	154,964
489040	OPA Gas Transp Only	95,948	94,193	1,755	56,079	61,487	(5,408)
489045	OPA Gas Transp Unbilled	(5,016)	(338)	(4,678)	(15,151)	(12,398)	(2,753)
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	0	0	0	74	0	74
496020	Provision for Rate Refund	0	0	0	0	0	0
	TOTAL	13,765,412	15,040,046		9,092,558	9,692,075	

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

		May			June		
Account	Description	2024	2025	Variance	2024	2025	Variance
450100	Late Payment	0	29,990	(29,990)	0	17,760	(17,760)
480000	Residential Sales-Gas	3,869,339	4,552,402	(683,063)	3,034,190	4,020,487	(986,297)
480990	Gas Residential Sales-Unbilled	(1,278,870)	(968,007)	(310,863)	(64,809)	(367,631)	302,822
481000	Industrial Sales-Gas	46,331	80,605	(34,274)	27,760	47,731	(19,971)
481090	Gas Industrial Sales Unbilled	(53,967)	(2,489)	(51,478)	(8,300)	(543)	(7,757)
481200	Gas Commercial Sales	1,475,012	1,795,251	(320,239)	881,365	1,317,502	(436,137)
481290	Gas Commercial Sales Unbilled	(374,807)	(351,972)	(22,835)	(67,753)	(254,895)	187,142
482000	Other Sales to Public Auth-Gas	107,074	167,007	(59,933)	55,381	145,229	(89,848)
482090	Gas OPA Unbilled	(20,128)	(6,525)	(13,603)	(10,439)	(22,378)	11,939
482200	Gas Public St Hwy Ltng	0	0	0	0	0	0
484000	Interdepartmental Sales	833	1,721	(888)	459	2,048	(1,589)
487001	Discounts Earn/Lost-Gas	29,992	0	29,992	17,761	0	17,761
488000	Misc Service Revenue-Gas	1,648	4,333	(2,685)	963	4,333	(3,370)
488100	IC Misc Svc Reg Gas Reg	0	0	0	0	0	0
489000	Transp Gas of Others	101,739	437,911	(336,172)	99,749	501,104	(401,355)
489010	IC Gas Transp Rev Reg	149,634	149,634	0	149,634	149,634	0
489020	Comm Gas Transp Only	112,438	252,806	(140,368)	706,264	246,447	459,817
489025	Comm Gas Transp Unbilled	(26,112)	(14,811)	(11,301)	(2,759)	(6,965)	4,206
489030	Indust Gas Transp Only	347,083	499,686	(152,603)	325,527	541,217	(215,690)
489035	Indust Gas Transp Unbilled	(167,378)	(10,529)	(156,849)	(16,262)	(1,409)	(14,853)
489040	OPA Gas Transp Only	33,995	43,774	(9,779)	26,725	27,721	(996)
489045	OPA Gas Transp Unbilled	(8,882)	(762)	(8,120)	(3,256)	(1,048)	(2,208)
489200	Transportation Fees	0	0	0	170	0	170
495031	Gas Losses Damaged Lines	232	0	232	4,183	0	4,183
496020	Provision for Rate Refund	0	0	0	0	0	0
	TOTAL	4,345,206	6,660,025		5,156,553	6,366,344	

DUKE ENERGY KENTUCKY, INC.
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED AUGUST 31, 2025
AND THE TWELVE MONTHS ENDED AUGUST 31, 2024

		July			August		
Account	Description	2024	2025	Variance	2024	2025	Variance
450100	Late Payment	0	25,620	(25,620)	0	20,210	(20,210)
480000	Residential Sales-Gas	2,841,751	3,737,748	(895,997)	2,787,062	3,684,492	(897,430)
480990	Gas Residential Sales-Unbilled	15,602	(191,281)	206,883	37,131	35,553	1,578
481000	Industrial Sales-Gas	33,413	55,364	(21,951)	31,523	61,756	(30,233)
481090	Gas Industrial Sales Unbilled	11,637	87	11,550	(11,288)	2,510	(13,798)
481200	Gas Commercial Sales	1,240,463	1,203,485	36,978	1,016,774	1,213,651	(196,877)
481290	Gas Commercial Sales Unbilled	(43,904)	(64,398)	20,494	5,216	155,259	(150,043)
482000	Other Sales to Public Auth-Gas	54,156	124,055	(69,899)	48,536	94,256	(45,720)
482090	Gas OPA Unbilled	458	2,541	(2,083)	1,245	33,566	(32,321)
482200	Gas Public St Hwy Ltng	0	0	0	0	0	0
484000	Interdepartmental Sales	104	2,555	(2,451)	26	2,732	(2,706)
487001	Discounts Earn/Lost-Gas	14,293	0	14,293	13,836	0	13,836
488000	Misc Service Revenue-Gas	1,093	4,333	(3,240)	1,374	4,333	(2,959)
488100	IC Misc Svc Reg Gas Reg	0	0	0	0	0	0
489000	Transp Gas of Others	99,421	545,175	(445,754)	106,884	548,906	(442,022)
489010	IC Gas Transp Rev Reg	149,634	149,634	0	149,634	149,634	0
489020	Comm Gas Transp Only	114,274	259,093	(144,819)	114,711	261,985	(147,274)
489025	Comm Gas Transp Unbilled	(2,439)	893	(3,332)	(374)	6,180	(6,554)
489030	Indust Gas Transp Only	313,229	554,897	(241,668)	363,313	589,214	(225,901)
489035	Indust Gas Transp Unbilled	35,901	2,073	33,828	(37,316)	11,942	(49,258)
489040	OPA Gas Transp Only	33,785	27,733	6,052	28,871	27,544	1,327
489045	OPA Gas Transp Unbilled	735	641	94	130	2,844	(2,714)
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	6,787	0	6,787	2,907	0	2,907
496020	Provision for Rate Refund	0	0	0	0	0	0
	TOTAL	4,920,393	6,440,248		4,660,195	6,906,567	

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-003

REQUEST:

As the historical data becomes available, provide detailed monthly income statements for each forecasted month of the base period including the month in which the Commission hears this case.

RESPONSE:

Please see STAFF-DR-01-003 Attachment which includes detailed revenue and expense for the actual months of September 2024 through April 2025 and the forecasted months of May 2025 through August 2025. The forecasted months will be updated as the actual information becomes available.

PERSON RESPONSIBLE: Jefferson "Jay" P. Brown

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: ORIGINAL "X" UPDATED REVISED

Account	Description	Code	FERC	Total	ACTUAL Sep-24	ACTUAL Oct-24	ACTUAL Nov-24	ACTUAL Dec-24	ACTUAL Jan-25	ACTUAL Feb-25
403002	Depreciation Expense	DEPR	403	20,392,503	1,641,673	1,652,319	1,668,736	1,716,559	1,698,137	1,705,799
404200	Amort Exp - Limited Term	DEPR	404	3,511,135	333,245	326,339	324,163	327,866	306,083	317,359
407305	Reg Asset Amortization	AMORT	407	237,816	29,727	29,727	29,727	29,727	29,727	29,727
407355	DSM Amortization	OTH	407	(386,904)	(10,017)	(13,642)	(26,047)	(88,365)	(132,149)	(129,415)
407394	Amortization Customer Connect	AMORT	407	82,696	10,337	10,337	10,337	10,337	10,337	10,337
407409	Smart Grid Deferral Gas	OTH	407	(1,935,859)	0	0	0	(1,498,597)	0	0
408121	Taxes Property-Operating	OTHTX	408	3,335,966	(252,033)	635,634	635,634	(1,261,833)	635,634	259,006
408150	State Unemployment Tax	OTHTX	408	5,216	10	0	19	16	4,458	622
408151	Federal Unemployment Tax	OTHTX	408	2,106	(236)	427	470	241	1,480	(313)
408152	Employer FICA Tax	OTHTX	408	254,312	27,698	25,607	43,375	533	36,447	31,969
408470	Franchise Tax	OTHTX	408	(2,825)	170	170	170	(4,253)	200	59
408700	Fed Social Security Tax-Elec	OTHTX	408	3,000	4,000	0	0	(3,000)	0	0
408851	Sales and Use Expense	OTHTX	408	(7,631)	(7,859)	0	0	0	0	0
408960	Allocated Payroll Taxes	OTHTX	408	258,190	6,367	(852)	(11,746)	28,718	14,642	35,141
409060	Federal Income Taxes Utility Op Income	FIT	409	2,443,651	203,638	203,638	203,638	203,638	203,638	203,638
409104	Current State Income Tax - PY	FIT	409	1,356,599	113,050	113,050	113,050	113,050	113,050	113,050
409160	State/Local Inc Tax Exp Utility Op Inc	FIT	409	608,384	50,699	50,699	50,699	50,699	50,699	50,699
409191	Federal Income Tax - PY	FIT	409	6,298,496	524,875	524,875	524,875	524,875	524,875	524,875
410060	Deferred FIT	FIT	410	4,001,774	333,481	333,481	333,481	333,481	333,481	333,481
410101	Deferred SIT	FIT	410	996,302	83,025	83,025	83,025	83,025	83,025	83,025
411060	Deferred FIT - ARAM	FIT	411	48,505	4,042	4,042	4,042	4,042	4,042	4,042
411065	Amortization of Investment Tax Credit	FIT	411	0	0	0	0	0	0	0
411101	Deferred SIT - ARAM	FIT	411	(92,648)	(7,721)	(7,721)	(7,721)	(7,721)	(7,721)	(7,721)
411102	DFIT - Other	FIT	411	(6,308,354)	(525,696)	(525,696)	(525,696)	(525,696)	(525,696)	(525,696)
411103	DSIT: PY	FIT	411	(1,311,692)	(109,308)	(109,308)	(109,308)	(109,308)	(109,308)	(109,308)
411113	DSIT: State Excess DIT Amort	FIT	411	(76,805)	(6,400)	(6,400)	(6,400)	(6,400)	(6,400)	(6,400)
411115	DFIT: Federal Excess DIT Amort	FIT	411	(732,854)	(61,071)	(61,071)	(61,071)	(61,071)	(61,071)	(61,071)
426509	Loss on Sale of A/R	CO	426	0	0	0	0	0	0	0
426591	I/C - Loss on Sale of A/R	CO	426	0	0	0	0	0	0	0
426891	IC Sale of AR Fees VIE	CO	426	0	0	0	0	0	0	0
450100	Late Payment	REV	450	93,580	0	0	0	0	0	0
480000	Residential Sales-Gas	REV	480	101,454,628	2,893,633	3,314,392	5,749,944	12,783,406	18,073,378	18,139,309
480990	Gas Residential Sales-Unbilled	REV	480	(431,681)	(351,322)	260,259	961,974	1,401,522	835,523	518,722
481000	Industrial Sales-Gas	REV	481	1,888,201	30,601	39,664	65,524	234,919	358,370	451,459
481090	Gas Industrial Sales Unbilled	REV	481	15,287	(3,564)	10,345	26,485	3,918	10,357	(7,485)
481200	Gas Commercial Sales	REV	481	38,081,708	1,057,525	1,618,682	1,925,013	4,399,860	6,614,331	6,971,591
481290	Gas Commercial Sales Unbilled	REV	481	(122,445)	72,302	(82,749)	629,826	494,814	299,717	285,147
482000	Other Sales to Public Auth-Gas	REV	482	2,341,232	51,375	59,464	115,543	223,139	361,313	394,988
482090	Gas OPA Unbilled	REV	482	24,857	(25,037)	19,288	49,551	22,164	13,941	12,969
482200	Gas Public St Hwy Ltng	REV	482	0	0	0	0	0	0	0
484000	Interdepartmental Sales	REV	484	34,254	35	36	402	1,413	5,179	8,822
487001	Discounts Earn/Lost-Gas	REV	487	374,839	13,960	12,764	16,164	27,558	63,998	79,199
488000	Misc Service Revenue-Gas	REV	488	28,849	1,042	2,323	1,715	1,686	1,183	1,797
488100	IC Misc Svc Reg Gas Reg	REV	488	0	0	0	0	0	0	0
489000	Transp Gas of Others	REV	489	2,881,985	102,686	124,928	112,915	111,067	123,169	86,495
489010	IC Gas Transp Rev Reg	REV	489	1,795,608	149,634	149,634	149,634	149,634	149,634	149,634
489020	Comm Gas Transp Only	REV	489	3,447,188	411,974	114,799	196,998	612,457	375,948	316,449
489025	Comm Gas Transp Unbilled	REV	489	14,467	22,356	(8,763)	49,624	48,559	32,779	(24,865)
489030	Indust Gas Transp Only	REV	489	5,453,691	313,668	373,625	378,361	437,765	522,086	451,290
489035	Indust Gas Transp Unbilled	REV	489	2,626	(9,527)	30,427	61,943	16,579	32,517	(73,222)
489040	OPA Gas Transp Only	REV	489	833,684	31,881	49,897	76,554	119,510	154,533	117,297

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: ORIGINAL "X" UPDATED REVISED

Account	Description	Code	FERC	Total	ACTUAL Sep-24	ACTUAL Oct-24	ACTUAL Nov-24	ACTUAL Dec-24	ACTUAL Jan-25	ACTUAL Feb-25
489045	OPA Gas Transp Unbilled	REV	489	9,411	(7,533)	12,353	26,626	12,439	9,893	(13,787)
489200	Transportation Fees	REV	489	(149)	(170)	0	0	0	0	21
495031	Gas Losses Damaged Lines	REV	495	3,862	1,561	215	161	16	333	295
496020	Provision for Rate Refund	REV	496	0	0	0	0	0	0	0
711000	Gas Boiler Labor	PO	711	0	0	0	0	0	0	0
712000	Gas Production-Other Power Ex	PO	712	0	0	0	0	0	0	0
717000	Liq Petro Gas Exp-Vapor Proc	PO	717	0	0	0	0	0	0	0
728000	Liquid Petroleum Gas	PO	728	0	0	0	0	0	0	0
735000	Gas Misc Production Exp	PO	735	2,053	260	281	309	272	257	248
742000	Maint Gas Production Equipment	PM	742	0	0	0	0	0	0	0
801000	Purchases Gas & NGL	Fuel	801	62,697,194	2,250,859	2,773,349	4,275,901	8,191,927	14,288,793	10,207,874
801001	Purchases Gas & NGL-Aff	Fuel	801	239,989	1,747	0	17,765	54,240	64,866	55,583
804000	Natural Gas City Gate Purchase	Fuel	804	384	47	49	0	100	52	47
805002	Unrecovered Purchase Gas Adj	Fuel	805	(361,507)	(1,332,830)	(1,338,223)	(2,182,153)	(484,446)	(2,538,639)	1,626,926
805003	Purchase Gas Cost Unbilled Rev	Fuel	805	472,711	170,211	153,285	2,508,736	777,008	1,198,772	827,349
807000	Gas Purchased Expenses	PO	807	629,781	42,982	76,210	55,838	51,634	48,072	59,495
807100	I/C Gas Purchased Expenses	PO	807	9,091	51	312	674	1,177	2,973	2,173
850001	Operation Supv & Eng-Tran	TO	850	6,375	407	355	274	635	603	328
856001	Mains Expenses	TO	856	(795,663)	0	0	0	(710,192)	0	0
859000	Other Expenses-Trans	TO	859	5,554	0	0	0	5,554	0	0
863000	Transm-Maint of Mains	TM	863	342,588	2,639	12,059	10,763	73,534	2,346	58,179
871000	Distribution Load Dispatching	DO	871	215,572	14,960	15,637	15,435	14,919	15,405	21,278
874000	Mains And Services	DO	874	2,135,457	38,170	140,304	169,421	91,124	128,332	111,860
875000	Measuring And Reg Stations-Ge	DO	875	162,656	10,273	4,414	7,792	3,883	12,338	673
876000	Measuring & Reg Station-Indus	DO	876	55,275	431	234	9,235	3,209	3,215	2,957
878000	Meter And House Regulator Exp	DO	878	580,649	71,066	44,024	37,584	21,496	39,483	42,413
879000	Customer Installation Expense	DO	879	1,312,230	94,575	86,623	135,533	118,514	166,607	106,293
880000	Gas Distribution-Other Expense	DO	880	1,925,099	101,720	91,825	170,790	67,664	307,572	108,663
887000	Maintenance of Mains	DM	887	834,044	55,000	40,441	69,897	72,010	61,124	72,736
889000	Maint-Meas/Reg Stn Equip-Gas	DM	889	63,204	8,391	521	4,226	7,955	3,805	5,555
892000	Maintenance of Services	DM	892	985,688	39,905	149,501	195,389	78,139	(76,731)	39,296
893000	Maint - Meters And House Reg	DM	893	33,901	4,120	106	213	133	632	8,127
894000	Maint-Other Distribution Equip	DM	894	4,329	21,241	(23,174)	1,779	10,076	(2,111)	(2,339)
901000	Supervision-Cust Accts	CO	901	100,397	12,371	10,759	11,481	6,657	10,389	15,288
902000	Meter Reading Expense	CO	902	84,447	974	1,188	4,791	12,075	10,385	9,340
903000	Cust Records & Collection Exp	CO	903	832,318	88,993	46,091	75,518	69,597	66,398	94,727
903100	Cust Contracts & Orders-Local	CO	903	568,305	40,649	34,117	42,433	72,176	38,212	56,639
903200	Cust Billing & Acct	CO	903	815,724	62,484	66,397	78,744	96,111	59,734	73,009
903300	Cust Collecting-Local	CO	903	464,502	28,834	30,940	36,397	54,909	26,207	38,557
903400	Cust Receiv & Collect Exp-Edp	CO	903	24,631	2,573	1,910	1,988	1,698	1,696	1,631
903891	IC Collection Agent Revenue	CO	903	0	0	0	0	0	0	0
904000	Uncollectible Accounts	CO	904	1,560,691	117,060	336,970	64,791	61,156	45,900	54,943
904001	BAD DEBT EXPENSE	CO	904	(56,567)	(119,695)	10,856	10,200	6,515	9,728	10,198
905000	Misc Customer Accts Expenses	CO	905	92	22	0	0	51	1	0
908000	Cust Asst Exp-Conservation Programs - I	CSI	908	58	0	0	6	11	8	33
908160	Cust Assist Exp-General	CSI	908	181,901	12,373	15,259	14,063	12,687	12,722	13,348
909650	Misc Advertising Expenses	CSI	909	5,853	1,586	0	300	183	681	0
910000	Misc Cust Serv/Inform Exp	CSI	910	418,735	36,735	32,499	36,332	34,111	29,625	32,518
910100	Exp-Rs Reg Prod/Svces-CstAccts	CSI	910	85,775	6	243	67	16,964	13,394	(2)
912000	Demonstrating & Selling Exp	SE	912	68,272	11,952	19,713	8,300	4,321	1,998	3,774
913001	Advertising Expense	SE	913	186	0	0	0	0	0	0

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: ORIGINAL "X" UPDATED REVISED

Account	Description	Code	FERC	Total	ACTUAL Sep-24	ACTUAL Oct-24	ACTUAL Nov-24	ACTUAL Dec-24	ACTUAL Jan-25	ACTUAL Feb-25
920000	A & G Salaries	AGO	920	2,424,292	176,979	199,815	228,026	21,597	270,847	198,317
920100	Salaries & Wages - Proj Supt - NCRC Re	AGO	920	54	9	8	7	7	3	0
921100	Employee Expenses	AGO	921	14,765	6,115	55,274	(56,235)	(14,138)	22,038	19,060
921110	Relocation Expenses	AGO	921	(91)	0	0	20	0	0	(113)
921200	Office Expenses	AGO	921	250,031	15,335	18,595	13,436	19,774	17,293	22,037
921300	Telephone And Telegraph Exp	AGO	921	61	3	46	5	0	0	0
921400	Computer Services Expenses	AGO	921	54,981	3,973	4,112	2,157	8,101	14,060	3,746
921540	Computer Rent (Go Only)	AGO	921	127,552	16,964	17,132	17,412	16,957	144	161
921600	Other	AGO	921	66	15	0	31	8	0	0
921980	Office Supplies & Expenses	AGO	921	1,227,448	100,465	100,033	112,532	110,910	95,176	106,435
923000	Outside Services Employed	AGO	923	638,836	65,903	76,135	43,633	53,133	63,341	44,248
923980	Outside Services Employee &	AGO	923	13,959	(1,518)	1,571	(5,825)	(1,562)	(147)	(1,982)
924000	Property Insurance	AGO	924	(1,914)	(894)	281	281	(894)	458	442
924050	Inter-Co Prop Ins Exp	AGO	924	1,343	125	125	125	125	119	64
924980	Property Insurance For Corp.	AGO	924	0	0	0	0	0	0	0
925000	Injuries & Damages	AGO	925	3,505	731	33	54	(3)	825	221
925051	INTER-CO GEN LIAB EXP	AGO	925	226,875	17,150	17,150	17,150	17,150	19,662	20,151
925052	Inter-Co Worker Comp Insur Exp	AGO	925	1,769	182	182	182	182	125	146
925100	Accrued Inj and Damages	AGO	925	(1)	0	0	1	0	3	0
925200	Injuries And Damages-Other	AGO	925	359	8	5	5	4	7	10
925300	Environmental Inj & Damages	AGO	925	25,782	0	0	0	0	0	0
925980	Injuries And Damages For Corp.	AGO	925	5,383	581	419	419	419	0	863
926000	EMPL PENSIONS AND BENEFITS	AGO	926	1,165,926	94,397	79,224	85,239	30,300	184,355	94,468
926430	Employees'Recreation Expense	AGO	926	4,445	0	0	5	1,642	(1,155)	0
926600	Employee Benefits-Transferred	AGO	926	402,869	83,599	26,136	(18,429)	65,966	101,043	(57,265)
926999	Non Serv Pension (ASU 2017-07)	AGO	926	(163,769)	88,787	(37,713)	(37,713)	(33,526)	(16,547)	(16,547)
928000	Regulatory Expenses (Go)	AGO	928	69,377	0	0	2,288	1,322	0	532
928006	State Reg Comm Proceeding	AGO	928	169,892	19,364	19,364	19,364	19,364	19,364	19,364
929000	Duplicate Chrgs-Enrgy To Exp	AGO	929	(22,939)	(33)	(47)	(281)	(1,054)	(4,399)	(7,274)
929500	Admin Exp Transf	AGO	929	(446,424)	(37,373)	(39,616)	(51,551)	(25,581)	(22,273)	(25,821)
930150	Miscellaneous Advertising Exp	AGO	930	82,924	269	9,415	321	499	28,134	(353)
930200	Misc General Expenses	AGO	930	691,257	25,258	19,513	32,448	221,468	72,869	91,858
930220	Exp Of Servicing Securities	AGO	930	188	0	0	0	0	188	0
930230	Dues To Various Organizations	AGO	930	12,384	144	2,584	2,934	53	1,573	0
930240	Director'S Expenses	AGO	930	20,768	0	2,229	0	2,279	0	65
930250	Buy\Sell Transf Employee Homes	AGO	930	691	50	79	164	0	23	137
930700	Research & Development	AGO	930	0	0	0	0	0	0	0
930940	General Expenses	AGO	930	58,474	4,343	5,805	5,986	(2,267)	5,786	5,766
931001	Rents-A&G	AGO	931	83,625	8,722	5,990	9,140	8,246	5,679	4,000
931008	A&G Rents-IC	AGO	931	747,239	73,395	72,276	72,770	72,736	73,311	73,399
932000	Maintenance Of Gen Plant-Gas	AGO	932	(11,463)	(6,908)	812	1,745	(5,655)	2,383	4,278
935200	Cust Infor & Computer Control	AGM	935	37	260	(441)	13	71	34	(134)
935250	Maint-CompSoftware-GenPlnt	AGM	935	151	0	0	0	0	151	0

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: ORIGINAL "X" UPDATED REVISED

Account	Description	Code	FERC	ACTUAL Mar-25	ACTUAL Apr-25	BUDGET May-25	BUDGET Jun-25	BUDGET Jul-25	BUDGET Aug-25
403002	Depreciation Expense	DEPR	403	1,706,088	1,705,192	1,715,607	1,719,552	1,724,840	1,738,001
404200	Amort Exp - Limited Term	DEPR	404	309,811	320,347	238,581	238,580	234,418	234,343
407305	Reg Asset Amortization	AMORT	407	29,727	29,727	0	0	0	0
407355	DSM Amortization	OTH	407	6,900	5,831	0	0	0	0
407394	Amortization Customer Connect	AMORT	407	10,337	10,337	0	0	0	0
407409	Smart Grid Deferral Gas	OTH	407	(437,262)	0	0	0	0	0
408121	Taxes Property-Operating	OTHTX	408	447,320	447,320	447,321	447,321	447,321	447,321
408150	State Unemployment Tax	OTHTX	408	68	23	0	0	0	0
408151	Federal Unemployment Tax	OTHTX	408	(320)	357	0	0	0	0
408152	Employer FICA Tax	OTHTX	408	53,420	35,263	0	0	0	0
408470	Franchise Tax	OTHTX	408	400	259	0	0	0	0
408700	Fed Social Security Tax-Elec	OTHTX	408	2,000	0	0	0	0	0
408851	Sales and Use Expense	OTHTX	408	0	228	0	0	0	0
408960	Allocated Payroll Taxes	OTHTX	408	(14,405)	16,588	53,399	43,155	43,617	43,566
409060	Federal Income Taxes Utility Op Income	FIT	409	203,638	203,638	203,638	203,638	203,638	203,633
409104	Current State Income Tax - PY	FIT	409	113,050	113,050	113,050	113,050	113,050	113,049
409160	State/Local Inc Tax Exp Utility Op Inc	FIT	409	50,699	50,699	50,699	50,699	50,699	50,695
409191	Federal Income Tax - PY	FIT	409	524,875	524,875	524,875	524,875	524,875	524,871
410060	Deferred FIT	FIT	410	333,481	333,481	333,481	333,481	333,481	333,483
410101	Deferred SIT	FIT	410	83,025	83,025	83,025	83,025	83,025	83,027
411060	Deferred FIT - ARAM	FIT	411	4,042	4,042	4,042	4,042	4,042	4,043
411065	Amortization of Investment Tax Credit	FIT	411	0	0	0	0	0	0
411101	Deferred SIT - ARAM	FIT	411	(7,721)	(7,721)	(7,721)	(7,721)	(7,721)	(7,717)
411102	DFIT - Other	FIT	411	(525,696)	(525,696)	(525,696)	(525,696)	(525,696)	(525,698)
411103	DSIT: PY	FIT	411	(109,308)	(109,308)	(109,308)	(109,308)	(109,308)	(109,304)
411113	DSIT: State Excess DIT Amort	FIT	411	(6,400)	(6,400)	(6,400)	(6,400)	(6,400)	(6,405)
411115	DFIT: Federal Excess DIT Amort	FIT	411	(61,071)	(61,071)	(61,071)	(61,071)	(61,071)	(61,073)
426509	Loss on Sale of A/R	CO	426	0	0	0	0	0	0
426591	I/C - Loss on Sale of A/R	CO	426	0	0	0	0	0	0
426891	IC Sale of AR Fees VIE	CO	426	0	0	0	0	0	0
450100	Late Payment	REV	450	0	0	29,990	17,760	25,620	20,210
480000	Residential Sales-Gas	REV	480	15,473,704	9,031,733	4,552,402	4,020,487	3,737,748	3,684,492
480990	Gas Residential Sales-Unbilled	REV	480	(2,031,647)	(535,346)	(968,007)	(367,631)	(191,281)	35,553
481000	Industrial Sales-Gas	REV	481	299,874	162,334	80,605	47,731	55,364	61,756
481090	Gas Industrial Sales Unbilled	REV	481	(223)	(24,111)	(2,489)	(543)	87	2,510
481200	Gas Commercial Sales	REV	481	6,311,453	3,653,364	1,795,251	1,317,502	1,203,485	1,213,651
481290	Gas Commercial Sales Unbilled	REV	481	(864,084)	(441,412)	(351,972)	(254,895)	(64,398)	155,259
482000	Other Sales to Public Auth-Gas	REV	482	379,103	225,760	167,007	145,229	124,055	94,256
482090	Gas OPA Unbilled	REV	482	(31,844)	(43,379)	(6,525)	(22,378)	2,541	33,566
482200	Gas Public St Hwy Ltng	REV	482	0	0	0	0	0	0
484000	Interdepartmental Sales	REV	484	6,751	2,560	1,721	2,048	2,555	2,732
487001	Discounts Earn/Lost-Gas	REV	487	91,454	69,742	0	0	0	0
488000	Misc Service Revenue-Gas	REV	488	2,673	(902)	4,333	4,333	4,333	4,333
488100	IC Misc Svc Reg Gas Reg	REV	488	0	0	0	0	0	0
489000	Transp Gas of Others	REV	489	93,300	94,329	437,911	501,104	545,175	548,906
489010	IC Gas Transp Rev Reg	REV	489	149,634	149,634	149,634	149,634	149,634	149,634
489020	Comm Gas Transp Only	REV	489	223,397	174,835	252,806	246,447	259,093	261,985
489025	Comm Gas Transp Unbilled	REV	489	(57,667)	(32,853)	(14,811)	(6,965)	893	6,180
489030	Indust Gas Transp Only	REV	489	431,266	360,616	499,686	541,217	554,897	589,214
489035	Indust Gas Transp Unbilled	REV	489	(3,589)	(54,579)	(10,529)	(1,409)	2,073	11,942
489040	OPA Gas Transp Only	REV	489	87,465	69,775	43,774	27,721	27,733	27,544

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: ORIGINAL "X" UPDATED REVISED

Account	Description	Code	FERC	ACTUAL Mar-25	ACTUAL Apr-25	BUDGET May-25	BUDGET Jun-25	BUDGET Jul-25	BUDGET Aug-25
489045	OPA Gas Transp Unbilled	REV	489	(12,132)	(20,123)	(762)	(1,048)	641	2,844
489200	Transportation Fees	REV	489	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	REV	495	649	632	0	0	0	0
496020	Provision for Rate Refund	REV	496	0	0	0	0	0	0
711000	Gas Boiler Labor	PO	711	0	0	0	0	0	0
712000	Gas Production-Other Power Ex	PO	712	0	0	0	0	0	0
717000	Liq Petro Gas Exp-Vapor Proc	PO	717	0	0	0	0	0	0
728000	Liquid Petroleum Gas	PO	728	0	0	0	0	0	0
735000	Gas Misc Production Exp	PO	735	212	214	0	0	0	0
742000	Maint Gas Production Equipment	PM	742	0	0	0	0	0	0
801000	Purchases Gas & NGL	Fuel	801	6,604,187	5,203,836	2,407,160	2,214,036	2,133,187	2,146,085
801001	Purchases Gas & NGL-Aff	Fuel	801	31,231	14,557	0	0	0	0
804000	Natural Gas City Gate Purchase	Fuel	804	45	44	0	0	0	0
805002	Unrecovered Purchase Gas Adj	Fuel	805	4,889,702	998,156	0	0	0	0
805003	Purchase Gas Cost Unbilled Rev	Fuel	805	(2,793,257)	(956,993)	(753,002)	(555,260)	(269,243)	165,105
807000	Gas Purchased Expenses	PO	807	47,160	48,672	53,040	48,753	48,894	49,031
807100	I/C Gas Purchased Expenses	PO	807	859	872	0	0	0	0
850001	Operation Supv & Eng-Tran	TO	850	354	427	748	748	748	748
856001	Mains Expenses	TO	856	(85,471)	0	0	0	0	0
859000	Other Expenses-Trans	TO	859	0	0	0	0	0	0
863000	Transm-Maint of Mains	TM	863	3,313	68,983	54,971	18,282	14,538	22,981
871000	Distribution Load Dispatching	DO	871	27,433	15,984	25,722	16,227	16,265	16,307
874000	Mains And Services	DO	874	156,877	173,214	283,052	289,955	277,076	276,072
875000	Measuring And Reg Stations-Ge	DO	875	803	13,431	35,933	24,279	24,368	24,469
876000	Measuring & Reg Station-Indus	DO	876	10,693	5,069	6,728	4,487	4,501	4,516
878000	Meter And House Regulator Exp	DO	878	50,717	64,537	54,154	52,227	51,366	51,582
879000	Customer Installation Expense	DO	879	113,831	94,018	120,811	91,526	91,796	92,103
880000	Gas Distribution-Other Expense	DO	880	144,010	89,134	223,929	233,215	185,030	201,547
887000	Maintenance of Mains	DM	887	65,838	51,412	99,335	68,179	108,754	69,318
889000	Maint-Meas/Reg Stn Equip-Gas	DM	889	5,852	6,891	5,939	4,682	4,689	4,698
892000	Maintenance of Services	DM	892	177,448	68,416	76,629	78,738	79,031	79,927
893000	Maint - Meters And House Reg	DM	893	1,271	3,807	5,110	3,450	3,460	3,472
894000	Maint-Other Distribution Equip	DM	894	2,994	(16,265)	6,680	1,780	1,814	1,854
901000	Supervision-Cust Accts	CO	901	15,918	17,534	0	0	0	0
902000	Meter Reading Expense	CO	902	9,687	9,484	8,841	5,894	5,894	5,894
903000	Cust Records & Collection Exp	CO	903	69,034	64,493	69,762	60,683	64,405	62,617
903100	Cust Contracts & Orders-Local	CO	903	40,958	25,672	57,951	53,694	50,275	55,529
903200	Cust Billing & Acct	CO	903	69,028	63,406	66,941	60,457	57,221	62,192
903300	Cust Collecting-Local	CO	903	34,510	29,459	49,536	45,452	42,862	46,839
903400	Cust Receiv & Collect Exp-Edp	CO	903	1,520	2,399	2,331	2,295	2,295	2,295
903891	IC Collection Agent Revenue	CO	903	0	0	0	0	0	0
904000	Uncollectible Accounts	CO	904	112,819	105,735	167,702	168,190	163,702	161,723
904001	BAD DEBT EXPENSE	CO	904	9,289	6,342	0	0	0	0
905000	Misc Customer Accts Expenses	CO	905	18	0	0	0	0	0
908000	Cust Asst Exp-Conservation Programs - I	CSI	908	0	0	0	0	0	0
908160	Cust Assist Exp-General	CSI	908	11,499	11,914	19,325	20,731	20,336	17,644
909650	Misc Advertising Expenses	CSI	909	1,540	1,563	0	0	0	0
910000	Misc Cust Serv/Inform Exp	CSI	910	38,786	34,718	36,947	35,353	36,048	35,063
910100	Exp-Rs Reg Prod/Svces-CstAccts	CSI	910	7,417	7,585	9,859	10,136	9,970	10,136
912000	Demonstrating & Selling Exp	SE	912	375	4,629	1,115	1,115	5,490	5,490
913001	Advertising Expense	SE	913	0	0	17	135	17	17

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
BASE PERIOD

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: ORIGINAL "X" UPDATED REVISED

Account	Description	Code	FERC	ACTUAL Mar-25	ACTUAL Apr-25	BUDGET May-25	BUDGET Jun-25	BUDGET Jul-25	BUDGET Aug-25
920000	A & G Salaries	AGO	920	298,633	208,022	218,996	176,887	213,091	213,082
920100	Salaries & Wages - Proj Supt - NCRC Re	AGO	920	13	7	0	0	0	0
921100	Employee Expenses	AGO	921	11,644	(3,417)	(6,657)	(5,450)	(6,954)	(6,515)
921110	Relocation Expenses	AGO	921	2	0	0	0	0	0
921200	Office Expenses	AGO	921	10,755	19,957	29,915	28,744	26,476	27,714
921300	Telephone And Telegraph Exp	AGO	921	7	0	0	0	0	0
921400	Computer Services Expenses	AGO	921	(15,546)	3,036	7,438	7,592	8,703	7,609
921540	Computer Rent (Go Only)	AGO	921	159	3,260	13,781	14,602	12,558	14,422
921600	Other	AGO	921	12	0	0	0	0	0
921980	Office Supplies & Expenses	AGO	921	105,063	103,974	97,545	98,388	98,409	98,518
923000	Outside Services Employed	AGO	923	58,641	52,625	41,558	46,899	53,434	39,286
923980	Outside Services Employee &	AGO	923	1,843	(1,448)	5,286	5,286	6,384	6,071
924000	Property Insurance	AGO	924	(770)	405	(462)	(1,343)	1,044	(462)
924050	Inter-Co Prop Ins Exp	AGO	924	92	92	119	119	119	119
924980	Property Insurance For Corp.	AGO	924	0	0	0	0	0	0
925000	Injuries & Damages	AGO	925	416	764	116	116	116	116
925051	INTER-CO GEN LIAB EXP	AGO	925	19,907	19,907	19,662	19,662	19,662	19,662
925052	Inter-Co Worker Comp Insur Exp	AGO	925	135	135	125	125	125	125
925100	Accrued Inj and Damages	AGO	925	0	(5)	0	0	0	0
925200	Injuries And Damages-Other	AGO	925	4	4	78	78	78	78
925300	Environmental Inj & Damages	AGO	925	25,782	0	0	0	0	0
925980	Injuries And Damages For Corp.	AGO	925	431	431	455	455	455	455
926000	EMPL PENSIONS AND BENEFITS	AGO	926	104,648	84,009	99,665	115,092	110,229	84,300
926430	Employees'Recreation Expense	AGO	926	0	24	0	3,929	0	0
926600	Employee Benefits-Transferred	AGO	926	(5,658)	36,117	38,257	43,619	44,925	44,559
926999	Non Serv Pension (ASU 2017-07)	AGO	926	(16,547)	(16,547)	(19,354)	(19,354)	(19,354)	(19,354)
928000	Regulatory Expenses (Go)	AGO	928	3,439	1,592	15,051	15,051	15,051	15,051
928006	State Reg Comm Proceeding	AGO	928	19,364	19,364	3,745	3,745	3,745	3,745
929000	Duplicate Chrgs-Enrgy To Exp	AGO	929	(6,548)	(3,303)	0	0	0	0
929500	Admin Exp Transf	AGO	929	(27,951)	(26,518)	(60,839)	(42,967)	(42,967)	(42,967)
930150	Miscellaneous Advertising Exp	AGO	930	297	313	10,861	11,448	10,860	10,860
930200	Misc General Expenses	AGO	930	90,218	76,510	17,099	15,543	13,824	14,649
930220	Exp Of Servicing Securities	AGO	930	0	0	0	0	0	0
930230	Dues To Various Organizations	AGO	930	38	1,130	1,043	949	949	987
930240	Director'S Expenses	AGO	930	2	2,434	11,515	0	2,244	0
930250	Buy\Sell Transf Employee Homes	AGO	930	75	150	1	6	3	3
930700	Research & Development	AGO	930	0	0	0	0	0	0
930940	General Expenses	AGO	930	4,599	5,303	5,788	5,789	5,788	5,788
931001	Rents-A&G	AGO	931	7,289	5,129	7,236	7,310	7,776	7,108
931008	A&G Rents-IC	AGO	931	73,529	73,223	40,650	40,650	40,650	40,650
932000	Maintenance Of Gen Plant-Gas	AGO	932	(15,244)	6,153	321	217	217	218
935200	Cust Infor & Computer Control	AGM	935	97	33	26	26	26	26
935250	Maint-CompSoftware-GenPlnt	AGM	935	0	0	0	0	0	0

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-004

REQUEST:

Provide Duke Kentucky's cash account balances at the beginning of the most recent calendar year and at the end of each month through the date of this request.

RESPONSE:

Please see STAFF-DR-01-004 Attachment.

PERSON RESPONSIBLE: Linda L. Miller

Duke Energy Kentucky, Inc.
Cash Account
January 2024 to April 2025

Account	January 1, 2024	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025
0131088 - Cash Wells Fargo 1157	$ 9,297.43	$ 9,297.43	$ 9,297.43	$ 9,297.43	$ 9,737.79	$ 9,297.43	$ 9,297.43	$ 9,297.43	$ 9,798.89	$ 10,964.10	$ 9,297.43	$ 10,047.62	$ 10,047.62	$ 10,047.62	$ 11,856.27	$ 132,218.88	$ 10,000.00
0131100 - Cash Various Banks	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131124 - Cash PNC 8836	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131147 - Cash PNC 4135	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131155 - Cash PNC 0659	-	256,203.47	-	879,019.14	(312,288.40)	758,328.87	(4,155,588.49)	(654,075.35)	75,831.20	(14,704.06)	8,978.47	12,179.42	(476,055.91)	(1,156,504.79)	(206,768.83)	(43,108.02)	(48,867.37)
0131156 - Cash PNC 3728	-	-	-	-	-	-	-	-	(11,951.96)	(39,950.77)	(23,386.92)	(9,850.25)	(340,643.04)	(52,909.12)	(1,458,274.64)	(220,908.34)	(7,323.75)
0131157 - Cash PNC 3648	-	-	-	-	-	-	-	-	(10,678.59)	(10,410.55)	(6,594.59)	(6,594.59)	(6,836.86)	(6,836.86)	(6,836.86)	(6,837.60)	(6,741.50)
0131158 - Cash Fifth Third 0926	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131159 - Cash JPM Chase 9831	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131160 - Cash JPM Chase 7099	27,487.96	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	27,555.19	-	-	-	-	-
0131199 - Cash - reclass	-	-	-	-	-	-	4,225,324.48	-	-	225,054.06	-	-	823,535.81	-	-	270,853.96	-
0131200 - Cash BOA 7068	-	-	-	-	-	-	-	-	(2,140.21)	-	-	-	-	-	-	-	-
0131201 - Cash BOA 7071	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131202 - Cash BOA 7084	927,999.24	762,707.47	-	-	1,138,507.15	(181,926.91)	151,578.37	217,457.42	452,605.50	461,340.54	1,321,821.92	106,904.85	1,072,400.20	339,557.10	383,378.19	821,163.66	1,350,425.17
0131264 - Cash JPM 4604 CRC-DEK	2,102,598.37	2,421,286.68	2,921,356.51	605,786.77	2,112,471.02	1,924,877.13	1,277,851.89	1,591,572.68	3,851,130.62	867,446.64	1,866,920.73	872,379.25	3,982,763.02	3,375,634.87	3,021,995.34	2,887,293.55	3,207,161.38
0131270 - Cash JPM 4547 DEK	-	-	-	-	(318,301.04)	(220,866.47)	(274,670.67)	(221,132.01)	(282,592.58)	(594,488.86)	(383,665.85)	(381,352.03)	(405,949.62)	(443,085.24)	(427,561.27)	(365,224.36)	(390,932.10)
0131327 - Cash-DPCBIS-BofA-Receipts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0136200 - Short-Term Investment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash	$ 3,067,383.00	$ 3,477,050.24	$ 2,958,209.13	$ 1,521,658.53	$ 2,657,681.71	$ 2,317,265.24	$ 1,261,348.20	$ 970,675.36	$ 4,109,558.06	$ 932,806.29	$ 2,820,926.38	$ 631,269.46	$ 4,659,261.22	$ 2,065,903.58	$ 1,317,788.20	$ 3,475,451.73	$ 4,113,721.83
0135000 - Working Funds - Miscellaneous	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0135101 - Oth Dep - Petty Cash Fund	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Working Funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Cash	$ 3,067,383.00	$ 3,477,050.24	$ 2,958,209.13	$ 1,521,658.53	$ 2,657,681.71	$ 2,317,265.24	$ 1,261,348.20	$ 970,675.36	$ 4,109,558.06	$ 932,806.29	$ 2,820,926.38	$ 631,269.46	$ 4,659,261.22	$ 2,065,903.58	$ 1,317,788.20	$ 3,475,451.73	$ 4,113,721.83

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-005

REQUEST:

Provide the following monthly account balances and a calculation of the average (13-month) account balances for the 12 months preceding the base period:

a. Plant in service (Account No. 101);

b. Plant purchased or sold (Account No. 102);

c. Property held for future use (Account No. 105);

d. Completed construction not classified (Account No. 106);

e. Construction work in progress (Account No. 107);

f. Depreciation reserve (Account No. 108);

g. Materials and supplies (include all accounts and subaccounts);

h. Computation and development of minimum cash requirements;

i. Balance in accounts payable applicable to amounts included in utility plant in service (if actual is indeterminable, provide a reasonable estimate.);

j. Balance in accounts payable applicable to amounts included in plant under construction (if actual is indeterminable, provide a reasonable estimate.); and

k. Balance in accounts payable applicable to prepayments by major category or subaccount.

RESPONSE:

Please see STAFF-DR-01-005 Attachment.

PERSON RESPONSIBLE: Sharif S. Mitchell

Line No.	Month	Plant in Service [1] (Account No. 101) (a)	Plant Purchased or Sold (Account No. 102) (b)	Property Held for Future Use (Account No. 105) (c)	Completed Construction Not Classified [2] (Account No. 106) (d)	CWIP (Account No. 107) (e)	Accumulated Depreciation & Amortization (Account No. 108) (f)	Materials & Supplies (Various Accounts) (g)	Cash Working Capital (Account No. 131) (h)	Balance in A/P Applicable to Utility Plant [4] (i)	Balance in A/P Applicable to CWIP (j)	Balance in A/P Applicable to Prepayments [4] (k)
1	**Total Company**											
2	Aug 2023	2,925,907,992	0	171,103	298,268,892	118,225,061	1,052,072,920	25,589,398	2,155,968	N/A	26,577,049	N/A
3	Sep 2023	2,920,786,214	0	190,188	303,840,221	125,083,113	1,053,887,547	26,760,422	9,403,264	N/A	25,812,143	N/A
4	Oct 2023	2,927,822,617	0	218,498	311,706,503	135,789,049	1,058,793,969	26,572,691	11,271,929	N/A	37,064,491	N/A
5	Nov 2023	2,931,411,339	0	251,028	324,798,725	131,890,909	1,063,206,769	26,707,611	24,349,038	N/A	33,801,645	N/A
6	Dec 2023	2,940,005,960	0	265,679	364,699,106	96,665,887	1,062,466,419	27,305,571	3,067,383	N/A	32,169,324	N/A
7	Jan 2024	2,941,206,530	0	58,361	377,577,937	92,916,630	1,061,180,091	28,029,234	3,477,050	N/A	24,491,141	N/A
8	Feb 2024	2,942,877,421	0	58,583	383,603,991	97,711,080	1,064,240,446	29,725,704	2,958,209	N/A	17,112,662	N/A
9	Mar 2024	2,964,434,219	0	57,871	366,844,570	106,865,810	1,068,000,025	29,356,420	1,521,659	N/A	16,706,190	N/A
10	Apr 2024	2,986,392,399	0	57,871	348,220,822	119,054,724	1,075,009,253	30,231,034	2,657,682	N/A	20,234,975	N/A
11	May 2024	3,011,209,947	0	39,499	337,960,475	121,044,154	1,084,709,627	30,307,301	2,317,265	N/A	17,273,541	N/A
12	Jun 2024	3,035,478,394	0	39,499	342,959,652	111,149,072	1,092,702,484	32,626,986	1,261,348	N/A	19,550,830	N/A
13	Jul 2024	3,048,658,644	0	39,499	342,433,614	118,234,926	1,096,995,597	29,810,036	970,675	N/A	20,944,619	N/A
14	Aug 2024	3,068,729,137	0	39,786	326,975,412	136,101,012	1,103,148,017	20,851,933	4,109,558	N/A	20,497,186	N/A
15	Total	38,644,920,813	0	1,487,466	4,429,889,920	1,510,731,428	13,936,413,164	363,874,342	69,521,028	0	312,235,796	0
16												
17	13-Month Average Balance	2,972,686,216	0	114,420	340,760,763	116,210,110	1,072,031,782	27,990,334	5,347,771	0	24,018,138	0
18												
19	**Gas Operations [3]**											
20	Aug 2023	819,346,361	0	171,103	79,571,184	59,501,811	195,799,279	1,057,301	593,322	N/A	16,021,710	N/A
21	Sep 2023	819,667,291	0	190,188	86,050,738	59,547,913	196,147,102	1,119,023	2,590,490	N/A	13,686,424	N/A
22	Oct 2023	820,276,187	0	218,498	93,940,526	58,631,842	197,279,443	1,171,030	3,095,481	N/A	14,500,911	N/A
23	Nov 2023	821,954,411	0	251,028	94,349,834	62,488,552	198,436,371	911,144	20,369,917	N/A	12,577,756	N/A
24	Dec 2023	830,241,415	0	265,679	114,837,860	40,140,457	199,296,009	634,543	844,144	N/A	8,627,381	N/A
25	Jan 2024	833,523,520	0	58,361	113,998,266	42,709,793	200,404,671	548,645	981,224	N/A	6,022,533	N/A
26	Feb 2024	830,535,269	0	58,583	121,392,889	40,887,841	197,785,343	322,440	835,630	N/A	6,561,269	N/A
27	Mar 2024	841,197,226	0	57,871	113,764,928	44,577,655	199,195,592	466,278	429,412	N/A	6,935,838	N/A
28	Apr 2024	847,573,869	0	57,871	109,759,412	49,920,011	202,107,778	490,526	749,998	N/A	10,230,132	N/A
29	May 2024	861,609,588	0	39,499	101,530,410	52,603,961	203,399,346	580,831	660,630	N/A	10,105,289	N/A
30	Jun 2024	871,327,893	0	39,499	111,365,079	41,781,792	205,541,867	642,209	406,610	N/A	12,008,855	N/A
31	Jul 2024	878,827,628	0	39,499	108,262,391	47,062,741	208,000,279	703,368	273,925	N/A	12,102,503	N/A
32	Aug 2024	883,029,396	0	39,786	106,986,766	53,177,387	209,943,816	755,257	31,536	N/A	12,536,327	N/A
33	Total	10,959,110,054	0	1,487,466	1,355,810,282	653,031,757	2,613,336,896	9,402,597	31,862,320	0	141,916,928	0
34												
35	13-Month Average Balance	843,008,466	0	114,420	104,293,099	50,233,212	201,025,915	723,277	2,450,948	0	10,916,687	0
36												
37	**Electric Operations [3]**											
38	Aug 2023	2,106,561,630	0	0	218,697,708	58,723,250	856,273,641	24,532,097	1,562,645	N/A	10,555,339	N/A
39	Sep 2023	2,101,118,923	0	0	217,789,483	65,535,200	857,740,445	25,641,399	6,812,774	N/A	12,125,719	N/A
40	Oct 2023	2,107,546,429	0	0	217,765,977	77,157,207	861,514,526	25,401,661	8,176,447	N/A	22,563,580	N/A
41	Nov 2023	2,109,456,928	0	0	230,448,891	69,402,357	864,770,398	25,796,467	3,979,121	N/A	21,223,889	N/A
42	Dec 2023	2,109,764,545	0	0	249,861,246	56,525,430	863,170,410	26,671,028	2,223,239	N/A	23,541,943	N/A
43	Jan 2024	2,107,683,010	0	0	263,579,671	50,206,837	860,775,419	27,480,589	2,495,827	N/A	18,468,608	N/A
44	Feb 2024	2,112,342,152	0	0	262,211,102	56,823,238	866,455,103	29,403,264	2,122,579	N/A	10,551,393	N/A
45	Mar 2024	2,123,236,993	0	0	253,079,642	62,288,156	868,804,433	28,890,142	1,092,246	N/A	9,770,352	N/A
46	Apr 2024	2,138,818,531	0	0	238,461,410	69,134,713	872,901,475	29,740,508	1,907,684	N/A	10,004,843	N/A
47	May 2024	2,149,600,359	0	0	236,430,065	68,440,194	881,310,281	29,726,470	1,656,636	N/A	7,168,252	N/A
48	Jun 2024	2,164,150,501	0	0	231,594,573	69,367,280	887,160,617	31,984,777	854,738	N/A	7,541,975	N/A
49	Jul 2024	2,169,831,016	0	0	234,171,223	71,172,186	888,995,317	29,106,668	696,751	N/A	8,842,116	N/A
50	Aug 2024	2,185,699,741	0	0	219,988,646	82,923,625	893,204,201	20,096,676	4,078,022	N/A	7,960,859	N/A
51	Total	27,685,810,760	0	0	3,074,079,638	857,699,672	11,323,076,267	354,471,745	37,658,708	0	170,318,868	0
52												
53	13-Month Average Balance	2,129,677,751	0	0	236,467,664	65,976,898	871,005,867	27,267,057	2,896,824	0	13,101,451	0

[1] Includes ARO.

[2] Included as Plant in Service.

[3] Plant in Service includes Common allocated to Gas Operations and to Electric Operations.

[4] Company records are not maintained in a manner to determine the amount applicable to accounts payable or to reasonably estimate the balances in accounts payable for the accounts requested.

LINE NO.	MONTH	ACCOUNT 0154100 $	ACCOUNT 0154140 $	ACCOUNT 0154200 $	ACCOUNT 0154410 $	ACCOUNT 0163110 $	ACCOUNT 0163120 $	TOTAL M&S $
	Total Company							
1	Aug 2023	18,544,540	0	4,072,529	244,736	2,727,593	0	25,589,398
2	Sep 2023	19,587,330	0	4,315,018	251,254	2,606,820	0	26,760,422
3	Oct 2023	19,421,639	0	4,362,952	254,078	2,534,023	0	26,572,691
4	Nov 2023	19,341,317	0	4,771,878	267,632	2,326,784	0	26,707,611
5	Dec 2023	19,469,843	0	5,714,267	270,409	1,851,053	0	27,305,571
6	Jan 2024	19,701,917	0	6,373,918	277,479	1,675,920	0	28,029,234
7	Feb 2024	21,879,289	0	6,138,903	286,398	1,421,113	0	29,725,704
8	Mar 2024	22,249,143	0	5,426,210	287,120	1,393,947	0	29,356,420
9	Apr 2024	22,457,398	0	6,019,985	297,103	1,456,548	0	30,231,034
10	May 2024	23,171,542	0	5,367,798	297,103	1,470,858	0	30,307,301
11	Jun 2024	24,642,842	0	6,231,320	297,103	1,455,721	0	32,626,986
12	Jul 2024	22,407,168	0	5,896,427	298,864	1,207,576	0	29,810,036
13	Aug 2024	15,001,554	0	5,237,392	298,990	313,997	0	20,851,933
14	Total	267,875,522	0	69,928,597	3,628,269	22,441,954	0	363,874,342
15								
16	Average Balance	20,605,809	0	5,379,123	279,098	1,726,304	0	27,990,334
17								
20	**Gas Operations**							
21	Aug 2023	305,188	0	0	176,922	575,192	0	1,057,301
22	Sep 2023	305,679	0	0	179,073	634,271	0	1,119,023
23	Oct 2023	299,108	0	0	181,898	690,024	0	1,171,030
24	Nov 2023	284,344	0	0	186,085	440,715	0	911,144
25	Dec 2023	298,528	0	0	186,085	149,930	0	634,543
26	Jan 2024	268,664	0	0	190,109	89,872	0	548,645
27	Feb 2024	240,972	0	0	198,990	(117,522)	0	322,440
28	Mar 2024	321,086	0	0	203,850	(58,658)	0	466,278
29	Apr 2024	291,622	0	0	208,409	(9,505)	0	490,526
30	May 2024	329,966	0	0	208,409	42,456	0	580,831
31	Jun 2024	338,323	0	0	208,409	95,477	0	642,209
32	Jul 2024	338,443	0	0	208,409	156,516	0	703,368
33	Aug 2024	338,836	0	0	208,409	208,012	0	755,257
34	Total	3,960,759	0	0	2,545,056	2,896,781	0	9,402,597
35								
36	Average Balance	304,674	0	0	195,774	222,829	0	723,277
37								
40	**Electric Operations**							
41	Aug 2023	18,239,352	0	4,072,529	67,815	2,152,401	0	24,532,097
42	Sep 2023	19,281,650	0	4,315,018	72,180	1,972,550	0	25,641,399
43	Oct 2023	19,122,531	0	4,362,952	72,180	1,843,998	0	25,401,661
44	Nov 2023	19,056,973	0	4,771,878	81,546	1,886,070	0	25,796,467
45	Dec 2023	19,171,316	0	5,714,267	84,323	1,701,122	0	26,671,028
46	Jan 2024	19,433,253	0	6,373,918	87,370	1,586,048	0	27,480,589
47	Feb 2024	21,638,317	0	6,138,903	87,409	1,538,635	0	29,403,264
48	Mar 2024	21,928,058	0	5,426,210	83,270	1,452,605	0	28,890,142
49	Apr 2024	22,165,776	0	6,019,985	88,694	1,466,053	0	29,740,508
50	May 2024	22,841,576	0	5,367,798	88,694	1,428,402	0	29,726,470
51	Jun 2024	24,304,519	0	6,231,320	88,694	1,360,244	0	31,984,777
52	Jul 2024	22,068,725	0	5,896,427	90,455	1,051,061	0	29,106,668
53	Aug 2024	14,662,718	0	5,237,392	90,581	105,985	0	20,096,676
54	Total	263,914,762	0	69,928,597	1,083,212	19,545,173	0	354,471,745
55								
56	Average Balance	20,301,136	0	5,379,123	83,324	1,503,475	0	27,267,057

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-006

REQUEST:

Provide a detailed analysis of expenses for professional services during the 12 months preceding the base period, as shown in Schedule B, and all workpapers supporting the analysis. At a minimum, the workpapers should show the payee, dollar amount, reference (i.e., voucher no., etc.), account charged, hourly rates and time charged to the company according to each invoice, and a description of the services provided.

RESPONSE:

Please see STAFF-DR-01-006 Attachment. The line items in which the vendor is blank or unknown is a charge resulting from an allocation. The Company can provide detail behind individual line items, but it is a manual process for each line item to research the allocation pool to go back to the original invoice and vendor. This analysis excludes contractor labor which has been charged to the 923 account.

PERSON RESPONSIBLE: Linda L. Miller

Duke Energy Kentucky, Inc.
Case No. 2025-00125
Professional Services Expenses
For the 12 Months Ended August 2024

Time Hierarchy Y-Q-M	(Multiple Items)
Business Unit Hierarchy	KENTUCKY_GAS - DE Kentucky Gas

Sum of Monetary Amount JD Account CB - Description	Resource Type CB - Description	Responsibility Center CB - Description	Journal ID JD	Journal Descr JD	Journal Line Descr JD	Vendor ID APRD	Vendor Name JD	Invoice ID JD	Total
0923000 - Outside Services Employed	**18000 - Labor Overhead Allocations**	3943 - Gas OH Alloc-KY	**GAS0070001**	DEK Funct Labor Alloc Gas Min		(blank)			380.70
	35000 - Direct Mat/Purchases Accrual	1227 - Customer & Marketing Apps Staf	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0
		1231 - Enviro & Safety Solutions	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			0
		1415 - Diversity & Inclusion	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		1482 - Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		4610 - ET Operations & Projects	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			454.58
		6393 - Outage Management Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			14.04
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			263.15
		6394 - Innovation Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			0
		6395 - GIS Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			(45.56)
		6396 - PGO Eng & Analytics Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0
		6407 - Telecom Operation Center	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0
		6547 - Technology, Engineering, and D	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			327.39
		702A - Midwest Telecom Eng & Delivey	**SRV3330001**	Telecom EE's ENT DUK		(blank)			(19.00)
		7109 - ENT Training and CM	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		7405 - Software Quality Engineering	**ACCRUL3948**	Allocate SAR019	**Allocate SAR019**	(blank)			0
			MXACCR2541	Accounting Entries from Maximo	**44392440|ACCTGACCRUALS**	(blank)			0
			MXACCR3860	Accounting Entries from Maximo	**48853632|ACCTGACCRUALS**	(blank)			0
			MXACCR4737	Accounting Entries from Maximo	**45162488|ACCTGACCRUALS**	(blank)			0
			MXACCR533	Accounting Entries from Maximo	**43660142|ACCTGACCRUALS**	(blank)			(198.68)
			MXACCR5784	Accounting Entries from Maximo	**49748198|ACCTGACCRUALS**	(blank)			0
			MXACCR6532	Accounting Entries from Maximo	**45936615|ACCTGACCRUALS**	(blank)			0
			MXACCR9387	Accounting Entries from Maximo	**51352163|ACCTGACCRUALS**	(blank)			0
			SRV3190001	Matls Mgmt Prcrmnt UTIL		(blank)			(87.23)
			SRV3370001	M&CR Customers Util ND		(blank)			0
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			(33.23)
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			11.83
		7802 - Be Human Cntrd	**SV336A0001**	ITS Mgt & Apps Svcs Util DE		(blank)			(392.50)
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			(466.48)
		7812 - Telecom Delivery Car West	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0
		7816 - Telecom DVV Network PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			(63.51)
			SRVC330001	Telecom EE's ENT		(blank)			(5.35)
		7826 - Telecom Field Serv Car Nwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			39.91
		7828 - Telecom Field Serv Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			(5.93)
		7836 - Telecom Delivery Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0.01
		7922 - Cloud Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			7.20
		8263 - EAM Portfolio ApplicationMaint	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			(18.79)
		8321 - RRE Solutions	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			146.24
		8408 - TA Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			16.80
		8502 - CORP Environment Mgmt	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0
		8536 - SC SUP Invoice Process Train	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			0
		8538 - SC SUP Vendor Payment Admin	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			(162.73)
		8651 - Employee Engagement	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		8782 - Adv, Acct Mgt & Ops	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			0
		8802 - Corporate Communications Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			0
		8930 - Vendor Mgt	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		9442 - Audit Svcs - Charlotte	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			94.58
		9482 - EAM Environment Mgmt	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)			0
		9501 - Identity & Access Management	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0
		9511 - Corporate Controller	**ACCRUL0014**	EY MSA Apr 2024 Accrual	**EY MSA Apr Accruals**	(blank)			(14,241.63)
							Ernst & Young LLP		14,241.63
			ACCRUL1229	EY MSA Jun 2024 Accrual	**EY MSA June Accruals**	(blank)			(11,538.90)
							Ernst & Young LLP		11,538.90
			ACCRUL1541	EY MSA Aug 2024 Accrual	**EY MSA August Accruals**	(blank)	**Ernst & Young LLP**		11,538.90
			ACCRUL2025	EY MSA May 2024 Accrual	**EY MSA Apr Accruals**	(blank)			(11,538.90)
							Ernst & Young LLP		11,538.90
			ACCRUL2031	EY MSA Jun 2024 Accrual	**EY MSA June Accruals**	(blank)			(11,538.90)
							Ernst & Young LLP		11,538.90
			ACCRUL2071	EY MSA Jul 2024 Accrual	**EY MSA July Accruals**	(blank)			(11,538.90)
							Ernst & Young LLP		11,538.90
			ACCRUL2603	EA, Finance, Admin Svcs, SC No	**November EY Services**	(blank)			(2,871.00)
							Ernst & Young LLP		2,871.00

0923000 - Outside Services Employed	**35000 - Direct Mat/Purchases Accrual**	9511 - Corporate Controller	**ACCRUL2603**	EA, Finance, Admin Svcs, SC No	**October EY Services**	(blank)		(3,915.00)
							Ernst & Young LLP	3,915.00
					September EY Services	(blank)		(3,915.00)
							Ernst & Young LLP	3,915.00
			ACCRUL4256	EA, Finance, Admin Svcs, SC De	**Dec Accruals**	(blank)		(13,572.00)
							Ernst & Young LLP	13,572.00
			ACCRUL6479	EA, Finance, Admin Svcs, SC De	**January 24 Accruals**	(blank)		(2,945.22)
							Ernst & Young LLP	2,945.22
			ACCRUL7114	EA, Finance, Admin Svcs, SC Se	**September EY Services**	(blank)		(3,915.00)
							Ernst & Young LLP	3,915.00
			ACCRUL7735	EA, Finance, Admin Svcs, SC Fe	**Feb Accruals**	(blank)		(10,637.99)
							Ernst & Young LLP	10,637.99
			ACCRUL8369	EA, Finance, Admin Svcs, SC Fe	**3-2024 Controller EY Svcs**	(blank)		(10,637.99)
							Ernst & Young LLP	10,637.99
			ACCRUL9690	EY MSA May 2024 Accrual	**EY MSA May Accruals**	(blank)		(11,538.90)
							Ernst & Young LLP	11,538.90
			ACCRUL9887	EA, Finance, Admin Svcs, SC Oc	**October EY Services**	(blank)		(3,915.00)
							Ernst & Young LLP	3,915.00
					September EY Services	(blank)		(3,915.00)
							Ernst & Young LLP	3,915.00
			MXACCR1146	Accounting Entries from Maximo	**51410338|ACCTGACCRUALS**	(blank)		0
			MXACCR3054	Accounting Entries from Maximo	**52281841|ACCTGACCRUALS**	(blank)		11,538.90
			MXACCR9389	Accounting Entries from Maximo	**51410338|ACCTGACCRUALS**	(blank)		0
			SRVC090001	Misc 3FF Svcs UTIL		(blank)		409.42
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)		7,454.97
			SRVG31MAN	MANUALLY ALLOCATE LATE JE	**MANUAL ALLOCATION**	(blank)		(6,170.78)
		9515 - Talent Mgmt & Engage	**SRV3040001**	HR Svcs EE's ENT		(blank)		0
		9517 - Managed Print Services	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		(21.85)
		9521 - Infrastructure Delivery/PLM	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		(6.88)
		9526 - Financial Reporting	**MXACCR5786**	Accounting Entries from Maximo	**50067697|ACCTGACCRUALS**	(blank)		0
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)		0
		9555 - Fusion Corporate	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
		9579 - Cust Web XP Engineering	**MXACCR9388**	Accounting Entries from Maximo	**51352163|ACCTGACCRUALS**	(blank)		0
		9604 - NERC CIP Security Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		119.46
		9605 - Integrated Command Center	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		(0.44)
		9606 - Database Services	**ITRC000004**	IT Reclass from A&G		(blank)		(451.61)
			ITRC000006	IT Reclass from A&G		(blank)		336.47
			SRV3070001	Info Servers Svcs ENT DUK		(blank)		(31.39)
		9612 - Infrastructure Delivery / PLM	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
		9630 - Workstation Management Service	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)		(49.49)
		9701 - Customer Mobile App	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		(2.74)
		9844 - PI Delivery & Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		279.30
		9863 - Cyber Vulnerability Risk Manag	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		13.41
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)		7.33
		9865 - NG Solutions Delivery-Ops Apps	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		227.31
		9866 - Modern Solutions and I&A	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)		(443.46)
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)		(14.21)
		9875 - DER, AMI, Grid, GIS, Outg Arch	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
		9877 - Natural Gas Commercial Ops	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		0
		9897 - Aviation Corporate Jets	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		(10.46)
		EH02 - EnvOps-Waste	**SRVC460001**	Env Affrs 3FF ENT		(blank)		0.01
		HR21 - Exec Dev & Planning	**SRV3040001**	HR Svcs EE's ENT		(blank)		(20.16)
			SRVG320001	HR EE's Gvrnce ENT		(blank)		0
		J756 - Cust IT Security & Licensing	**MXACCR111**	Accounting Entries from Maximo	**46975112|ACCTGACCRUALS**	(blank)		0
					47600923|ACCTGACCRUALS	(blank)		0
			SRV3370001	M&CR Customers Util ND		(blank)		0
		J813 - Marketing Delivery & Support	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		(799.74)
		J840 - Natural Gas Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		(99.90)
		J873 - Data Office	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
		J875 - App Transformation	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
		Q177 - Social Media & Content	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		36.66
		R017 - DPHR MEDICAL MANAGEMENT	**SRV3040001**	HR Svcs EE's ENT		(blank)		(0.14)
		R102 - Enterprise Comms & Digital Med	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		0
		S817 - MPS Tier 3	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)		0
		SC85 - Industrial & Admin Services	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		6.90
		W517 - Streaming Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		0
		W972 - Enterprise Security App Supp	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
	60004 - Outside Engineering	0047 - Metering & MDM Support	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0.83
		7816 - Telecom DVV Network PLM	**SRVC330001**	Telecom EE's ENT		(blank)		75.59
		9657 - CAO Staff	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0.19
		9865 - NG Solutions Delivery-Ops Apps	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		166.63
	60005 - Audit Fees	8975 - SC Policy Controls	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)		(12.91)
		9511 - Corporate Controller	**ACCFINFEES**	To record Q1 2024 financing fe	**Q1 Out of scope fees**	(blank)		(2,203.94)

0923000 - Outside Services Employed	**60005 - Audit Fees**	9511 - Corporate Controller	**ACCFINFEQ3**	To record Q3 Deloitte out of s	**Q3 Out of scope fees**	(blank)			718.78
			ACCFINFEQ4	To record Q4 Deloitte out of s	**Q4 Out of scope fees**	(blank)			1,102.14
			ACCRUL0225	Accrue Deloitte Audit Fees Apr	**Deloitte Audit Fee Accrual**	(blank)			(14,807.19)
							DELOITTE		14,807.19
			ACCRUL1817	Accrue August 24 Deloitte Audi	**Deloitte Audit Fee Accrual**	(blank)	**DELOITTE**		11,003.36
			ACCRUL1897	Accrue Deloitte audit fees Jun	**Deloitte Audit Fee Accrual**	(blank)	**DELOITTE**		13,435.85
			ACCRUL1967	Accrue Deloitte Audit Fees May	**Deloitte Audit Fee Accrual**	(blank)	**DELOITTE**		25,941.15
			ACCRUL7057	Accrue July 24 Deloitte Audit	**Deloitte Audit Fee Accrual**	(blank)	**DELOITTE**		7,917.83
			ACCRULADFE	To record 2023 base audit fee	**Accrue 2023 base audit fees**	(blank)			39,932.44
				To record 2024 (January and Fe	**Accrue 2024 base audit fees**	(blank)			31,222.44
	60007 - Rent	7395 - CIO Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0.19
	63000 - Contract/Outside Services NLBR	1231 - Enviro & Safety Solutions	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1,141.53
		2804 - Cybersecurity Arch, Eng & Pro	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			45.72
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			177.31
		3160 - Tax Study	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			2,340.80
		6082 - Environmental, H&S Staff	**SRVC460001**	Env Affrs 3FF ENT		(blank)			503.00
		6108 - CICD Engineering	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			13.62
		6394 - Innovation Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			279.02
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			81.36
		6396 - PGO Eng & Analytics Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			708.05
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			209.25
		6547 - Technology, Engineering, and D	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			392.75
		702A - Midwest Telecom Eng & Delivey	**SRV3330001**	Telecom EE's ENT DUK		(blank)			14.06
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			235.86
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			1,505.81
		7812 - Telecom Delivery Car West	**SRV3330001**	Telecom EE's ENT DUK		(blank)			32.59
		7816 - Telecom DVV Network PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			2,670.18
		7823 - Telecom Field Serv Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			32.00
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			233.19
		7922 - Cloud Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			12.57
		8321 - RRE Solutions	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			644.19
		8408 - TA Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		8532 - SC SUP Credit Card Rebate	**ACCRUL3184**	Accrue for Rebate wires that w	**Accrue Rebate Wires**	(blank)			0
			SRV3080001	Matls Mgmt Prcrmnt ENT		(blank)			(50,859.35)
		8727 - Tax	**APACR59763**	Accounts Payable - Accrual	**DEK RATE CASE PROCEEDING**	0000068193	**ERNST & YOUNG US LLP**	US01U001403	7,000.00
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			12,095.90
		8755 - Financial Officer Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			10.47
		8764 - SVP Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			1.48
		8907 - Compensation	**SRV3040001**	HR Svcs EE's ENT		(blank)			95.71
		8930 - Vendor Mgt	**SRV3040001**	HR Svcs EE's ENT		(blank)			(632.22)
		8937 - Executive Rewards	**SRV3040001**	HR Svcs EE's ENT		(blank)			428.26
		9459 - Investor Relations & FP Staff	**SRVGD10001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			3.74
		9517 - Managed Print Services	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			15.48
		9521 - Infrastructure Delivery/PLM	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.20
		9526 - Financial Reporting	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			264.00
		9587 - Enterprise Collab&Message Sols	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			177.31
		9604 - NERC CIP Security Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			138.94
		9605 - Integrated Command Center	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1,878.88
		9606 - Database Services	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			177.31
		9612 - Infrastructure Delivery / PLM	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			(276.69)
		9630 - Workstation Management Service	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			262.32
		9653 - Operations Architecture	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			165.00
		9865 - NG Solutions Delivery-Ops Apps	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			222.37
		9877 - Natural Gas Commercial Ops	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			21.03
		J019 - TA Sourcing	**SRV3040001**	HR Svcs EE's ENT		(blank)			52.80
		S812 - SC Compliance Initiative	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			476.02
		SC85 - Industrial & Admin Services	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			38.48
		W277 - TA Support	**SRV3040001**	HR Svcs EE's ENT		(blank)			7.56
	65002 - Other Real Property Leases	9608 - Gas SCADA and Facility Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			259.37
	66001 - Telephone/Communications	6547 - Technology, Engineering, and D	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			76.00
	69000 - Staff Augmentation	0047 - Metering & MDM Support	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			70.90
		0855 - Office of CAO Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0
		1017 - IT Compliance Operation Servic	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			393.23
		1033 - DER/RRE Site Plng, Del, & Supt	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			19.22
		1106 - Regulated Generation Solutions	**ITRC000002**	IT Reclass from A&G		(blank)			(17.68)
			ITRC000004	IT Reclass from A&G		(blank)			(9.51)
			ITRC000005	IT Reclass from A&G		(blank)			(2.68)
			ITRC000006	IT Reclass from A&G		(blank)			0
			ITRC000007	IT Reclass from A&G		(blank)			(24.65)
			SRVC130001	Server Svcs UTIL		(blank)			330.35
		1137 - ES&S Change Mgmt & Strategy	**SRV3040001**	HR Svcs EE's ENT		(blank)			101.58
		1210 - Nuclear Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			46.65
		1228 - Innovation Portfolio Strat&Gov	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			228.93
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			76.15

0923000 - Outside Services Employed	**69000 - Staff Augmentation**	1231 - Enviro & Safety Solutions	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			307.14
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			602.67
		1391 - CYBER PROGRAMS DEC	**SRV35A0001**	IT Mgmt & Apps 3FF ENT - NonSV		(blank)			10.10
		1415 - Diversity & Inclusion	**SRV3040001**	HR Svcs EE's ENT		(blank)			21.00
		1717 - Employee Digital Experience	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			44.41
		2804 - Cybersecurity Arch, Eng & Pro	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			254.58
		3158 - T&D Sourcing Materials & Svcs	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			2,448.00
		4025 - Cloud Transformation Enablemen	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			3.13
		4093 - NERC CIP Enterprise	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			346.72
		4161 - GS Distributed Energy	**SRV0890001**	M&CR Smart Grid Util O&M_ALL		(blank)			165.91
		4513 - Public Affairs & Jurisdictiona	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			5.54
		4610 - ET Operations & Projects	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1,186.54
		4920 - Telecom ECI	**SRV3330001**	Telecom EE's ENT DUK		(blank)			135.86
		6074 - CD ENTERPRISE PC	**SRV0890001**	M&CR Smart Grid Util O&M_ALL		(blank)			4,630.87
		6084 - EHS Systems & Metrics-DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)			141.00
		6089 - H&S-Duke East Nursing Support	**SRVC460001**	Env Affrs 3FF ENT		(blank)			396.74
		6090 - H&S-Duke West Nursing Support	**SRVC460001**	Env Affrs 3FF ENT		(blank)			7.32
		6106 - IOT & Grid Database Services	**ITRC000001**	IT Reclass from A&G		(blank)			(6.59)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			23.05
		6108 - CICD Engineering	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			139.33
		6205 - Predictive Digital Products	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			286.94
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			4.84
		6307 - Renewables Solutions & Support	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			5.80
		6327 - ET&S Product Innovation	**SRV3090001**	Misc 3FF Svcs UTIL - Both		(blank)			0.10
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			199.85
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			0.18
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			143.72
		6356 - Data Science Innovation	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			4.56
		6387 - Software Engineering A	**SV336A0001**	ITS Mgt & Apps Svcs Util DE		(blank)			170.24
		6395 - GIS Delivery	**APACR18444**	Accounts Payable - Accrual	**IQGEO 2024 Labor Ext for Small**	0000122993	**IQGEO AMERICA INC**	16710	285.19
								16711	43.92
								16712	352.97
								16763	267.64
			APACR21001	Accounts Payable - Accrual	**Extension of EAM152 CR#01 Next**	0000201030	**COGNIZANT WORLDWIDE LIMITED**	CW10100018	153.00
								CW10100018	153.00
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			0
			SRV8920001	Cust Info Sys Util-EAM O&M		(blank)			695.30
		6407 - Telecom Operation Center	**SRV3330001**	Telecom EE's ENT DUK		(blank)			13.92
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			31.50
		6468 - Renewables - Contract Mgmt	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			10.81
		6501 - Digital Exp and Content Ops	**CSRV380001**	M&CR Customers Util ND		(blank)			17.39
		6519 - Enterprise Systems	**SRV0890001**	M&CR Smart Grid Util O&M_ALL		(blank)			125.27
		6547 - Technology, Engineering, and D	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			294.23
		6630 - Customer Data & Insights	**CSRV380001**	M&CR Customers Util ND		(blank)			11.71
		6644 - Customer Data Program Delivery	**SRV35A0001**	IT Mgmt & Apps 3FF ENT - NonSV		(blank)			13.90
			SRVC460001	Env Affrs 3FF ENT		(blank)			77.00
		6817 - Enterprise Data Products	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			381.02
			SRVC460001	Env Affrs 3FF ENT		(blank)			46.76
		6830 - CX Platform Advancement	**CSRV380001**	M&CR Customers Util ND		(blank)			297.71
			SRV3370001	M&CR Customers Util ND		(blank)			35.21
		6833 - CIS DEBS	**SRV3370001**	M&CR Customers Util ND		(blank)			5.42
		7012 - DEC MP SUPPORT SERVICES	**SRV33A0001**	Telecom EE's ENT DUK - Non SRV		(blank)			2.80
		701A - CW Telecom Eng and Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			206.85
		702A - Midwest Telecom Eng & Delivey	**SRV3330001**	Telecom EE's ENT DUK		(blank)			61.20
		7338 - CIOPS Support & Solutions	**ITRC000001**	IT Reclass from A&G		(blank)			(7.44)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			26.03
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			167.01
		7402 - Carolinas Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			106.67
		7515 - Cybersecurity Compliance	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			79.34
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			82.12
		7534 - ITSM, LIT, EHD End User Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			72.38
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			50.37
		7802 - Be Human Cntrd	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			303.18
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			363.59
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			340.63
		7803 - Telecom Delivery Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			117.06
		7809 - Telecom Field Serv Car Swest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			671.40
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			92.43
		7812 - Telecom Delivery Car West	**ITRC000001**	IT Reclass from A&G		(blank)			(0.25)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			0.87
			SRV3330001	Telecom EE's ENT DUK		(blank)			342.10
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			3.14
		7813 - Telecom Support Services	**SRV3330001**	Telecom EE's ENT DUK		(blank)			182.11
		7816 - Telecom DVV Network PLM	**SRV3040001**	HR Svcs EE's ENT		(blank)			9.11

0923000 - Outside Services Employed	**69000 - Staff Augmentation**	7816 - Telecom DVV Network PLM	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			39.87
			SRV3330001	Telecom EE's ENT DUK		(blank)			561.07
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			37.59
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			33.99
		7817 - Telecom Architects	**SRV3330001**	Telecom EE's ENT DUK		(blank)			179.13
		7823 - Telecom Field Serv Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			617.38
		7824 - LIT Carolinas Region	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			54.53
		7825 - LIT Midwest and Carolinas East	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			231.15
		7826 - Telecom Field Serv Car Nwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			186.18
		7828 - Telecom Field Serv Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			665.21
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			0.36
		7829 - CE Telecom Eng & Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			15.19
		7832 - Telecom	**SRV3330001**	Telecom EE's ENT DUK		(blank)			226.88
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			135.68
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			67.47
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			26.66
		7835 - Software Engineering B	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			74.76
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			(109.17)
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			144.64
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			13.60
		7836 - Telecom Delivery Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			199.92
		7920 - Data Solutions	**SRV3090001**	Misc 3FF Svcs UTIL - Both		(blank)			84.00
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			116.10
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			0.10
		7921 - Analytics & Data Services	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			41.04
		7922 - Cloud Data Platforms	**SRV3040001**	HR Svcs EE's ENT		(blank)			2.18
			SRV3190001	Matls Mgmt Prcrmnt UTIL		(blank)			162.36
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			99.14
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			2.35
		8001 - CEO-Expenses	**SRVGD10001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1,227.56
		8048 - D OH Alloc-DEC	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		8051 - Network Defense	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			293.95
		8109 - AMI Meter & PI Systems	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			12.30
		8222 - Remediation DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)			6.69
		8249 - iGrid Services	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			18.50
		8263 - EAM Portfolio ApplicationMaint	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)			50.43
		8295 - Generation Transition Sol	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			161.00
		8372 - AI Solutions - MADLab	**MISCOR1122**	Contractor time correction	**contractor correction**	(blank)			298.37
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			119.38
		8391 - AI Solutions & Transformation	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			9.10
		8396 - Corp, HUB & App Services	**SRV3030001**	Misc 3FF Svcs ENT - Both		(blank)			725.13
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			1.47
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			185.95
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			44.24
		8408 - TA Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			74.96
		8536 - SC SUP Invoice Process Train	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			97.56
		8682 - Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			26.42
		8727 - Tax	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			3.26
		8750 - Corporate Books & Records	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			177.00
		8764 - SVP Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			3.91
		8782 - Adv, Acct Mgt & Ops	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			912.65
		8875 - Legal Disclosure & Governance	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			(2.53)
		8950 - SC CPO Staff	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			1.73
		9048 - PGO, NGBU, EAM Arch	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			13.54
		9128 - Customer Sol and Insights DEBS	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			3.34
		9292 - Enhanced Customer Solutions	**CSRV380001**	M&CR Customers Util ND		(blank)			120.57
		9341 - Nuclear Data & Station Scienc	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			56.45
		9351 - Cust Center Sol Del & Sup	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			61.38
		9355 - DCC Grid Solutions	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			5.95
		9372 - Customer Care Products	**CSRV380001**	M&CR Customers Util ND		(blank)			135.80
		9417 - Cust Spec Portals & Outage XP	**APACR42164**	Accounts Payable - Accrual	**CUS133 - Sitecore Developer Se**	0000065299	**ACCENTURE LLP**	1100967230	160.00
			APACR53294	Accounts Payable - Accrual	**CUS133 - Sitecore Developer Se**	0000065299	**ACCENTURE LLP**	1100974134	152.00
			APACR65597	Accounts Payable - Accrual	**CUS133 - Sitecore Developer Se**	0000065299	**ACCENTURE LLP**	1100979277	184.37
		9421 - Foundation	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			416.66
		9442 - Audit Svcs - Charlotte	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			255.51
		9471 - MDM & DSDR Delivery Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			84.28
		9486 - Employee Xp & Emerging Tech	**CSRV380001**	M&CR Customers Util ND		(blank)			130.22
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			226.30
		9501 - Identity & Access Management	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1.61
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			1.61
		9505 - IT Contracts	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			762.90
		9511 - Corporate Controller	**APACR22567**	Accounts Payable - Accrual	**GUI Acct & Report Staff Aug**	0000224477	**EXPERIS US INC**	8116332827	2,544.75
			APACR27312	Accounts Payable - Accrual	**GUI Acct & Report Staff Aug**	0000224477	**EXPERIS US INC**	8116348593	2,281.50
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			66.69

0923000 - Outside Services Employed	**69000 - Staff Augmentation**	9517 - Managed Print Services	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			15.11
		9518 - Telecom Ent Comm Grid Pgrm Spt	**SRV3330001**	Telecom EE's ENT DUK		(blank)			127.90
		9519 - LIT Greater Charlotte	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			261.56
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			166.36
		9526 - Financial Reporting	**APACR16356**	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116098994A	2,308.50
			APACR19214	Accounts Payable - Accrual	**GUI Acct & Report Staff Aug**	0000224477	**EXPERIS US INC**	8116306447	850.50
								8116317392	2,092.50
			APACR53515	Accounts Payable - Accrual	**CW DEF accounting supplement -**	0000224477	**EXPERIS US INC**	8116115917	810.00
			APACR58582	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116136501	3,719.25
			APACR65860	Accounts Payable - Accrual	**CW GUI Account Supplement**	0000224477	**EXPERIS US INC**	8116148233	2,281.50
					CW GUI accounting supplement	0000224477	**EXPERIS US INC**	8116164935	2,230.88
			APACR74457	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116182790	2,281.50
			APACR81109	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116198055	2,504.26
			APACR83319	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116210347	2,126.25
			APACR91079	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116227420	2,595.38
			APACR93541	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116247052	2,241.00
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			104.43
		9555 - Fusion Corporate	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			7.76
		9578 - Corp Apps & Gen Database Svcs	**ITRC000001**	IT Reclass from A&G		(blank)			(28.15)
			ITRC000002	IT Reclass from A&G		(blank)			(32.33)
			ITRC000003	IT Reclass from A&G		(blank)			(28.56)
			ITRC000004	IT Reclass from A&G		(blank)			(65.53)
			ITRC000005	IT Reclass from A&G		(blank)			(13.34)
			ITRC000006	IT Reclass from A&G		(blank)			(68.65)
			ITRC000007	IT Reclass from A&G		(blank)			(17.44)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			1,280.81
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			5.09
		9579 - Cust Web XP Engineering	**APACR72251**	Accounts Payable - Accrual	**CUS133 - Sitecore Developer Se**	0000065299	**ACCENTURE LLP**	1100983702	73.13
			APACR85632	Accounts Payable - Accrual	**CUS133 - Sitecore Developer Se**	0000065299	**ACCENTURE LLP**	1100991605	2.06
			CSRV380001	M&CR Customers Util ND		(blank)			6.21
			MISPRJ1215	To move contract labor from DX		(blank)			51.28
		9582 - Cust Del App Supt & PPM	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			10.82
		9603 - Enhanced Cust Prod & Insights	**CSRV380001**	M&CR Customers Util ND		(blank)			126.70
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			68.31
		9604 - NERC CIP Security Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			140.82
		9605 - Integrated Command Center	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			262.30
		9608 - Gas SCADA and Facility Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			234.74
			SRVC350001	IT Mgmt & Apps 3FF ENT		(blank)			147.40
		9615 - Cybersecurity Ops Center	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1,611.48
		9633 - Pulse & Automation	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			5.26
		9635 - Software Engineering D	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			1.57
		9636 - Data Solutions - Functional	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			2.78
		9637 - Network Security & Connect	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			301.20
		9642 - Monitoring & Performance Mgt.	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			90.03
		9643 - Consulting Services	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0.48
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			46.13
		9649 - PeopleSoft Finance Solutions	**SRV3030001**	Misc 3FF Svcs ENT - Both		(blank)			487.06
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			0.07
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			56.29
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			89.49
		9653 - Operations Architecture	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			8.87
		9690 - Web & Connectivity Services	**ITRC000001**	IT Reclass from A&G		(blank)			(11.99)
			ITRC000002	IT Reclass from A&G		(blank)			(49.82)
			ITRC000003	IT Reclass from A&G		(blank)			(26.98)
			ITRC000004	IT Reclass from A&G		(blank)			(57.23)
			ITRC000005	IT Reclass from A&G		(blank)			(9.52)
			ITRC000006	IT Reclass from A&G		(blank)			(78.43)
			ITRC000007	IT Reclass from A&G		(blank)			(13.84)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			1,216.54
			SRV3370001	M&CR Customers Util ND		(blank)			84.19
		9692 - Advanced Analytics	**CSRV380001**	M&CR Customers Util ND		(blank)			265.47
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			40.98
		9701 - Customer Mobile App	**SRV3370001**	M&CR Customers Util ND		(blank)			1.91
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			640.62
		9759 - AI Governance and Operations	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			46.02
		9762 - Big Data Analytics Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			10.51
		9763 - Data Solutions - Durable	**SRV3090001**	Misc 3FF Svcs UTIL - Both		(blank)			137.96
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			167.36
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			10.79
		9776 - Data Management & Modeling	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			387.42
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			66.97
		9777 - Modeling & Adv Analytics	**CSRV380001**	M&CR Customers Util ND		(blank)			298.03
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			402.04
		9844 - PI Delivery & Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			115.94

0923000 - Outside Services Employed	**69000 - Staff Augmentation**	9844 - PI Delivery & Support	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	85.62
		9863 - Cyber Vulnerability Risk Manag	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	96.69
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split	(blank)	107.05
		9866 - Modern Solutions and I&A	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	14.17
		9874 - Natural Gas PMO & and Business	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	19.39
		9875 - DER, AMI, Grid, GIS, Outg Arch	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	13.99
		9877 - Natural Gas Commercial Ops	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	39.79
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke	(blank)	943.85
		9897 - Aviation Corporate Jets	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke	(blank)	187.00
		9909 - IT / Telecom & VMO	**SRV3080001**	Matls Mgmt Prcrmnt ENT	(blank)	281.84
		CS33 - Cust Exp Strategy & Management	**CSRV380001**	M&CR Customers Util ND	(blank)	311.15
			SRV3370001	M&CR Customers Util ND	(blank)	5.57
		E385 - RNP MECHANICAL MAINTENANCE	**SRV35B0001**	IT Mgmt & Apps 3FF PGN - NonSV	(blank)	0
		EH02 - EnvOps-Waste	**SRVC460001**	Env Affrs 3FF ENT	(blank)	62.89
		J575 - Relay Wildwood	**SRV33B0001**	Telecom EE's ENT PGN - Non SRV	(blank)	0.33
		J741 - CIOPS Staff	**ITRC000006**	IT Reclass from A&G	(blank)	(0.40)
			SRV3070001	Info Servers Svcs ENT DUK	(blank)	2.40
		J749 - Enterprise Help Desk	**SRV3060001**	Workstatins Svcs ENT DUK	(blank)	87.52
			SRV3330001	Telecom EE's ENT DUK	(blank)	293.68
		J757 - IT Backline Remote Support-StP	**SRV3330001**	Telecom EE's ENT DUK	(blank)	8,056.11
		J765 - SAP Duke Support	**SRV3370001**	M&CR Customers Util ND	(blank)	56.56
		J766 - Data and Integration	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	5.96
			SRV3370001	M&CR Customers Util ND	(blank)	4.65
		J768 - Software Engineering D	**SRV3090001**	Misc 3FF Svcs UTIL - Both	(blank)	6.37
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke	(blank)	0.46
		J769 - Cust Solutions Prod	**ITRC000002**	IT Reclass from A&G	(blank)	(12.24)
			ITRC000004	IT Reclass from A&G	(blank)	(24.49)
			SRV3070001	Info Servers Svcs ENT DUK	(blank)	128.56
			SRV3350001	IT Mgmt & Apps 3FF ENT	(blank)	27.43
		J772 - Cloud and Platforms Team	**CSRV380001**	M&CR Customers Util ND	(blank)	0.71
			SRV3350001	IT Mgmt & Apps 3FF ENT	(blank)	320.11
		J773 - Network Operations Center	**SRV3330001**	Telecom EE's ENT DUK	(blank)	4,995.40
		J774 - Automation Engineering	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	243.93
		J788 - Analytics & Durable Prod	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	275.31
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke	(blank)	0.17
		J792 - Software Engineering E	**SRV3040001**	HR Svcs EE's ENT	(blank)	85.70
			SRV3350001	IT Mgmt & Apps 3FF ENT	(blank)	2.72
		J793 - Customer Architecture	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	1.48
		J798 - Cybersecurity ITOT	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	129.08
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split	(blank)	162.45
		J813 - Marketing Delivery & Support	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	50.39
		J816 - iGrid Distribution Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	108.21
		J817 - IoT & Wise Lab	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	118.90
		J827 - Maximo & Scheduling Tools	**SRV3190001**	Matls Mgmt Prcrmnt UTIL	(blank)	4.76
		J833 - Compliance Operations	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	242.27
		J843 - XR Lab	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	8.60
		J864 - Infrastructure Automation	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	560.57
		J865 - Critical Infra Security & Comp	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	84.27
		J868 - Telecom Network Support	**SRV3330001**	Telecom EE's ENT DUK	(blank)	1,281.95
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split	(blank)	20.75
		J869 - Internal Product Design	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	67.24
		J873 - Data Office	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	112.83
		J875 - App Transformation	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	56.73
		J878 - HR Automation, Time & Data Ops	**SRV3040001**	HR Svcs EE's ENT	(blank)	263.43
		J897 - Enterprise CIP Tools	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	86.57
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split	(blank)	97.23
		J973 - Nuc Fuel Mech & T/H Analysis	**SRV35B0001**	IT Mgmt & Apps 3FF PGN - NonSV	(blank)	4.51
		NU10 - IT & ES NERC CIP & Tools	**SRV3350001**	IT Mgmt & Apps 3FF ENT	(blank)	0
		R006 - TA Recruiting	**SRV3040001**	HR Svcs EE's ENT	(blank)	232.46
		R018 - Total Rewards & HR Ops	**SRV3040001**	HR Svcs EE's ENT	(blank)	171.59
		R651 - SC T&D Sourcing Logistics and	**SRV3080001**	Matls Mgmt Prcrmnt ENT	(blank)	761.96
		R788 - Maintenance & Diagnostics-DEBS	**SRV35A0001**	IT Mgmt & Apps 3FF ENT - NonSV	(blank)	20.85
		S089 - Renewables Operations Admin	**SRV35A0001**	IT Mgmt & Apps 3FF ENT - NonSV	(blank)	(9.58)
		S786 - ES Roadmap	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split	(blank)	19.07
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split	(blank)	133.21
		SC85 - Industrial & Admin Services	**SRV3080001**	Matls Mgmt Prcrmnt ENT	(blank)	347.26
		W504 - Trad, Fuels & Non-Retail Blng	**ITRC000001**	IT Reclass from A&G	(blank)	(13.24)
			ITRC000002	IT Reclass from A&G	(blank)	(31.20)
			ITRC000003	IT Reclass from A&G	(blank)	(5.29)
			ITRC000004	IT Reclass from A&G	(blank)	(65.78)
			ITRC000005	IT Reclass from A&G	(blank)	(0.55)
			ITRC000006	IT Reclass from A&G	(blank)	(55.28)
			ITRC000007	IT Reclass from A&G	(blank)	(13.99)
			SRV3350001	IT Mgmt & Apps 3FF ENT	(blank)	11.89

0923000 - Outside Services Employed	**69000 - Staff Augmentation**	W504 - Trad, Fuels & Non-Retail Blng	**SRVC130001**	Server Svcs UTIL		(blank)			868.12
		W517 - Streaming Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			218.29
		W554 - STAFF	**SRV3040001**	HR Svcs EE's ENT		(blank)			149.22
		W607 - ESG & Sustainability	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			78.80
		W678 - Cloud & Automation Services	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			13.64
		W971 - Ent Innov, IT Ops, Secur Arch	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			49.71
		W972 - Enterprise Security App Supp	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			238.90
	69010 - SA Ctrct Emp Exp-50% Deduct	1017 - IT Compliance Operation Servic	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			2.07
		7832 - Telecom	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0.19
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			3.20
		J833 - Compliance Operations	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.04
	69020 - SA Vendor Emp Exp-Per Diem	1017 - IT Compliance Operation Servic	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			7.28
		7832 - Telecom	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0.58
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1.45
		J833 - Compliance Operations	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1.15
	69030 - SA Vndr Emp Exp - 100% Deduct	1017 - IT Compliance Operation Servic	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			7.94
		6468 - Renewables - Contract Mgmt	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			1.04
		701A - CW Telecom Eng and Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			1.97
		702A - Midwest Telecom Eng & Delivey	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0.76
		7534 - ITSM, LIT, EHD End User Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0.03
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			81.95
		7809 - Telecom Field Serv Car Swest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			7.69
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			1.52
		7823 - Telecom Field Serv Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			45.88
		7824 - LIT Carolinas Region	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.09
		7825 - LIT Midwest and Carolinas East	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			10.32
		7832 - Telecom	**SRV3330001**	Telecom EE's ENT DUK		(blank)			4.51
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			0.28
		8051 - Network Defense	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.38
		9519 - LIT Greater Charlotte	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			0.38
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			14.06
		9608 - Gas SCADA and Facility Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			(178.66)
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			2.27
		J833 - Compliance Operations	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			2.02
		W554 - STAFF	**SRV3040001**	HR Svcs EE's ENT		(blank)			0.28
	69100 - Baseload Contract Labor	4093 - NERC CIP Enterprise	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			67.66
		6074 - CD ENTERPRISE PC	**SRVCO89_M2**	LATE JE - Manual DSGA Dec23 Co	**Manual DSGA Dec23 Corr**	(blank)			(1,314.16)
		6393 - Outage Management Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0.19
		6449 - Envr MW East FS-DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)			0.27
		6817 - Enterprise Data Products	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			9.97
		702A - Midwest Telecom Eng & Delivey	**SRV3330001**	Telecom EE's ENT DUK		(blank)			40.13
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			75.64
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			19.00
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			56.77
		7922 - Cloud Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			70.37
		9615 - Cybersecurity Ops Center	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			103.47
		9630 - Workstation Management Service	**SRV3060001**	Workstatins Svcs ENT DUK		(blank)			412.02
		9690 - Web & Connectivity Services	**ITRC000006**	IT Reclass from A&G		(blank)			(10.35)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			36.24
		9777 - Modeling & Adv Analytics	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			1.49
		9866 - Modern Solutions and I&A	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			3.61
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			46.98
		J873 - Data Office	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1.92
		JLCE - Midwest - JLL Crit Engineers	**SRV0710001**	MW RE Fac Svcs SF		(blank)			127.90
		S737 - Midwest Regional Fac-JLL OH F	**SRV0710001**	MW RE Fac Svcs SF		(blank)			46.38
		S742 - Midwest Regional Fac - AM	**SRV0710001**	MW RE Fac Svcs SF		(blank)			(212.64)
		U821 - FLT Substation Team Delta	**SRV33B0001**	Telecom EE's ENT PGN - Non SRV		(blank)			8.66
	69110 - Security	S737 - Midwest Regional Fac-JLL OH F	**SRV0710001**	MW RE Fac Svcs SF		(blank)			8.75
	69400 - Turnkey Service Contract Labor	4161 - GS Distributed Energy	**SRV0890001**	M&CR Smart Grid Util O&M_ALL		(blank)			126.14
		4610 - ET Operations & Projects	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			319.31
		6393 - Outage Management Solutions	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			156.25
		6394 - Innovation Solutions	**SRV8920001**	Cust Info Sys Util-EAM O&M		(blank)			3,929.79
		6407 - Telecom Operation Center	**SRV3330001**	Telecom EE's ENT DUK		(blank)			1.73
		6547 - Technology, Engineering, and D	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			(0.03)
		6817 - Enterprise Data Products	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			5.35
		6969 - Finance Program Office	**SRV3030001**	Misc 3FF Svcs ENT - Both		(blank)			109.61
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			12.25
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			4,049.18
		7109 - ENT Training and CM	**SRV3040001**	HR Svcs EE's ENT		(blank)			580.54
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			36.55
		7534 - ITSM, LIT, EHD End User Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			496.39
			SRVMAN1223	LATE JE - Manual Misc Alloc 12	**Manual DEMA Dec23 Corr**	(blank)			(496.39)
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			738.42
		7802 - Be Human Cntrd	**APACR17065**	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110117515	601.72

0923000 - Outside Services Employed	**69400 - Turnkey Service Contract Labor**	7802 - Be Human Cntrd	**APACR17065**	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110117516	601.72
			APACR19394	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110118930	528.56
			APACR23619	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110119505	576.12
								110119506	20.70
			APACR36147	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110106697	392.52
			APACR66352	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110110564	497.87
			APACR75835	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110112304	497.87
			APACR86498	Accounts Payable - Accrual	**Digital Transformation Innovat**	0000221054	**GLOBALLOGIC INC**	110113993	497.87
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			790.18
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			42.68
		7803 - Telecom Delivery Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			11.12
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			1,247.69
		7812 - Telecom Delivery Car West	**SRV3330001**	Telecom EE's ENT DUK		(blank)			343.41
		7816 - Telecom DVV Network PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			6,981.98
			SRVC330001	Telecom EE's ENT		(blank)			33.13
		7826 - Telecom Field Serv Car Nwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			229.45
		7828 - Telecom Field Serv Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			178.39
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			107.77
		7836 - Telecom Delivery Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			73.07
		7922 - Cloud Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			28.19
		8263 - EAM Portfolio ApplicationMaint	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)			10,816.26
		8321 - RRE Solutions	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			246.53
		8396 - Corp, HUB & App Services	**SRV3030001**	Misc 3FF Svcs ENT - Both		(blank)			3,694.99
			SRV3040001	HR Svcs EE's ENT		(blank)			449.50
			SRV3080001	Matls Mgmt Prcrmnt ENT		(blank)			0.90
			SRV3190001	Matls Mgmt Prcrmnt UTIL		(blank)			1,260.84
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			584.15
		8930 - Vendor Mgt	**SRV3040001**	HR Svcs EE's ENT		(blank)			9,975.05
		8951 - SC ENT Tier 3	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			1,058.40
		9501 - Identity & Access Management	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			40.80
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			11.20
		9518 - Telecom Ent Comm Grid Pgrm Spt	**SRV3330001**	Telecom EE's ENT DUK		(blank)			4.95
		9555 - Fusion Corporate	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			216.75
		9604 - NERC CIP Security Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			210.26
		9635 - Software Engineering D	**SV336A0001**	ITS Mgt & Apps Svcs Util DE		(blank)			70.95
		9701 - Customer Mobile App	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1.88
		9863 - Cyber Vulnerability Risk Manag	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			771.09
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			333.98
		9867 - EAM Work Mgmt, GIS & Eng Del	**APACR07835**	Accounts Payable - Accrual	**ACCENTURE_MPSA_2018_SOW_AMS01**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709452398	1,445.40
			APACR15274	Accounts Payable - Accrual	**ACCENTURE_MPSA_2018_SOW_AMS01**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709460224	364.32
			APACR24392	Accounts Payable - Accrual	**ACCENTURE_MPSA_2018_SOW_AMS01**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709469245	1,123.20
			APACR66352	Accounts Payable - Accrual	**ACCENTURE_MPSA_2018_SOW_AMS01**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709412796	2,455.68
			APACR71578	Accounts Payable - Accrual	**ACCENTURE_MPSA_2018_SOW_AMS01**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709423750	5,861.16
			APACR98318	Accounts Payable - Accrual	**ACCENTURE_MPSA_2018_SOW_AMS01**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709442006	1,013.76
			SRV8920001	Cust Info Sys Util-EAM O&M		(blank)			25,065.71
		J768 - Software Engineering D	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			133.40
		J792 - Software Engineering E	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			22.08
		J798 - Cybersecurity ITOT	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			(3.57)
		J813 - Marketing Delivery & Support	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			3,184.68
		J897 - Enterprise CIP Tools	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			82.22
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			112.89
		NU10 - IT & ES NERC CIP & Tools	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			189.08
		R017 - DPHR MEDICAL MANAGEMENT	**SRV3040001**	HR Svcs EE's ENT		(blank)			643.98
		S414 - Utility Aviation	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			891.37
		S735 - Midwest Regional Fac - FM Tech	**SRV0710001**	MW RE Fac Svcs SF		(blank)			45.29
		S812 - SC Compliance Initiative	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			763.55
		S817 - MPS Tier 3	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			219.75
		W517 - Streaming Data Platforms	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			82.27
	69500 - Other Contracts	0193 - DE Carolinas Other Misc	**SRVC090001**	Misc 3FF Svcs UTIL		(blank)			4.29
		1017 - IT Compliance Operation Servic	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0.64
		1237 - STAFF	**SRV3040001**	HR Svcs EE's ENT		(blank)			1.16
		1249 - Leg Affairs - Corp	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			10.92
		1265 - Legislative & Regulatory Affai	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			12.17
		1267 - Fed Govt & Corp Affairs Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			106.31
		1312 - Telecom Staff	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			5.86
		1415 - Diversity & Inclusion	**SRV3040001**	HR Svcs EE's ENT		(blank)			1.53
			SRVG320001	HR EE's Gvrnce ENT		(blank)			0.35
		1482 - Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			37.63
		4035 - ES&SFinancials,Ops&Improvement	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			34.30
		4039 - ES&S Tech Planning Services	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			14.70
		4093 - NERC CIP Enterprise	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			2.29
		4513 - Public Affairs & Jurisdictiona	**DEOH240001**	DEO DEK Oth Cust Elec Gas		(blank)			92.37
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			243.13
		4610 - ET Operations & Projects	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			58.89

0923000 - Outside Services Employed	**69500 - Other Contracts**	5732 - DEC Cherokee 1	**SRV33A0001**	Telecom EE's ENT DUK - Non SRV		(blank)				0.43
		6049 - Natural Resources - DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)				112.14
		6057 - WR Car East & Midwest-DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)				93.92
		6062 - Permit & Compl- Carolinas	**SRVC460001**	Env Affrs 3FF ENT		(blank)				406.59
		6082 - Environmental, H&S Staff	**SRVC460001**	Env Affrs 3FF ENT		(blank)				2.12
		6083 - H&S Programs-DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)				4.47
		6089 - H&S-Duke East Nursing Support	**SRV3040001**	HR Svcs EE's ENT		(blank)				0.28
			SRVC460001	Env Affrs 3FF ENT		(blank)				6.02
		6090 - H&S-Duke West Nursing Support	**SRVC460001**	Env Affrs 3FF ENT		(blank)				5.08
		6117 - Grid Solutions Reg Planning	**SRV3040001**	HR Svcs EE's ENT		(blank)				1.32
		6393 - Outage Management Solutions	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)				121.86
		6424 - ENT Ops Excellence Assess-DEBS	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)				10.06
		6487 - EHS Field Supt DIR & CCP BUPM	**SRVC460001**	Env Affrs 3FF ENT		(blank)				2.96
		6547 - Technology, Engineering, and D	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)				4.29
		6828 - Customer IT Control Center	**SRV3370001**	M&CR Customers Util ND		(blank)				242.85
		6851 - Legal eDiscovery	**SRVC090001**	Misc 3FF Svcs UTIL		(blank)				13.57
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)				0
		6852 - OGC Operations & Analysis	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)				2,950.45
		6969 - Finance Program Office	**SRV3030001**	Misc 3FF Svcs ENT - Both		(blank)				22.81
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)				395.99
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)				573.12
		6973 - Gas Acctg & Reporting.Map Gas	**APACR21147**	Accounts Payable - Accrual	**CW Gas Accounting supplemental**	0000224477	**EXPERIS US INC**	8115999891		2,160.00
								8116018548		2,160.00
								8116026727		202.50
			APACR37227	Accounts Payable - Accrual	**CW GUI Accounting support - KY**	0000224477	**EXPERIS US INC**	8116030290		2,423.25
								8116066084		2,106.00
			APACR37381	Accounts Payable - Accrual	**CW GUI Accounting support - KY**	0000224477	**EXPERIS US INC**	8116052535		2,498.48
			APACR40602	Accounts Payable - Accrual	**CW GUI Accounting support - KY**	0000224477	**EXPERIS US INC**	8116083536		2,241.00
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)				380.70
			SRVM122303	LATE JE - Manual Alloc Dec23 C	**Manual DGAC Dec23 Corr**	(blank)				684.64
		6984 - Natural Gas Legal Support	**APACR01500**	Accounts Payable - Accrual	**2023-0818**	0000146517	**PORTER WRIGHT MORRIS & ARTHUR LLP**	1308550		227.00
			APACR08255	Accounts Payable - Accrual	**2023-0223**	0000034259	**TAFT STETTINIUS & HOLLISTER LLP**	6123907		35.15
			APACR34582	Accounts Payable - Accrual	**2023-0818**	0000146517	**PORTER WRIGHT MORRIS & ARTHUR LLP**	1314587		2,282.50
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)				27.02
		6990 - FERC Gas Legal	**ACCRUL3Q3L**	To record 3rd Quarter Accruals	**Rec 3rd Qtr Legal Accruals**	(blank)				7,000.00
				To reverse 3rd Quarter Accrual	**Rev 3rd Qtr Legal Accruals**	(blank)				(7,000.00)
			ACCRUL4Q2L	To record Legal accruals for 4	**Rec 4th Qtr Legal Accruals**	(blank)				2,000.00
				To reverse Legal accruals for	**REV 4th Qtr Legal Accruals**	(blank)				(2,000.00)
			APACR09646	Accounts Payable - Accrual	**2023-0403**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30758170		128.70
					2023-1065	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30758186		17.16
			APACR12994	Accounts Payable - Accrual	**2022-0535**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30616011		1,451.50
					2023-0405	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30616022		3,527.20
								30621404		890.95
			APACR16737	Accounts Payable - Accrual	**2023-0405**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30758177		1,529.85
			APACR21142	Accounts Payable - Accrual	**2023-0405**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30632331		1,606.50
			APACR26092	Accounts Payable - Accrual	**2022-0535**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30771622		2,028.50
					2023-0405	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30771627		1,372.80
					2023-1065	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30771628		83.01
			APACR27754	Accounts Payable - Accrual	**2023-0403**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30641872		214.50
					2023-0405	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30641875		1,379.50
			APACR36147	Accounts Payable - Accrual	**2023-0403**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30659951		407.70
					2023-0405	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30659952		2,048.85
			APACR59102	Accounts Payable - Accrual	**2023-0403**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30682517		214.64
					2023-0405	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30682521		2,452.45
			APACR72783	Accounts Payable - Accrual	**2023-0405**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30695007		2,181.80
					2023-1065	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30695009		59.34
			APACR84007	Accounts Payable - Accrual	**2023-0405**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30709877		1,762.55
					2023-1065	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30709883		242.97
			APACR93666	Accounts Payable - Accrual	**2023-0405**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30728939		2,005.65
					2023-1065	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30728945		177.75
			APACR99883	Accounts Payable - Accrual	**2023-0405**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30743391		1,780.75
					2023-1065	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30743392		78.96
		6998 - Distributed Generation, IT&IP	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)				121.73
		7103 - Analytical Lab - DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)				8.22
		7109 - ENT Training and CM	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)				2,257.63
		7385 - Groundwater Science	**SRVC460001**	Env Affrs 3FF ENT		(blank)				17.14
		7395 - CIO Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)				226.32
		73OD - ORG DEVELOPMENT	**SRVG320001**	HR EE's Gvrnce ENT		(blank)				0.04
		7405 - Software Quality Engineering	**APACR04761**	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709442566		129.07
			APACR12994	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709370276		94.14
			APACR15957	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709451796		168.10
			APACR28050	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709379066		108.02
			APACR30383	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709470775		173.67
			APACR36674	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709387975		93.55

0923000 - Outside Services Employed	**69500 - Other Contracts**	7405 - Software Quality Engineering	**APACR54778**	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709397926	79.88
			APACR65686	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709406793	77.39
								709415065	76.56
			APACR81742	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709423576	84.08
			APACR92335	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709433907	84.42
			APACR98450	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709361023	195.48
			SRV3190001	Matls Mgmt Prcrmnt UTIL		(blank)			324.59
			SRV3370001	M&CR Customers Util ND		(blank)			110.57
			SRV35C0001	IT Mgmt & Apps 3FF ENT Split		(blank)			444.43
			SV336A0001	ITS Mgt & Apps Svcs Util DE		(blank)			1.09
		7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)			28.10
		7803 - Telecom Delivery Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			72.29
		7809 - Telecom Field Serv Car Swest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			215.83
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			8,069.01
		7812 - Telecom Delivery Car West	**SRV3330001**	Telecom EE's ENT DUK		(blank)			66.12
		7823 - Telecom Field Serv Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			2.08
		7826 - Telecom Field Serv Car Nwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)			7.01
		7828 - Telecom Field Serv Car East	**SRV3330001**	Telecom EE's ENT DUK		(blank)			8.28
		7831 - Business Operations	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1.56
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)			16.92
		7920 - Data Solutions	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			(0.13)
		8001 - CEO-Expenses	**SRVGD10001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			2,541.66
		8018 - CEO-STAFF EXPENSES	**SRVC090001**	Misc 3FF Svcs UTIL		(blank)			12.11
			SRVGD10001	Misc 3FF Gvrnce ENT - New Duke		(blank)			43.83
		8048 - D OH Alloc-DEC	**SRV3040001**	HR Svcs EE's ENT		(blank)			0
		8109 - AMI Meter & PI Systems	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			(162.63)
		8120 - Envr Science Staff -DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)			9.65
		8172 - Transactional Enterprise Legal	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			167.20
		8221 - Envr Inst & Data Mgmt	**SRVC460001**	Env Affrs 3FF ENT		(blank)			21.42
		8262 - Electric Acct & Reporting	**SRVC090001**	Misc 3FF Svcs UTIL		(blank)			1.11
		8273 - DER, AMI, Grid Delivery	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			42.00
		8351 - Strategic Engagement	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			430.88
		8408 - TA Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			289.87
			SRVG320001	HR EE's Gvrnce ENT		(blank)			1.29
		8431 - Major Projects & Renewables Le	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			119.76
		8502 - CORP Environment Mgmt	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			63.05
		8536 - SC SUP Invoice Process Train	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			24.95
		8538 - SC SUP Vendor Payment Admin	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			315.04
		8646 - Learning & Dev	**SRV3040001**	HR Svcs EE's ENT		(blank)			44.74
		8651 - Employee Engagement	**SRV3040001**	HR Svcs EE's ENT		(blank)			181.72
		8711 - DEBS PQRI Plan Gov	**SRV0890001**	M&CR Smart Grid Util O&M_ALL		(blank)			0.78
		8727 - Tax	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			0.77
		8744 - SC Ops Asset Recovery	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)			2.50
		8749 - OGC Staff	**SRVC090001**	Misc 3FF Svcs UTIL		(blank)			470.00
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			4,236.81
		8750 - Corporate Books & Records	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			357.36
		8764 - SVP Staff	**SRV3040001**	HR Svcs EE's ENT		(blank)			0.67
		8771 - FERC Electric Legal	**APACR21142**	Accounts Payable - Accrual	**2023-1065**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30632337	210.36
			APACR27754	Accounts Payable - Accrual	**2023-1065**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30641877	7.74
			APACR59102	Accounts Payable - Accrual	**2023-1065**	0000097763	**TROUTMAN PEPPER HAMILTON SANDERS LLP**	30682531	23.19
			SRVC090001	Misc 3FF Svcs UTIL		(blank)			859.90
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			37.76
		8772 - Legal Financing Support	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			32.30
		8774 - Nuclear EH&S Legal Support	**SRVC090001**	Misc 3FF Svcs UTIL		(blank)			21.30
		8782 - Adv, Acct Mgt & Ops	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1,111.64
		8802 - Corporate Communications Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			238.05
		8829 - Car West Regional Fac - JLL FM	**SRV3330001**	Telecom EE's ENT DUK		(blank)			34.49
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			244.76
		8875 - Legal Disclosure & Governance	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1,052.55
		8929 - SE Labor and Employment	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			187.54
		8937 - Executive Rewards	**SRVGD10001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			998.10
		8950 - SC CPO Staff	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			2.32
		8951 - SC ENT Tier 3	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			434.72
		8987 - Corporate Litigation	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			464.66
		8996 - Internal Communications	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			40.25
		9398 - Infra, CIOPS & Ops Staff	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			5.86
		9421 - Foundation	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			12.86
		9428 - Reg Renew Projects - East	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)			36.70
		9442 - Audit Svcs - Charlotte	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			633.89
		9459 - Investor Relations & FP Staff	**SRVGD10001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			235.86
		9462 - Business Support Finance	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			12.88
		9482 - EAM Environment Mgmt	**SRV3190001**	Matls Mgmt Prcrmnt UTIL		(blank)			1,085.18
		9486 - Employee Xp & Emerging Tech	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			2.66
		9511 - Corporate Controller	**APACR26852**	Accounts Payable - Accrual	**EY MSP May 2024**	0000068193	**ERNST & YOUNG US LLP**	US01U001570	11,538.90

0923000 - Outside Services Employed	**69500 - Other Contracts**	9511 - Corporate Controller	**APACR27644**	Accounts Payable - Accrual	**Finance Controller's Managed S**	0000068193	**ERNST & YOUNG US LLP**	US01U001608	11,552.62
			APACR30368	Accounts Payable - Accrual	**CW DEF accounting supplement -**	0000224477	**EXPERIS US INC**	8116362077	2,133.00
			APACR48677	Accounts Payable - Accrual	**Controllers EY MSA Sept 2023**	0000068193	**Ernst & Young LLP**	US01U001371	3,915.00
			APACR53160	Accounts Payable - Accrual	**EY MSP Oct 2023 services**	0000068193	**ERNST & YOUNG US LLP**	US01U001439	2,757.57
			APACR53515	Accounts Payable - Accrual	**EY MSP Nov 2023**	0000068193	**ERNST & YOUNG US LLP**	US01U001439	2,870.86
			APACR55278	Accounts Payable - Accrual	**EY MSP Dec 2023**	0000068193	**ERNST & YOUNG US LLP**	US01U001439	2,870.86
			APACR64580	Accounts Payable - Accrual	**EY Managed Services January 20**	0000068193	**ERNST & YOUNG US LLP**	US01U001456	2,942.75
			APACR72223	Accounts Payable - Accrual	**EY Finance Managed Services FE**	0000068193	**ERNST & YOUNG US LLP**	US01U001477	10,627.86
			APACR88932	Accounts Payable - Accrual	**EY MSP March 2024**	0000068193	**ERNST & YOUNG US LLP**	US01U001514	10,637.99
			APACR93541	Accounts Payable - Accrual	**EY Managed Services April 2024**	0000068193	**ERNST & YOUNG US LLP**	US01U001532	14,241.63
			SRVC090001	Misc 3FF Svcs UTIL		(blank)			1,529.05
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			4,291.06
		9515 - Talent Mgmt & Engage	**SRV3040001**	HR Svcs EE's ENT		(blank)			27.06
		9526 - Financial Reporting	**APACR97866**	Accounts Payable - Accrual	**CW GUI accounting supplement**	0000224477	**EXPERIS US INC**	8116259492	42.40
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			4,224.48
		9533 - Payroll	**SRV3040001**	HR Svcs EE's ENT		(blank)			49.70
		9544 - Treasury	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			1.68
		9555 - Fusion Corporate	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.52
		9579 - Cust Web XP Engineering	**APACR04689**	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709442566	51.69
			APACR15988	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709451796	60.46
			APACR30387	Accounts Payable - Accrual	**SAR019 - IT Application Testin**	0000215061	**ACCENTURE INTERNATIONAL LIMITED**	709470775	47.68
		9603 - Enhanced Cust Prod & Insights	**CSRV380001**	M&CR Customers Util ND		(blank)			1.13
			SRV3350001	IT Mgmt & Apps 3FF ENT		(blank)			6.75
		9604 - NERC CIP Security Delivery	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			413.58
		9606 - Database Services	**ITRC000001**	IT Reclass from A&G		(blank)			(253.87)
			ITRC000002	IT Reclass from A&G		(blank)			(471.00)
			ITRC000003	IT Reclass from A&G		(blank)			(167.89)
			ITRC000004	IT Reclass from A&G		(blank)			(610.84)
			ITRC000005	IT Reclass from A&G		(blank)			(177.93)
			ITRC000006	IT Reclass from A&G		(blank)			(752.64)
			ITRC000007	IT Reclass from A&G		(blank)			(177.93)
			SRV3070001	Info Servers Svcs ENT DUK		(blank)			12,862.37
		9608 - Gas SCADA and Facility Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			8.81
			SRVC350001	IT Mgmt & Apps 3FF ENT		(blank)			403.50
		9611 - SC Supplier Diversity	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)			0.91
		9615 - Cybersecurity Ops Center	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			15.72
		9657 - CAO Staff	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			10.56
		9701 - Customer Mobile App	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			36.16
		9765 - Strategy & Innovation	**SV336A0001**	ITS Mgt & Apps Svcs Util DE		(blank)			(0.99)
		9843 - Real Estate Legal Support	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			112.34
		9844 - PI Delivery & Support	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			34.68
		9864 - Empl Care Nursing- DEBS	**SRVC460001**	Env Affrs 3FF ENT		(blank)			2.54
		9865 - NG Solutions Delivery-Ops Apps	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			1,343.54
		9877 - Natural Gas Commercial Ops	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0
		9889 - UAS Department	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			363.09
		9897 - Aviation Corporate Jets	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			12,948.29
		9899 - Aircraft Ops and Support	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			10.87
		AG02 - Integrated Planning MWFL	**MISPRJ1695**	FLMW Resp Center Correction	**invoice RC correction**	(blank)	**S&P GLOBAL MARKET INTELLIGENCE INC**		(1,716.67)
			MISPRJ6380	S&P Global Resp Center Correct	**invoice RC correction**	(blank)	**S&P GLOBAL MARKET INTELLIGENCE INC**	INV114910	1,716.67
		CS39 - RCPS Staff_CAR	**CSRV380001**	M&CR Customers Util ND		(blank)			123.30
		CS41 - Contact Center Technology-CAR	**CSRV880001**	M&CR Customers Util ND_PEF		(blank)			1,177.30
		D056 - Transactional Legal Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)			82.55
		EE14 - Garner Garage-Svc Co	**SRV3040001**	HR Svcs EE's ENT		(blank)			0.13
		EH02 - EnvOps-Waste	**SRVC460001**	Env Affrs 3FF ENT		(blank)			765.64
		FLMW - Florida & Midwest Exec Staff	**MISPRJ1695**	FLMW Resp Center Correction	**invoice RC correction**	(blank)	**S&P GLOBAL MARKET INTELLIGENCE INC**		1,716.67
		HR21 - Exec Dev & Planning	**SRV3040001**	HR Svcs EE's ENT		(blank)			326.83
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)			108.46
		J109 - PQR&I / Planning - Car	**SRV3040001**	HR Svcs EE's ENT		(blank)			1.20
		J747 - SAP Customer Platform	**SRV3370001**	M&CR Customers Util ND		(blank)			117.00
		J756 - Cust IT Security & Licensing	**APACR40683**	Accounts Payable - Accrual	**SAP_Order Form_304792874_Enabl**	0000199342	**SAP INDUSTRIES INC**	10265230002	39.60
			APACR57788	Accounts Payable - Accrual	**Change Order 1Change Order t**	0000199342	**SAP INDUSTRIES INC**	10265240000	27.90
					SAP_Order Form_304792874_Enabl	0000199342	**SAP INDUSTRIES INC**	10265230003	45.90
			APACR70633	Accounts Payable - Accrual	**Change Order 1**	0000199342	**SAP INDUSTRIES INC**	10265240000	115.20
			SRV3370001	M&CR Customers Util ND		(blank)			6,266.49
			SRV8910001	Cust Info Sys Util		(blank)			0
			SRVMIXMAN1	Clear Suspense Acct - Septembe	**Remove Project/Act**	(blank)			499.92
		J790 - IT Lighthouse Prod	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			6.90
		J798 - Cybersecurity ITOT	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			(2.36)
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)			2,014.94
		J833 - Compliance Operations	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.62
		J875 - App Transformation	**SRV35D0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			81.23
		J897 - Enterprise CIP Tools	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)			0.16
		JLCE - Midwest - JLL Crit Engineers	**SRV0710001**	MW RE Fac Svcs SF		(blank)			107.22
		NU10 - IT & ES NERC CIP & Tools	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)			0.18

0923000 - Outside Services Employed	**69500 - Other Contracts**	Q177 - Social Media & Content	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		854.94
		Q378 - Meterology	**SRVC460001**	Env Affrs 3FF ENT		(blank)		71.40
		R017 - DPHR MEDICAL MANAGEMENT	**ALLOCORR**	Correct December Allocations	**Outside Services Employed**	(blank)		0
			DEKY050001	DEK Oth Labor Elec Gas		(blank)		1,007.26
		R023 - Ethics	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		526.28
		R028 - Labor Relations	**SRV3040001**	HR Svcs EE's ENT		(blank)		4.49
		R102 - Enterprise Comms & Digital Med	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		1,357.93
		R638 - Public Affairs & Federal Comms	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		141.32
		RG02 - Executive Comms & Positioning	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		160.41
		S042 - Legal Ethics & Compliance	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		1,474.47
		S044 - Exec Comp & Benefits	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		3,220.33
		S388 - Economic Development - IN	**EXACCT1203**	Expense Accrual Journal	**271971**	(blank)	**FEDEX OFFIC15900015966**	5.66
		S394 - Public Policy	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		7.54
		S396 - State President OH/KY Staff	**EXACCT5371**	Expense Accrual Journal	**095268**	(blank)	**4ALLPROMOS**	44.71
			EXACCT6707	Expense Accrual Journal	**095268**	(blank)	**IN DESIGN 2 WELLNESS**	18.87
		S667 - Non Workforce Vendors	**CSRV380001**	M&CR Customers Util ND		(blank)		684.20
		S735 - Midwest Regional Fac - FM Tech	**SRV0710001**	MW RE Fac Svcs SF		(blank)		29.25
		S737 - Midwest Regional Fac-JLL OH F	**SRV0710001**	MW RE Fac Svcs SF		(blank)		7,459.12
			SRV3330001	Telecom EE's ENT DUK		(blank)		58.80
		S742 - Midwest Regional Fac - AM	**SRV0710001**	MW RE Fac Svcs SF		(blank)		4,989.16
		S786 - ES Roadmap	**SRV35C0001**	IT Mgmt & Apps 3FF ENT Split		(blank)		0
			SRV35D0001	IT Mgmt & Apps 3FF ENT Split		(blank)		2.19
		S829 - Nuc & Bus Support Staff	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)		74.10
		S970 - Legal M&A Support	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		194.49
		SC85 - Industrial & Admin Services	**SRV3350001**	IT Mgmt & Apps 3FF ENT		(blank)		46.08
		SC99 - HR Corporate Sourcing	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)		9.13
		U320 - Florida Regional Fac - JLL FM	**SRV33B0001**	Telecom EE's ENT PGN - Non SRV		(blank)		45.48
		W277 - TA Support	**SRV3040001**	HR Svcs EE's ENT		(blank)		274.12
		W315 - Car East Regional Fac - JLL FM	**SRV3330001**	Telecom EE's ENT DUK		(blank)		1.79
		W554 - STAFF	**SRV3040001**	HR Svcs EE's ENT		(blank)		0.33
		W607 - ESG & Sustainability	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		2,117.37
	69700 - Consultants	1267 - Fed Govt & Corp Affairs Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		75.44
		3160 - Tax Study	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		549.90
		6447 - External Affairs Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		587.90
		8001 - CEO-Expenses	**SRVGD10001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		2,468.99
		8351 - Strategic Engagement	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		56.58
		8727 - Tax	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		18,040.03
		8755 - Financial Officer Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		4,009.28
		8782 - Adv, Acct Mgt & Ops	**DEKY050001**	DEK Oth Labor Elec Gas		(blank)		8,379.00
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)		367.93
		8802 - Corporate Communications Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		1,930.72
		8996 - Internal Communications	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		3.33
		9515 - Talent Mgmt & Engage	**SRV3040001**	HR Svcs EE's ENT		(blank)		7.00
		ES01 - Strategy Bus & Plng Supp	**SRV3090001**	Misc 3FF Svcs UTIL - Both		(blank)		23.94
		R102 - Enterprise Comms & Digital Med	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		1,608.15
		W607 - ESG & Sustainability	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		23.94
	78000 - Allocated S&E (Non-Labor)	3943 - Gas OH Alloc-KY	**GAS0090001**	DEK Funct NonLbr Alloc Gas Min		(blank)		250.57
			GAS0140001	Gas Serv Co Alloc DEK		(blank)		143.95
	94029 - SPONSORSHIPS	1267 - Fed Govt & Corp Affairs Staff	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		22.00
		1415 - Diversity & Inclusion	**SRVG320001**	HR EE's Gvrnce ENT		(blank)		0.60
	99810 - Accounting Entry	8532 - SC SUP Credit Card Rebate	**SRV3080001**	Matls Mgmt Prcrmnt ENT		(blank)		(28,104.72)
		S414 - Utility Aviation	**SRVG310001**	Misc 3FF Gvrnce ENT - New Duke		(blank)		3,241.96
0923980 - Outside Services Employee &	**69100 - Baseload Contract Labor**	7800 - Telecom MRTP Delivery	**SRV3330001**	Telecom EE's ENT DUK		(blank)		0.59
		7803 - Telecom Delivery Midwest	**SRV3330001**	Telecom EE's ENT DUK		(blank)		32.13
		7811 - Telecom MRTP PLM	**SRV3330001**	Telecom EE's ENT DUK		(blank)		6.59
		7812 - Telecom Delivery Car West	**SRV3330001**	Telecom EE's ENT DUK		(blank)		5.84
		7833 - Telecom Delivery Florida	**SRV3330001**	Telecom EE's ENT DUK		(blank)		33.51
		8829 - Car West Regional Fac - JLL FM	**SRV3330001**	Telecom EE's ENT DUK		(blank)		36.07
			SRVG310001	Misc 3FF Gvrnce ENT - New Duke		(blank)		70.82
		JLCE - Midwest - JLL Crit Engineers	**SRV0710001**	MW RE Fac Svcs SF		(blank)		270.11
		S737 - Midwest Regional Fac-JLL OH F	**SRV0710001**	MW RE Fac Svcs SF		(blank)		10,020.96
			SRV3330001	Telecom EE's ENT DUK		(blank)		27.93
		S742 - Midwest Regional Fac - AM	**SRV0710001**	MW RE Fac Svcs SF		(blank)		(3,828.36)
		U320 - Florida Regional Fac - JLL FM	**SRV33B0001**	Telecom EE's ENT PGN - Non SRV		(blank)		23.61
		W315 - Car East Regional Fac - JLL FM	**SRV3330001**	Telecom EE's ENT DUK		(blank)		18.41
Grand Total								**580,786.80**

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-007

REQUEST:

Provide the following information. If any amounts were allocated, show a calculation of the factor used to allocate each amount.

a. A detailed analysis of charges booked for advertising expenditures during the 12 months preceding the base period. Include a complete breakdown of Account No. 913 – Advertising Expenses, and any other advertising expenditures included in any other expense accounts, as shown in Schedule C1. The analysis should specify the purpose of the expenditure and the expected benefit to be derived.

b. An analysis of Account No. 930 – Miscellaneous General Expenses for the 12 months preceding the base period. Include a complete breakdown of this account as shown in Schedule C2 and provide detailed workpapers supporting this analysis. At a minimum, the analysis should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule C2.

c. An analysis of Account No. 426 – Other Income Deductions for the 12 months preceding the base period. Include a complete breakdown of this account as shown in Schedule C3 and provide detailed workpapers supporting this analysis. At a minimum, the analysis should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and a brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule C3.

RESPONSE:

a. Please see STAFF-DR-01-007(a) Attachment.

b. Please see STAFF-DR-01-007(b) Attachment.

c. Please see STAFF-DR-01-007(c) Attachment.

PERSON RESPONSIBLE: Linda L. Miller

Duke Energy Kentucky, Inc.
Case No. 2025-00125
Analysis of Advertising Expenses
(Including Account No. 913)
For the 12 months Ended August 31, 2024

LINE NO.	ITEM (A)	SALES OR PROMOTIONAL ADVERTISING (B)	INSTITUTIONAL ADVERTISING (C)	CONSERVATION ADVERTISING (D)	SAFETY (E)	RATE CASE (F)	OTHER (G)	TOTAL (H)
1	**Newspaper**							-
2								
3	**Magazines and Other**						-	-
4								
5	**Television**							-
6								
7	**Radio**						-	-
8								
9	**Direct Mail**						10,616	10,616
10								
11	**Sales Aids**						80	80
12								
13	**Undetermined**						72,419	72,419
14								
15	**Total**	-	-	-	-	-	83,115	83,115
16								
17	**Amount Assigned to**							
18	**KY Retail**	-	-	-	-	-	-	-

Note: For informational purposes only. Duke Energy Kentucky has excluded these costs in their application to increase rates.
* This analysis of advertising expenses includes amounts reflected in account 0930150 classified as undetermined, which are also reflected in DR 7(b), which is an analysis of 930 accounts.

DuJe Energy Kentucky, Inc.
Case No. 2025-00125
Analysis of Account No. 930 - Miscellaneous General Expenses
For the 12 Months Ended August 31, 2024

Line No.	Item (a)	Amount (b)
1	Industry Association Dues	54,243
2	Stockholder and Debt Service Expenses	64,958
3	Directors' Fees and Expenses	19,647
4	Dues and Subscriptions	9,367
5	Miscellaneous	517,359
6	Total	665,574
7	Amount Assigned to Kentucky Jurisdictional	665,574

* This schedule includes amounts in 0930150 account,
which are also represented in DR 7(a) and DR 8.

Duke Energy Kentucky, Inc.
Case No. 2025-00125
Analysis of Account No. 426 - Other Income Deductions
For the 12 Months Ended August 31, 2024

Line No.	Item	Amount
1	Donations	223,161
2	Civic Activities	-
3	Political Activities	334,289
4	Other	888,948
5	Total	1,446,398

Note: For informational purposes only.
Duke Energy Kentucky has excluded these costs in their application to increase rates.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-008

REQUEST:

Provide an analysis of Duke Kentucky's expenses for research and development activities for the base period and the three most recent calendar years. The analysis should include the following:

a. The basis of fees paid to research organizations and Duke Kentucky's portion of the total revenue of each organization; including where the contribution is monthly and the current rate and effective date;

b. Details of the research activities conducted by each organization;

c. Details of services and other benefits provided to Duke Kentucky by each organization;

d. Annual expenditures of each organization with a basic description of the nature of costs incurred by the organization; and

e. Details of the expected benefits to Duke Kentucky.

RESPONSE:

Please see STAFF-DR-01-008 Attachment.

PERSON RESPONSIBLE: Linda L. Miller

Duke Energy Kentucky, Inc.
Case No. 2025-00125
Analysis of R&D Activities
For the 3 Most Recent Calendar Years and Base Period

Year NO.	Costs Incurred Internally (A) [1, 2]	Costs Incurred Externally (B) [1, 2]	Sum
2022	-	(10)	(10)
2023	-	-	-
2024	-	-	-
Base Period	-	-	-
	-	(10)	(10)

Notes:

1) Columns A and B are reflected in FERC Form 2; page 335, line 2b. These costs have been allocated to DEK.
2) This analysis represents amounts in account 0930700 which are also represented in DR 7(B), which is an analysis of 930 accounts.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-009

REQUEST:

Provide the following information for the most recent calendar year concerning Duke Kentucky and any affiliated service corporation or corporate service division/unit:

a. A schedule detailing the costs charged, either directly or allocated, by Duke Kentucky to the service corporation. Indicate Duke Kentucky's accounts in which these costs were originally recorded. For costs that are allocated, include a description of the allocation factors utilized.

b. A schedule detailing the costs charged, either directly or allocated, by the service corporation to Duke Kentucky. Identify Duke Kentucky's accounts in which these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

RESPONSE:

a. Please see STAFF-DR-01-009(a) Attachment.

b. Please see STAFF-DR-01-009(b) Attachment.

PERSON RESPONSIBLE: Rebekah E. Buck

Case No 2025-00125
Staff-DR-01-009a Attachment
DEK to DEBS - direct-charged

FISCAL_YEAR	2024

	Business Unit ID CE	FERC Account CB	FERC Account Description CB	Account ID CB	Account Description CB	Total	
Duke Energy Kentucky	**20013**	184	**Clearing accounts (Major only)**	0803290	**Miscellaneous Expense**	$	28
Grand Total						**$**	**28**

19				
20	**Non-power Goods or Services Provided for Affiliated**			
21	Customer and Market Services	Duke Energy Carolinas, LLC	See Footnote	229
22	Gas Distribution Services	Duke Energy Carolinas, LLC	See Footnote	614
23	Generation Services	Duke Energy Carolinas, LLC	See Footnote	9,194
24	Other Goods and Services	Duke Energy Carolinas, LLC		
25	Transmission and Distribution Services	Duke Energy Carolinas, LLC	See Footnote	381,239
26	Customer and Market Services	Duke Energy Progress, LLC	See Footnote	580
27	Gas Distribution Services	Duke Energy Progress, LLC		
28	Generation Services	Duke Energy Progress, LLC	See Footnote	6,958
29	Transmission and Distribution Services	Duke Energy Progress, LLC	See Footnote	94,368
30	Customer and Market Services	Duke Energy Florida, LLC	See Footnote	302
31	Generation Services	Duke Energy Florida, LLC		
32	Gas Distribution Services	Duke Energy Florida, LLC		
33	Transmission and Distribution Services	Duke Energy Florida, LLC	See Footnote	389,236
34	Transmission and Distribution Services	Duke Energy Business Services LLC	See Footnote	28
35	Customer and Market Services	Duke Energy Indiana, LLC	See Footnote	7
36	Gas Distribution Services	Duke Energy Indiana, LLC		
37	Generation Services	Duke Energy Indiana, LLC	See Footnote	1,564,752
38	Transmission and Distribution Services	Duke Energy Indiana, LLC	See Footnote	204,442
39	Customer and Market Services	Duke Energy Ohio, Inc.	See Footnote	369,586
40	Gas Distribution Services	Duke Energy Ohio, Inc.	See Footnote	(2,134,311)
41	Other Goods and Services	Duke Energy Ohio, Inc.	See Footnote	1,833,024
42	Transmission and Distribution Services	Duke Energy Ohio, Inc.	See Footnote	1,031,502
43	Generation Services	Duke Energy Ohio, Inc.	See Footnote	(30)
44	Gas Distribution Services	KO Transmission Company		
45	Transmission and Distribution Services	Piedmont Natural Gas Company, Inc.		
46	Gas Distribution Services	Piedmont Natural Gas Company, Inc.		
42				

FERC FORM NO. 1 ((NEW))

Page 429

Name of Respondent: Duke Energy Kentucky, Inc.	This report is: (1) ☑ An Original (2) ☐ A Resubmission	Date of Report: 04/16/2025	Year/Period of Report End of: 2024/ Q4

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			Type			
Service Function	FERC Account	Method	Allocated	Direct	Grand Total	
Accounting	0105	(blank)		286	286	
	0107	(blank)		507,242	507,242	
	0108	(blank)		4,464	4,464	
	0186	(blank)		321,612	321,612	
	0403	Three Factor Formula	1,328,584		1,328,584	
	0408	Three Factor Formula	18,242		18,242	
		(blank)		27,397	27,397	
	0419	Three Factor Formula	(1,471)		(1,471)	
	0421	Three Factor Formula	(1,136)		(1,136)	
	0426	Three Factor Formula	6		6	
	0431	Three Factor Formula	0		0	
	0500	Three Factor Formula	-		-	
	0804	(blank)		595	595	
	0807	(blank)		60,180	60,180	
	0863	(blank)		969	969	
	0874	(blank)		315,218	315,218	
	0876	(blank)		47,444	47,444	
	0880	(blank)		17,934	17,934	
	0887	(blank)		119,215	119,215	
	0889	(blank)		38,197	38,197	
	0903	Three Factor Formula	-		-	
	0920	Three Factor Formula	68,677		68,677	
		(blank)		179,639	179,639	
	0921	Three Factor Formula	(914)		(914)	
		(blank)		19,149	19,149	
	0923	Three Factor Formula	67,977		67,977	
		(blank)		290,086	290,086	
	0924	Three Factor Formula	(269)		(269)	
	0926	Three Factor Formula	14,825		14,825	
		(blank)		88,487	88,487	
	0929	Three Factor Formula	(579)		(579)	
	0930	Three Factor Formula	(112,858)		(112,858)	
		(blank)		1,298	1,298	
	0931	Three Factor Formula	1		1	
		(blank)		462,758	462,758	
Accounting Total			**1,381,086**	**2,502,171**	**3,883,257**	
Electric System Maintenance	0107	(blank)		12,728	12,728	
	0408	(blank)		30	30	
	0892	(blank)		466	466	
	0921	(blank)		-	-	
	0926	(blank)		101	101	
Electric System Maintenance Total				**13,325**	**13,325**	
Electric Transmission & Distribution Engineering & Construction	0105	(blank)		4,330	4,330	
	0107	(blank)		47,232,932	47,232,932	
	0108	(blank)		306,461	306,461	
	0186	(blank)		(4,973,833)	(4,973,833)	
	0408	(blank)		55,772	55,772	
	0426	(blank)		2,193	2,193	
	0588	(blank)		(2)	(2)	
	0807	(blank)		166,521	166,521	
	0863	(blank)		395,559	395,559	
	0871	(blank)		12,446	12,446	
	0874	(blank)		653,249	653,249	
	0875	(blank)		6,580	6,580	
	0876	(blank)		1,575	1,575	
	0878	(blank)		46,667	46,667	
	0879	(blank)		450,286	450,286	
	0880	(blank)		72,800	72,800	
	0887	(blank)		45,495	45,495	
	0889	(blank)		2,140	2,140	
	0892	(blank)		70,052	70,052	
	0893	(blank)		2,064	2,064	
	0894	(blank)		11,991	11,991	
	0903	(blank)		45,292	45,292	
	0904	(blank)		46,856	46,856	
	0908	(blank)		7,396	7,396	
	0920	(blank)		3,804	3,804	
	0921	(blank)		2,042	2,042	
	0923	(blank)		1,164	1,164	
	0926	(blank)		179,818	179,818	
	0930	(blank)		117,031	117,031	
	0931	(blank)		-	-	
	0932	(blank)		561	561	
Electric Transmission & Distribution Engineering & Construction Total				**44,969,244**	**44,969,244**	

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			**Type**			
Service Function	**FERC Account**	**Method**	**Allocated**	**Direct**	**Grand Total**	
Environmental Health & Safety	**0107**	(blank)		96,774	96,774	
	0108	(blank)		882	882	
	0186	(blank)		308,606	308,606	
	0408	Three Factor Formula	1,599		1,599	
		(blank)		2,470	2,470	
	0426	Three Factor Formula	61		61	
	0502	Three Factor Formula	0		0	
		(blank)		(0)	(0)	
	0506	Three Factor Formula	0		0	
	0511	Three Factor Formula	0		0	
	0520	Three Factor Formula	0		0	
	0588	Three Factor Formula	-		-	
		(blank)		(54)	(54)	
	0880	(blank)		38,864	38,864	
	0903	(blank)		2,355	2,355	
	0920	Three Factor Formula	27,887		27,887	
	0921	Sales Ratio	114		114	
		Three Factor Formula	6,610		6,610	
	0923	Three Factor Formula	4,579		4,579	
		(blank)		(442)	(442)	
	0926	Three Factor Formula	5,458		5,458	
		(blank)		7,918	7,918	
	0928	Three Factor Formula	12		12	
		(blank)		(12)	(12)	
	0930	Three Factor Formula	(2,616)		(2,616)	
		(blank)		12	12	
Environmental Health & Safety Total			**43,703**	**457,373**	**501,077**	
Executive	**0408**	Three Factor Formula	3,588		3,588	
		(blank)		6,279	6,279	
	0426	Three Factor Formula	1,007		1,007	
		(blank)		111,650	111,650	
	0912	(blank)		2,455	2,455	
	0920	Three Factor Formula	260,709		260,709	
		(blank)		105,175	105,175	
	0921	Three Factor Formula	1,235		1,235	
		(blank)		7,839	7,839	
	0923	Three Factor Formula	8,199		8,199	
		(blank)		2,178	2,178	
	0926	Three Factor Formula	90,658		90,658	
		(blank)		20,330	20,330	
	0930	Three Factor Formula	1,072		1,072	
		(blank)		11,549	11,549	
	0931	Three Factor Formula	3,446		3,446	
		(blank)		40	40	
Executive Total			**369,914**	**267,494**	**637,408**	
Facilities	**0107**	(blank)		265,775	265,775	
	0108	(blank)		2,155	2,155	
	0408	Square Footage Ratio	1,150		1,150	
		(blank)		3,780	3,780	
	0874	(blank)		3,961	3,961	
	0880	(blank)		58,366	58,366	
	0887	(blank)		567	567	
	0920	Square Footage Ratio	19,143		19,143	
	0921	Square Footage Ratio	14,336		14,336	
	0923	Square Footage Ratio	(4,717)		(4,717)	
	0926	Square Footage Ratio	3,700		3,700	
		(blank)		12,140	12,140	
	0931	(blank)		976	976	
Facilities Total			**33,612**	**347,719**	**381,331**	
Facilities Rate of Return Allocation	**0931**	Three Factor Formula	40,815		40,815	
Facilities Rate of Return Allocation Total			**40,815**		**40,815**	

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			**Type**			
Service Function	**FERC Account**	**Method**	**Allocated**	**Direct**	**Grand Total**	
Finance	**0107**	(blank)		75,703	75,703	
	0408	Three Factor Formula	3,825		3,825	
		(blank)		569	569	
	0421	Three Factor Formula	3,012		3,012	
	0480	(blank)		(3,023,629)	(3,023,629)	
	0481	(blank)		(479,537)	(479,537)	
	0482	(blank)		(23,751)	(23,751)	
	0489	(blank)		(23,246)	(23,246)	
	0903	Three Factor Formula	1		1	
	0920	Three Factor Formula	74,252		74,252	
		(blank)		9,356	9,356	
	0921	Three Factor Formula	27,803		27,803	
	0923	Three Factor Formula	3,586		3,586	
		(blank)		2,945	2,945	
	0924	Three Factor Formula	13,139		13,139	
	0925	Three Factor Formula	6,592		6,592	
	0926	Three Factor Formula	(162,002)		(162,002)	
		(blank)		1,762	1,762	
	0930	Three Factor Formula	50,361		50,361	
	0931	Three Factor Formula	1		1	
Finance Total			**20,568**	**(3,459,829)**	**(3,439,261)**	
Human Resources	**0107**	(blank)		437	437	
	0186	(blank)		151	151	
	0408	Number of Employees Ratio	2,113		2,113	
	0426	Number of Employees Ratio	102		102	
	0588	Number of Employees Ratio	-		-	
	0593	Number of Employees Ratio	-		-	
	0920	Number of Employees Ratio	38,959		38,959	
	0921	Number of Employees Ratio	1,727		1,727	
	0923	Number of Employees Ratio	12,749		12,749	
	0926	Number of Employees Ratio	6,797		6,797	
	0930	Number of Employees Ratio	(17,061)		(17,061)	
	0931	Number of Employees Ratio	0		0	
Human Resources Total			**45,386**	**589**	**45,974**	

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			**Type**			
Service Function	**FERC Account**	**Method**	**Allocated**	**Direct**	**Grand Total**	
Information Systems	**0107**	(blank)		3,022,745	3,022,745	
	0108	(blank)		188	188	
	0163	(blank)		30	30	
	0186	(blank)		33,915	33,915	
	0402	Number of Workstations 2016	-		-	
	0408	No. of Personal Computer Workstations Ratio	442		442	
		Number of Employees Ratio	3,587		3,587	
		Number of Info Systems Servers Ratio	4,121		4,121	
		Number of Workstations 2016	7,267		7,267	
		(blank)		5,101	5,101	
	0417	Number of Workstations 2016	0		0	
	0426	Number of Workstations 2016	(181)		(181)	
	0500	Number of Workstations 2016	2		2	
		(blank)		(2)	(2)	
	0524	Number of Workstations 2016	-		-	
	0528	No. of Personal Computer Workstations Ratio	1		1	
	0529	Number of Workstations 2016	-		-	
	0557	(blank)		(101)	(101)	
	0569	Number of Workstations 2016	-		-	
	0588	Number of Employees Ratio	-		-	
		Number of Workstations 2016	-		-	
		(blank)		(6,520)	(6,520)	
	0807	(blank)		8	8	
	0850	(blank)		8,061	8,061	
	0880	(blank)		35,028	35,028	
	0903	Number of Employees Ratio	9		9	
		Number of Workstations 2016	97		97	
		(blank)		16	16	
	0908	Number of Workstations 2016	1		1	
	0910	Number of Workstations 2016	0		0	
	0912	Number of Workstations 2016	2		2	
	0920	No. of Personal Computer Workstations Ratio	7,340		7,340	
		Number of Employees Ratio	60,955		60,955	
		Number of Info Systems Servers Ratio	66,739		66,739	
		Number of Workstations 2016	121,911		121,911	
		(blank)		69,235	69,235	
	0921	No. of Personal Computer Workstations Ratio	6,429		6,429	
		Number of Employees Ratio	81,693		81,693	
		Number of Info Systems Servers Ratio	66,889		66,889	
		Number of Workstations 2016	67,279		67,279	
		(blank)		7,588	7,588	
	0923	No. of Personal Computer Workstations Ratio	2,466		2,466	
		Number of Employees Ratio	44,442		44,442	
		Number of Info Systems Servers Ratio	17,253		17,253	
		Number of Workstations 2016	27,726		27,726	
		(blank)		79,040	79,040	
	0926	No. of Personal Computer Workstations Ratio	1,431		1,431	
		Number of Employees Ratio	11,540		11,540	
		Number of Info Systems Servers Ratio	13,352		13,352	
		Number of Workstations 2016	23,766		23,766	
		(blank)		16,299	16,299	
	0930	No. of Personal Computer Workstations Ratio	(2,053)		(2,053)	
		Number of Employees Ratio	(49,924)		(49,924)	
		Number of Info Systems Servers Ratio	(61,612)		(61,612)	
		Number of Workstations 2016	(77,845)		(77,845)	
		(blank)		209	209	
	0931	Number of Employees Ratio	25,952		25,952	
		Number of Info Systems Servers Ratio	16,680		16,680	
		Number of Workstations 2016	4		4	
		(blank)		110	110	
	0932	Number of Workstations 2016	25		25	
	0935	Number of Employees Ratio	501		501	
Information Systems Total			**488,286**	**3,270,950**	**3,759,236**	

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			Type			
Service Function	FERC Account	Method	Allocated	Direct	Grand Total	
Interest	0419	Interest	(135)		(135)	
	0431	Interest	137,282		137,282	
Interest Total			137,147		137,147	
Internal Auditing	0408	Three Factor Formula	1,427		1,427	
	0426	Three Factor Formula	1		1	
	0910	Three Factor Formula	11		11	
	0920	Three Factor Formula	25,641		25,641	
	0921	Three Factor Formula	759		759	
	0923	Three Factor Formula	63		63	
	0926	Three Factor Formula	4,590		4,590	
	0931	Three Factor Formula	1		1	
Internal Auditing Total			32,493		32,493	
Investor Relations	0408	Three Factor Formula	331		331	
	0920	Three Factor Formula	7,189		7,189	
	0921	Three Factor Formula	18,361		18,361	
	0923	Three Factor Formula	240		240	
	0926	Three Factor Formula	1,063		1,063	
Investor Relations Total			27,184		27,184	
Legal	0107	(blank)		20,663	20,663	
	0408	Three Factor Formula	3,551		3,551	
		(blank)		4,078	4,078	
	0426	Three Factor Formula	390		390	
	0910	Three Factor Formula	14		14	
	0920	Three Factor Formula	73,726		73,726	
		(blank)		68,164	68,164	
	0921	Three Factor Formula	5,974		5,974	
	0923	Three Factor Formula	20,456		20,456	
		(blank)		31,251	31,251	
	0924	Three Factor Formula	(1,058)		(1,058)	
	0925	Three Factor Formula	18		18	
	0926	Three Factor Formula	11,453		11,453	
		(blank)		13,336	13,336	
	0928	(blank)		6,100	6,100	
	0930	Three Factor Formula	19,831		19,831	
Legal Total			134,356	143,591	277,947	
Marketing & Customer Relations	0107	Number of Customers Ratio	515,050		515,050	
		(blank)		397,906	397,906	
	0108	(blank)		676	676	
	0163	(blank)		14,015	14,015	
	0186	(blank)		1,373,413	1,373,413	
	0403	Number of Customers Ratio	-		-	
	0408	Number of Customers Ratio	31,978		31,978	
		(blank)		2,335	2,335	
	0421	Number of Customers Ratio	-		-	
	0426	(blank)		23,603	23,603	
	0431	Number of Customers Ratio	(1,364)		(1,364)	
	0557	(blank)		(782)	(782)	
	0588	Number of Customers Ratio	9,563		9,563	
		(blank)		(545)	(545)	
	0593	Number of Customers Ratio	(0)		(0)	
	0880	(blank)		847	847	
	0903	Number of Customers Ratio	947,966		947,966	
		(blank)		(3,374)	(3,374)	
	0908	(blank)		36,770	36,770	
	0910	Number of Customers Ratio	110,475		110,475	
		(blank)		68,913	68,913	
	0912	(blank)		22,595	22,595	
	0920	Number of Customers Ratio	19,559		19,559	
		(blank)		645	645	
	0921	Number of Customers Ratio	110,553		110,553	
		(blank)		810	810	
	0923	Number of Customers Ratio	38,405		38,405	
	0926	Number of Customers Ratio	96,220		96,220	
		(blank)		7,239	7,239	
	0930	Number of Customers Ratio	177		177	
		(blank)		782	782	
	0931	Number of Customers Ratio	430		430	
Marketing & Customer Relations Total			1,879,012	1,945,846	3,824,857	
Meters	0107	(blank)		493,057	493,057	
	0108	(blank)		27,362	27,362	
	0186	(blank)		30,395	30,395	
	0408	(blank)		2,660	2,660	
	0876	(blank)		29	29	
	0880	(blank)		2,136	2,136	
	0893	(blank)		40,456	40,456	
	0926	(blank)		8,253	8,253	
	0930	(blank)		1,321	1,321	
Meters Total				605,669	605,669	
Overhead Allocation (Gov)	0930	Gov OH	356,309		356,309	
Overhead Allocation (Gov) Total			356,309		356,309	

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			Type			
Service Function	FERC Account	Method	Allocated	Direct	Grand Total	
Planning	0408	Three Factor Formula	2,250		2,250	
		(blank)		2,180	2,180	
	0417	Three Factor Formula	144		144	
	0553	Three Factor Formula	(4)		(4)	
	0908	Three Factor Formula	5		5	
	0910	Three Factor Formula	3,450		3,450	
	0920	Three Factor Formula	35,123		35,123	
		(blank)		36,293	36,293	
	0921	Three Factor Formula	5,195		5,195	
		(blank)		7,379	7,379	
	0923	Three Factor Formula	4,122		4,122	
	0926	Three Factor Formula	7,181		7,181	
		(blank)		7,066	7,066	
	0930	Three Factor Formula	(988)		(988)	
	0931	Three Factor Formula	0		0	
Planning Total			**56,478**	**52,918**	**109,396**	
Power Engineering & Construction	0107	(blank)		7,241,735	7,241,735	
	0108	(blank)		21,230	21,230	
	0186	(blank)		116,079	116,079	
	0408	(blank)		14,894	14,894	
	0807	(blank)		6,851	6,851	
	0859	(blank)		5,554	5,554	
	0863	(blank)		5,553	5,553	
	0874	(blank)		51,001	51,001	
	0875	(blank)		235	235	
	0878	(blank)		290	290	
	0879	(blank)		277	277	
	0880	(blank)		48,258	48,258	
	0887	(blank)		19,643	19,643	
	0892	(blank)		2,297	2,297	
	0893	(blank)		25	25	
	0894	(blank)		3,196	3,196	
	0920	(blank)		108,182	108,182	
	0921	(blank)		3,484	3,484	
	0926	(blank)		49,098	49,098	
	0930	(blank)		-	-	
	0932	(blank)		95	95	
Power Engineering & Construction Total				**7,697,978**	**7,697,978**	
Power Planning & Operations	0107	(blank)		945,292	945,292	
	0108	(blank)		3,429	3,429	
	0186	(blank)		41,814	41,814	
	0408	(blank)		3,245	3,245	
	0588	(blank)		(208)	(208)	
	0880	(blank)		61,217	61,217	
	0887	(blank)		1,185	1,185	
	0920	(blank)		990	990	
	0921	(blank)		9,134	9,134	
	0926	(blank)		10,728	10,728	
Power Planning & Operations Total				**1,076,826**	**1,076,826**	
Public Affairs	0408	Three Factor Formula	3,534		3,534	
		(blank)		1,982	1,982	
	0426	Three Factor Formula	67,462		67,462	
		(blank)		198,198	198,198	
	0910	Three Factor Formula	135		135	
	0912	(blank)		4,198	4,198	
	0920	Three Factor Formula	71,170		71,170	
		(blank)		33,139	33,139	
	0921	Three Factor Formula	4,463		4,463	
		Weighted Average of # of Customers Ratio and # of Em	1		1	
		(blank)		1,044	1,044	
	0923	Three Factor Formula	12,902		12,902	
	0926	Three Factor Formula	11,396		11,396	
		(blank)		6,446	6,446	
	0930	Three Factor Formula	8,895		8,895	
		(blank)		10,637	10,637	
	0931	Three Factor Formula	8		8	
		(blank)		984	984	
Public Affairs Total			**179,966**	**256,627**	**436,593**	
Rates	0186	(blank)		43,153	43,153	
	0408	(blank)		16,017	16,017	
	0426	(blank)		45,318	45,318	
	0912	(blank)		11,296	11,296	
	0920	(blank)		265,400	265,400	
	0921	Sales Ratio	(0)		(0)	
		(blank)		11,244	11,244	
	0923	(blank)		244	244	
	0926	(blank)		51,423	51,423	
	0928	(blank)		188,825	188,825	
	0930	(blank)		396	396	
Rates Total			**(0)**	**633,315**	**633,315**	

Case No 2025-00125						
Staff-DR-01-009b Attachment						
Fiscal Year CMD	2024					
Sum of Total DEK - Gas			**Type**			
Service Function	**FERC Account**	**Method**	**Allocated**	**Direct**	**Grand Total**	
Rights Of Way	**0107**	(blank)		20,850	20,850	
	0408	(blank)		493	493	
	0880	(blank)		8,223	8,223	
	0926	(blank)		1,581	1,581	
Rights Of Way Total				**31,147**	**31,147**	
Supply Chain	**0107**	(blank)		(4,114)	(4,114)	
	0163	(blank)		359,268	359,268	
	0408	Procurement Spending Ratio	4,826		4,826	
	0426	Procurement Spending Ratio	111		111	
	0903	Procurement Spending Ratio	5		5	
	0910	Procurement Spending Ratio	21		21	
	0916	Procurement Spending Ratio	271,267		271,267	
	0920	Procurement Spending Ratio	82,172		82,172	
	0921	Procurement Spending Ratio	2,069		2,069	
	0923	Procurement Spending Ratio	(43,352)		(43,352)	
		(blank)		-	-	
	0926	Procurement Spending Ratio	15,806		15,806	
	0930	Procurement Spending Ratio	(4,341)		(4,341)	
	0931	Procurement Spending Ratio	1		1	
	0932	Procurement Spending Ratio	(14,841)		(14,841)	
Supply Chain Total			**313,745**	**355,154**	**668,900**	
Transportation	**0408**	Three Factor Formula	1,674		1,674	
	0920	Three Factor Formula	29,150		29,150	
	0921	Three Factor Formula	14,353		14,353	
	0923	Three Factor Formula	17,106		17,106	
	0924	Three Factor Formula	1,401		1,401	
	0926	Three Factor Formula	5,385		5,385	
	0930	Three Factor Formula	(52)		(52)	
Transportation Total			**69,017**		**69,017**	
Grand Total			**5,609,076**	**61,168,106**	**66,777,182**	

STAFF-DR-01-010

REQUEST:

Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 9:

a. Provide the names of affiliates that provided some form of service to Duke Kentucky and the type of service Duke Kentucky received from each affiliate.

b. Provide the names of affiliates to whom Duke Kentucky provided some form of service and the type of service Duke Kentucky provided to each affiliate.

c. Identify the service agreement with each affiliate, state whether the service agreement has been previously filed with the Commission and identify the proceeding in which it was filed. Provide each service agreement that has not been previously filed with the Commission.

RESPONSE:

a. Please refer to Duke Energy Kentucky, Inc.'s FERC Form 1 Page 429 included in STAFF-DR-01-010 Attachment.

b. Please refer to Duke Energy Kentucky, Inc.'s FERC Form 1 Page 429 included in STAFF-DR-01-010 Attachment.

c. Please refer to the Direct Testimony of Rebekah E. Buck and the Cost Allocation Manual included with our application.

PERSON RESPONSIBLE: Rebekah E. Buck

THIS FILING IS
Item 1: ☑ An Initial (Original) Submission OR ☐ Resubmission No.

FERC FINANCIAL REPORT
FERC FORM No. 1: Annual Report of Major Electric Utilities, Licensees and Others and Supplemental Form 3-Q: Quarterly Financial Report

These reports are mandatory under the Federal Power Act, Sections 3, 4(a), 304 and 309, and 18 CFR 141.1 and 141.400. Failure to report may result in criminal fines, civil penalties and other sanctions as provided by law. The Federal Energy Regulatory Commission does not consider these reports to be of confidential nature

Exact Legal Name of Respondent (Company)	Year/Period of Report
Duke Energy Kentucky, Inc.	End of: 2024/ Q4

FERC FORM NO. 1 (REV. 02-04)

Name of Respondent: Duke Energy Kentucky, Inc.	This report is: (1) ☑ An Original (2) ☐ A Resubmission	Date of Report: 04/16/2025	Year/Period of Report End of: 2024/ Q4

TRANSACTIONS WITH ASSOCIATED (AFFILIATED) COMPANIES

1. Report below the information called for concerning all non-power goods or services received from or provided to associated (affiliated) companies.
2. The reporting threshold for reporting purposes is $250,000. The threshold applies to the annual amount billed to the respondent or billed to an associated/affiliated company for non-power goods and services. The good or service must be specific in nature. Respondents should not attempt to include or aggregate amounts in a nonspecific category such as "general".
3. Where amounts billed to or received from the associated (affiliated) company are based on an allocation process, explain in a footnote.

Line No.	Description of the Good or Service (a)	Name of Associated/Affiliated Company (b)	Account(s) Charged or Credited (c)	Amount Charged or Credited (d)
1	**Non-power Goods or Services Provided by Affiliated**			
2	[a] Services Provided by Duke Energy Business Services	Duke Energy Business Services, LLC	See [b] Footnote	173,494,091
3	Customer and Market Services	Duke Energy Carolinas, LLC	See [c] Footnote	6,936,988
4	Generation Services	Duke Energy Carolinas, LLC	See [d] Footnote	970,173
5	Other Goods and Services	Duke Energy Carolinas, LLC	See [e] Footnote	982,056
6	Transmission and Distribution Services	Duke Energy Carolinas, LLC	See [f] Footnote	1,406,247
7	Customer and Market Services	Duke Energy Progress, LLC	See [g] Footnote	221,358
8	Generation Services	Duke Energy Progress, LLC	See [h] Footnote	187,121
9	Other Goods and Services	Duke Energy Progress, LLC	See [i] Footnote	445,838
10	Transmission and Distribution Services	Duke Energy Progress, LLC	See [j] Footnote	119,858
11	Customer & Market Services	Duke Energy Florida, LLC	See [k] Footnote	324,737
12	Generation Services	Duke Energy Florida, LLC	See [l] Footnote	35,621
13	Other Goods and Services	Duke Energy Florida, LLC	See [m] Footnote	2,050
14	Transmission and Distribution Services	Duke Energy Florida, LLC	See [n] Footnote	22,927
15	Customer and Market Services	Duke Energy Indiana, LLC	See [o] Footnote	163,097
16	Generation Services	Duke Energy Indiana, LLC	See [p] Footnote	6,651,528
17	Other Goods and Services	Duke Energy Indiana, LLC	See [q] Footnote	1,313,956
18	Transmission and Distribution Services	Duke Energy Indiana, LLC	See [r] Footnote	81,976
19	Customer and Market Services	Duke Energy Ohio, Inc.	See [s] Footnote	1,843,706
20	Gas Distribution Services	Duke Energy Ohio, Inc.	See [t] Footnote	1,470,777
21	Other Goods and Services	Duke Energy Ohio, Inc.	See [u] Footnote	1,446,668
22	Transmission and Distribution Services	Duke Energy Ohio, Inc.	See [v] Footnote	10,651,537

23	Customer & Market Services	Piedmont Natural Gas Company Inc	See Footnote (w)	33,937
24	Gas Distribution Services	Piedmont Natural Gas Company Inc	See Footnote (x)	8,157,373
25	Other Goods and Services	Piedmont Natural Gas Company Inc	See Footnote (y)	732,417
26	Other Goods and Services	Duke Energy Commercial Enterprises	See Footnote (z)	222
19				
20	**Non-power Goods or Services Provided for Affiliated**			
21	Customer and Market Services	Duke Energy Carolinas, LLC	See Footnote (aa)	229
22	Gas Distribution Services	Duke Energy Carolinas, LLC	See Footnote (ab)	614
23	Generation Services	Duke Energy Carolinas, LLC	See Footnote (ac)	9,194
24	Other Goods and Services	Duke Energy Carolinas, LLC		
25	Transmission and Distribution Services	Duke Energy Carolinas, LLC	See Footnote (ad)	381,239
26	Customer and Market Services	Duke Energy Progress, LLC	See Footnote (ae)	580
27	Gas Distribution Services	Duke Energy Progress, LLC		
28	Generation Services	Duke Energy Progress, LLC	See Footnote (af)	6,958
29	Transmission and Distribution Services	Duke Energy Progress, LLC	See Footnote (ag)	94,368
30	Customer and Market Services	Duke Energy Florida, LLC	See Footnote (ah)	302
31	Generation Services	Duke Energy Florida, LLC		
32	Gas Distribution Services	Duke Energy Florida, LLC		
33	Transmission and Distribution Services	Duke Energy Florida, LLC	See Footnote (ai)	389,236
34	Transmission and Distribution Services	Duke Energy Business Services LLC	See Footnote (aj)	28
35	Customer and Market Services	Duke Energy Indiana, LLC	See Footnote (ak)	7
36	Gas Distribution Services	Duke Energy Indiana, LLC		
37	Generation Services	Duke Energy Indiana, LLC	See Footnote (al)	1,564,752
38	Transmission and Distribution Services	Duke Energy Indiana, LLC	See Footnote (am)	204,442
39	Customer and Market Services	Duke Energy Ohio, Inc.	See Footnote (an)	369,586
40	Gas Distribution Services	Duke Energy Ohio, Inc.	See Footnote (ao)	(2,134,311)
41	Other Goods and Services	Duke Energy Ohio, Inc.	See Footnote (ap)	1,833,024
42	Transmission and Distribution Services	Duke Energy Ohio, Inc.	See Footnote (aq)	1,031,502
43	Generation Services	Duke Energy Ohio, Inc.	See Footnote (ar)	(30)
44	Gas Distribution Services	KO Transmission Company		
45	Transmission and Distribution Services	Piedmont Natural Gas Company, Inc.		
46	Gas Distribution Services	Piedmont Natural Gas Company, Inc.		

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Name of Respondent: Duke Energy Kentucky, Inc.	This report is: (1) ☑ An Original (2) ☐ A Resubmission	Date of Report: 04/16/2025	Year/Period of Report End of: 2024/ Q4

FOOTNOTE DATA

(a) Concept: DescriptionOfNonPowerGoodOrService

When an employee of the Service Company performs services for a Client Company, costs will be directly assigned or distributed or allocated. For allocated services, the allocation method will be on a basis reasonably related to the service performed. The Service Company Utility Service Agreement prescribes 24 Service Company functions and approximately 20 allocation methods. When an employee of an Operating Company performs services for a Client Company, costs will be directly assigned or distributed or allocated. For allocated services, the allocation method will be on a basis reasonably related to the service performed. The Operating Companies Service Agreement utilizes roughly 12 of the 24 Service Company functions and approximately 12 allocation methods.

Service Company Utility Service Agreement Functions and Allocation Methods Implemented:

Information Systems

Number of Central Processing Unit Seconds Ratio/Millions of Instructions per Second

Number of Personal Computer Workstations Ratio

Number of Information Systems Servers Ratio

Number of Employees Ratio

Meters

Number of Customers Ratio

Transportation

Number of Employees Ratio

Three Factor Formula

Electric System Maintenance

Circuit Miles of Electric Transmission Lines Ratio

Circuit Miles of Electric Distribution Lines Ratio

Marketing and Customer Relations and Grid Solutions

Number of Customers Ratio

Electric Transmission & Distribution Engineering & Construction

Electric Transmission Plant's Construction - Expenditures Ratio
Electric Distribution Plant's Construction - Expenditures Ratio
Power Engineering & Construction
Electric Production Plant's Construction - Expenditures Ratio
Human Resources
Number of Employees Ratio
Supply Chain
Procurement Spending Ratio
Inventory Ratio
Facilities
Square Footage Ratio
Accounting
Three Factor Formula
Generating Unit MW Capability Ratio
Power Planning and Operations
Electric Peak Load Ratio
Weighted Avg of the Circuit Miles of Electric Distribution Lines Ratio and the Electric
Peak Load Ratio
Sales Ratio
Weighted Avg of the Circuit Miles of Electric Transmission Lines Ratio and the Electric
Peak Load Ratio
Generating Unit MW Capability Ratio
Public Affairs
Three Factor Formula
Weighted Avg of Number of Customers Ratio and Number of Employees Ratio
Legal
Three Factor Formula
Rates
Sales Ratio
Finance
Three Factor Formula
Rights of Way
Circuit Miles of Electric Transmission Lines Ratio
Circuit Miles of Electric Distribution Lines Ratio
Electric Peak Load Ratio
Internal Auditing
Three Factor Formula
Environmental, Health and Safety
Three Factor Formula
Sales Ratio
Fuels
Sales Ratio
Investor Relations
Three Factor Formula
Planning
Three Factor Formula

Executive
Three Factor Formula
Operating Companies Service Agreement Functions and Allocation Methods Implemented
Electric System Maintenance
Circuit Miles of Electric Transm Lines Ratio
Circuit Miles of Electric Dist. Lines Ratio
Marketing and Customer Relations Grid Solutions
Number of Customers Ratio
Electric Transmission & Distribution Engineering & Construction
(Electric Transmission Plant's) Construction - Expenditures Ratio
(Electric Distribution Plant's) Construction - Expenditures Ratio
Power Engineering & Construction
(Electric Production Plant's) Construction - Expenditures Ratio
Power Planning and Operations
Elec Peak Load Ratio
Weighted Avg of the Circ Miles of ED Lines Ratio and the Elec Peak Load Ratio
Sales Ratio
Weighted Average of the Circ Miles of Elec Transm Lines Ratio and the Elec Peak Load Ratio
Generating Unit MW Capability /MDC Ratio
Environmental, Health and Safety
Sales Ratio
Fuels
Sales Ratio
Nuclear
Generating Unit MW Capability /MDC Ratio
Fossil Hydro
MDC Ratio

(b) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from Duke Energy Business Services LLC to the utility:
105, 106, 107, 108, 121, 163, 182, 183, 185, 186, 403, 408, 415, 416, 417, 419, 421, 426, 428, 431, 451, 454, 457, 480, 481, 482, 489, 500, 501, 502, 506, 510, 511, 512, 513, 514, 520, 528, 541, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 560, 561, 562, 563, 565, 566, 569, 570, 571, 575, 580, 581, 582, 583, 584, 586, 587, 588, 589, 590, 592, 593, 594, 596, 597, 598, 804, 807, 850, 859, 863, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 893, 894, 902, 903, 904, 908, 910, 912, 913, 920, 921, 923, 924, 925, 926, 928, 929, 930, 931, 932, 935

(c) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(d) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(e) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(f) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(g) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(h) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(i) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(j) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(k) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(l) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(m) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(n) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(o) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(p) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(q) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(r) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(s) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:
105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(t) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(u) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(v) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(w) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(x) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(y) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(z) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC Accounts were utilized in transactions from affiliates (Duke Energy Business Services LLC not included) to the utility:

105, 107, 108, 121, 154, 163, 183, 185, 186, 408, 416, 417, 426, 451, 500, 501, 506, 510, 511, 512, 513, 514, 524, 528, 530, 531, 546, 547, 548, 549, 551, 552, 553, 554, 557, 560, 561, 562, 566, 569, 570, 571, 582, 583, 586, 587, 588, 590, 592, 593, 594, 596, 597, 807, 871, 874, 875, 876, 878, 879, 880, 887, 889, 892, 894, 901, 902, 903, 905, 908, 909, 910, 912, 913, 920, 921, 923, 926, 929, 930.2, 931, 932, 935

(aa) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC accounts were utilized in transactions from the utility to the affiliates:

107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

(ab) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC accounts were utilized in transactions from the utility to the affiliates:

107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

(ac) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC accounts were utilized in transactions from the utility to the affiliates:

107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

(ad) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC accounts were utilized in transactions from the utility to the affiliates:

107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

(ae) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC accounts were utilized in transactions from the utility to the affiliates:

107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

(af) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies

The following FERC accounts were utilized in transactions from the utility to the affiliates:

107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

(ag) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(ah) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(ai) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(aj) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(ak) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(al) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(am) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(an) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(ao) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(ap) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(aq) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932
(ar) Concept: AccountsChargedOrCreditedTransactionsWithAssociatedAffiliatedCompanies
The following FERC accounts were utilized in transactions from the utility to the affiliates: 107, 108, 154, 163, 165, 186, 408, 416, 506, 514, 520, 535, 541, 546, 548, 549, 552, 553, 554, 566, 570, 582, 584, 586, 587, 588, 592, 593, 594, 597, 803, 863, 874, 875, 878, 879, 880, 887, 889, 892, 893, 894, 901, 902, 903, 921, 926, 930.2, 932

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

PUBLIC STAFF-DR-01-011

REQUEST:

Describe Duke Kentucky's lobbying activities and provide a schedule showing the name, salary, and job title of each individual whose job function involves lobbying on the local, state, or national level.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky's lobbying activities include advocacy before the Legislative and Executive branch to achieve the strategic objectives of the company and its business units. Duke Energy Business Services (DEBS) employs the following lobbyists registered with the Kentucky Legislative Ethics Commission.

Name	Title	Salary	Kentucky Gas Lobbying
Patrick Keal	State Government Affairs Director	[redacted]	$66,207
Jennifer Loraine	VP Government Affairs	[redacted]	$23,788

Duke Energy Kentucky's natural gas business has allocated labor expense for these employees based on the amount of time they devote to Duke Energy Kentucky natural gas-related matters. These employees also have other non-lobbying job responsibilities so only a portion of their Duke Energy natural gas time is charged to lobbying activities. Any charge related to lobbying activities is recorded to Duke Energy Kentucky's below-the-line expense and therefore is not included in the forecasted test period in this case.

Duke Energy Kentucky has also retained third party consultants to provide lobbying activities on its behalf.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

CONFIDENTIAL STAFF-DR-01-012
(As to Attachments 1 and 3 only)

REQUEST:

For gas operations, provide the following information concerning the costs for the preparation of this case:

a. A detailed schedule of expenses incurred to date for the following categories:

(1) Accounting;

(2) Engineering;

(3) Legal;

(4) Consultants; and

(5) Other Expenses (Identify separately).

b. For each category identified in Item 12a, the schedule should include the date of each transaction, check number or other document reference, the vendor, the hours worked, the rates per hour, amount, a description of the services performed, and the account number in which the expenditure was recorded. Provide copies of contracts or other documentation that support charges incurred in the preparation of this case. Identify any costs incurred for this case that occurred during the base period.

c. An itemized estimate of the total cost to be incurred for this case. Expenses should be broken down into the same categories as identified in Item 12a, with an estimate

of the hours to be worked and the rates per hour. Include a detailed explanation of how the estimate was determined, along with all supporting workpapers and calculations.

d. Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in Items 12a and 12b, and a cumulative total of cost incurred to date for each category. Updates will be due when Duke Kentucky files its monthly financial statements with the Commission, through the month of the public hearing.

RESPONSE:

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

a. Please see STAFF-DR-01-012 Confidential Attachment 1 (Section A: Expenses incurred to date) for a detailed schedule of actual expenses incurred to date in the categories prescribed in the data request.

b. Objection to the extent this request includes information that is protected under the doctrine of attorney client privilege. Without waiving said objection, please see STAFF-DR-01-012 Confidential Attachment 1 (Section A: Expenses incurred to date) for the requested details of actual rate case expenses incurred to date. STAFF-DR-01-012 Attachment 2 - Invoices contains supporting invoice documentation for non-privileged expenses incurred to date. STAFF-DR-01-012 Confidential Attachment 3 contains supporting contracts and letters of arrangement. All actual costs incurred to date have occurred during the base period.

c. STAFF-DR-01-012 Confidential Attachment 1 also includes estimated remaining costs to be incurred (Section B: Itemized estimates of total costs to be incurred) with a total estimated cost to be incurred for this case. Estimates for the depreciation study,

rate of return and lead lag study were based on information received from the expert witnesses. The other expenses were estimated by reviewing the actual expenses incurred in the Company's most recent two rate cases filed with this Commission and applying professional judgement and knowledge of the issues involved in this case. A comparison of the current case estimate with the actual and estimated expenses of the prior two cases is included in the filing on Schedule F-6.

d. Monthly updates of actual costs incurred in conjunction with this rate case will be included along with the monthly financial statements filed with the Commission through the month of the public hearing.

PERSON RESPONSIBLE: As to objection, Legal
As to response, Jefferson "Jay" P. Brown

Duke Energy Kentucky, Inc.
Gas Rate Case Expense
Case No. 2025-0125
Account 0186119

Document/ Journal Entry No.	Invoice Date	Payment Date	Vendor Name / Description	Hours Worked	Rate Per Hour	Consultants: Accounting	Engineering	Legal	Depreciation Study	Rate of Return	Rate Case	Lead Lag Study	Publish Legal Notices	Transport/ Lodging/Meals	Misc.	Total
A) EXPENSES INCURRED TO DATE																
August 2024																
APACR23227	5-Aug-24	19-Aug-24	Guidant Group | Contractor Staffing	18.00	$ 135.03						2,430.55					2,430.55
APACR27312	19-Aug-24	30-Aug-24	Guidant Group | Contractor Staffing	18.00	$ 135.03						2,430.55					2,430.55
APACR29904	28-Aug-24	11-Sep-24	Guidant Group | Contractor Staffing	18.00	$ 135.03						2,430.55					2,430.55
Total August 2024						0.00	0.00	0.00	0.00	0.00	7,291.65	0.00	0.00	0.00	0.00	7,291.65
Total Actual Costs to Date						0.00	0.00	0.00	0.00	0.00	7,291.65	0.00	0.00	0.00	0.00	7,291.65
September 2024																
APACR31874	3-Sep-24	17-Sep-24	Guidant Group | Contractor Staffing	32.00	$ 135.03						4,320.95					4,320.95
APACR34415	9-Sep-24	30-Sep-24	Guidant Group | Contractor Staffing	12.80	$ 135.03						1,728.38					1,728.38
APACR36574	16-Sep-24	23-Sep-24	Guidant Group | Contractor Staffing	16.00	$ 135.03						2,160.48					2,160.48
APACR39633	24-Sep-24	8-Oct-24	Guidant Group | Contractor Staffing	0.25	$ 139.65							34.91				34.91
APACR39633	24-Sep-24	8-Oct-24	Guidant Group | Contractor Staffing	16.00	$ 135.03						2,160.45					2,160.45
Total September 2024						0.00	0.00	0.00	0.00	0.00	10,370.26	34.91	0.00	0.00	0.00	10,405.17
Total Actual Costs to Date						0.00	0.00	0.00	0.00	0.00	17,661.91	34.91	0.00	0.00	0.00	17,696.82
October 2024																
APACR41441	1-Oct-24	15-Oct-24	Guidant Group | Contractor Staffing	0.75	$ 139.65							104.74				104.74
APACR50918	30-Oct-24	13-Nov-24	Guidant Group | Contractor Staffing	0.51	$ 139.65							71.22				71.22
Total October 2024						0.00	0.00	0.00	0.00	0.00	0.00	175.96	0.00	0.00	0.00	175.96
Total Actual Costs to Date						0.00	0.00	0.00	0.00	0.00	17,661.91	210.87	0.00	0.00	0.00	17,872.78
November 2024																
410JMC001	19-Nov-24	3-Dec-24	Guidant Group | Contractor Staffing	0.25	$ 139.65							34.91				34.91
410JMC001	26-Nov-24	10-Dec-24	Guidant Group | Contractor Staffing	1.63	$ 139.65							227.63				227.63
APACR52836	4-Nov-24	18-Nov-24	Guidant Group | Contractor Staffing	16.00	$ 135.03						2,160.50					2,160.50
APACR53610	5-Nov-24	19-Nov-24	Guidant Group | Contractor Staffing	2.75	$ 139.65							384.04				384.04
APACR55906	12-Nov-24	20-Nov-24	Guidant Group | Contractor Staffing	3.63	$ 139.65							506.93				506.93
APACR55906	12-Nov-24	26-Nov-24	Guidant Group | Contractor Staffing	8.00	$ 135.03						1,080.25					1,080.25
APACR58001	19-Nov-24	3-Dec-24	Guidant Group | Contractor Staffing	0.51	$ 139.65							71.22				71.22
APACR58001	19-Nov-24	3-Dec-24	Guidant Group | Contractor Staffing	8.00	$ 135.03						1,080.25					1,080.25
APACR59655	25-Nov-24	9-Dec-24	Guidant Group | Contractor Staffing	12.00	$ 135.03						1,620.35					1,620.35
APACR60133	26-Nov-24	10-Dec-24	Guidant Group | Contractor Staffing	0.38	$ 139.65							53.07				53.07
Total November 2024						0.00	0.00	0.00	0.00	0.00	5,941.35	1,277.80	0.00	0.00	0.00	7,219.15
Total Actual Costs to Date						0.00	0.00	0.00	0.00	0.00	23,603.26	1,488.67	0.00	0.00	0.00	25,091.93
December 2024																
APACR62353	3-Dec-24	17-Dec-24	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR62353	3-Dec-24	17-Dec-24	Guidant Group | Contractor Staffing	7.20	$ 135.03						972.21					972.21
APACR63064	4-Dec-24	18-Dec-24	Guidant Group | Contractor Staffing	0.26	$ 139.65							36.31				36.31
APACR64696	4-Dec-24	27-Dec-24	Gannett Fleming | Depreciation Consultants	8.50	$ 190.00				1,615.00							1,615.00
APACR64696	4-Dec-24	27-Dec-24	Gannett Fleming | Depreciation Consultants	1.00	$ 230.00				230.00							230.00
APACR64696	4-Dec-24	27-Dec-24	Gannett Fleming | Depreciation Consultants	4.00	$ 320.00				1,280.00							1,280.00
APACR64696	4-Dec-24	27-Dec-24	Gannett Fleming | Depreciation Consultants	1.00	$ 130.00				130.00							130.00
APACR64696	4-Dec-24	27-Dec-24	Gannett Fleming | Depreciation Consultants	1.00	$ 140.00				140.00							140.00
APACR64696	9-Dec-24	23-Dec-24	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR64696	9-Dec-24	23-Dec-24	Guidant Group | Contractor Staffing	12.00	$ 135.03						1,620.35					1,620.35
APACR66803	16-Dec-24	30-Dec-24	Guidant Group | Contractor Staffing	18.00	$ 54.31						977.58					977.58
APACR66803	16-Dec-24	30-Dec-24	Guidant Group | Contractor Staffing	5.50	$ 139.65							768.08				768.08
APACR66803	16-Dec-24	30-Dec-24	Guidant Group | Contractor Staffing	12.00	$ 135.03						1,620.35					1,620.35
APACR69206	23-Dec-24	6-Jan-25	Guidant Group | Contractor Staffing	16.00	$ 54.31						868.96					868.96
APACR69206	23-Dec-24	6-Jan-25	Guidant Group | Contractor Staffing	2.00	$ 139.65							279.30				279.30
APACR69206	23-Dec-24	6-Jan-25	Guidant Group | Contractor Staffing	20.00	$ 135.03						2,700.60					2,700.60
APACR71084	30-Dec-24	13-Jan-25	Guidant Group | Contractor Staffing	16.00	$ 54.31						868.96					868.96
APACR71574	31-Dec-24	14-Jan-25	Guidant Group | Contractor Staffing	2.00	$ 139.65							279.30				279.30
APACR71574	31-Dec-24	14-Jan-25	Guidant Group | Contractor Staffing	24.00	$ 135.03						3,240.72					3,240.72
Total December 2024						0.00	0.00	0.00	3,395.00	0.00	15,042.13	1,362.99	0.00	0.00	0.00	19,800.12
Total Actual Costs to Date						0.00	0.00	0.00	3,395.00	0.00	38,645.39	2,851.66	0.00	0.00	0.00	44,892.05
January 2025																

Duke Energy Kentucky, Inc.
Gas Rate Case Expense
Case No. 2025-0125
Account 0186119

Document/ Journal Entry No.	Invoice Date	Payment Date	Vendor Name / Description	Hours Worked	Rate Per Hour	Accounting	Engineering	Legal	Consultants: Depreciation Study	Consultants: Rate of Return	Consultants: Rate Case	Consultants: Lead Lag Study	Publish Legal Notices	Transport/ Lodging/Meals	Misc.	Total
APACR73187	3-Jan-25	17-Jan-25	Guidant Group | Contractor Staffing	32.00	$ 54.31						1,737.92					1,737.92
APACR74418	6-Jan-25	17-Jan-25	Guidant Group | Contractor Staffing	5.50	$ 139.65							768.08				768.08
APACR75146	7-Jan-25	21-Jan-25	Guidant Group | Contractor Staffing	32.00	$ 135.03						4,320.96					4,320.96
APACR76661	13-Jan-25	27-Jan-25	Guidant Group | Contractor Staffing	6.00	$ 139.65							837.90				837.90
APACR76913	14-Jan-25	28-Jan-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR76913	14-Jan-25	28-Jan-25	Guidant Group | Contractor Staffing	10.00	$ 135.03						1,350.30					1,350.30
APACR78411	20-Jan-25	3-Feb-25	Guidant Group | Contractor Staffing	2.50	$ 139.65							349.13				349.13
APACR78684	21-Jan-25	4-Feb-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR80235	27-Jan-25	10-Feb-25	Guidant Group | Contractor Staffing	16.00	$ 54.31						868.96					868.96
APACR80235	27-Jan-25	10-Feb-25	Guidant Group | Contractor Staffing	2.00	$ 139.65							279.30				279.30
APACR80649	20-Dec-24	29-Jan-25	Gannett Fleming | Depreciation Consultants	1.50	$ 190.00				285.00							285.00
APACR80649	20-Dec-24	29-Jan-25	Gannett Fleming | Depreciation Consultants	0.50	$ 320.00				160.00							160.00
APACR80649	20-Dec-24	29-Jan-25	Gannett Fleming | Depreciation Consultants	1.50	$ 140.00				210.00							210.00
APACR80649	20-Jan-25	14-Feb-25	Gannett Fleming | Depreciation Consultants	14.50	$ 190.00				2,755.00							2,755.00
APACR80649	20-Jan-25	14-Feb-25	Gannett Fleming | Depreciation Consultants	3.50	$ 230.00				805.00							805.00
APACR80649	20-Jan-25	14-Feb-25	Gannett Fleming | Depreciation Consultants	1.50	$ 320.00				480.00							480.00
APACR80649	20-Jan-25	14-Feb-25	Gannett Fleming | Depreciation Consultants	4.00	$ 130.00				520.00							520.00
APACR80649	20-Jan-25	14-Feb-25	Gannett Fleming | Depreciation Consultants	0.50	$ 140.00				70.00							70.00
APACR81416	30-Jan-25	13-Feb-25	Guidant Group | Contractor Staffing	16.50	$ 54.31						896.12					896.12
Total January 2025						0.00	0.00	0.00	5,285.00	0.00	11,346.66	2,234.41	0.00	0.00	0.00	18,866.07
Total Actual Costs to Date						0.00	0.00	0.00	8,680.00	0.00	49,992.05	5,086.07	0.00	0.00	0.00	63,758.12
February 2025																
APACR82834	3-Feb-25	14-Feb-25	Guidant Group | Contractor Staffing	0.50	$ 139.65							69.83				69.83
APACR82834	3-Feb-25	14-Feb-25	Guidant Group | Contractor Staffing	40.00	$ 135.03						5,401.20					5,401.20
APACR86236	11-Feb-25	25-Feb-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR86236	11-Feb-25	25-Feb-25	Guidant Group | Contractor Staffing	11.50	$ 139.65							1,605.98				1,605.98
APACR86236	11-Feb-25	25-Feb-25	Guidant Group | Contractor Staffing	40.00	$ 135.03						5,401.20					5,401.20
APACR87752	17-Feb-25	3-Mar-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR87752	17-Feb-25	3-Mar-25	Guidant Group | Contractor Staffing	16.50	$ 139.65							2,304.23				2,304.23
APACR87752	17-Feb-25	3-Mar-25	Guidant Group | Contractor Staffing	12.00	$ 135.03						1,620.35					1,620.35
APACR89744	24-Feb-25	10-Mar-25	Guidant Group | Contractor Staffing	8.75	$ 139.65							1,221.94				1,221.94
APACR90119	19-Feb-25	17-Mar-25	Gannett Fleming | Depreciation Consultants	6.00	$ 205.00				1,230.00							1,230.00
APACR90119	19-Feb-25	17-Mar-25	Gannett Fleming | Depreciation Consultants	15.50	$ 240.00				3,720.00							3,720.00
APACR90119	19-Feb-25	17-Mar-25	Gannett Fleming | Depreciation Consultants	17.00	$ 340.00				5,780.00							5,780.00
APACR90119	19-Feb-25	17-Mar-25	Gannett Fleming | Depreciation Consultants	4.00	$ 140.00				560.00							560.00
APACR90119	19-Feb-25	17-Mar-25	Gannett Fleming | Depreciation Consultants	2.00	$ 150.00				300.00							300.00
Total February 2025						0.00	0.00	0.00	11,590.00	0.00	14,595.15	5,201.98	0.00	0.00	0.00	31,387.13
Total Actual Costs to Date						0.00	0.00	0.00	20,270.00	0.00	64,587.20	10,288.05	0.00	0.00	0.00	95,145.25
March 2025																
APACR00292	26-Mar-25	9-Apr-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR01771	31-Mar-25	14-Apr-25	Guidant Group | Contractor Staffing	18.00	$ 54.31						977.58					977.58
APACR92404	3-Mar-25	17-Mar-25	Guidant Group | Contractor Staffing	1.00	$ 139.65							139.65				139.65
APACR94714	4-Mar-25	20-Mar-25	Concentric Energy Advisors | Rate of Return	14.50	$ 695.00					10,077.50						10,077.50
APACR94714	4-Mar-25	20-Mar-25	Concentric Energy Advisors | Rate of Return	n/a	n/a					3,500.00						3,500.00
APACR95289	10-Mar-25	24-Mar-25	Guidant Group | Contractor Staffing	1.50	$ 139.65							209.48				209.48
APACR95289	10-Mar-25	24-Mar-25	Guidant Group | Contractor Staffing	40.00	$ 135.03						5,401.20					5,401.20
APACR96503	13-Mar-25	27-Mar-25	Guidant Group | Contractor Staffing	16.00	$ 54.31						868.96					868.96
APACR96503	13-Mar-25	27-Mar-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR97281	17-Mar-25	31-Mar-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR97281	17-Mar-25	31-Mar-25	Guidant Group | Contractor Staffing	0.25	$ 139.65							34.91				34.91
APACR97281	17-Mar-25	31-Mar-25	Guidant Group | Contractor Staffing	40.00	$ 135.03						5,401.20					5,401.20
APACR98141	12-Mar-25	9-May-25	Ernst & Young US LLP | Contractor Staffing	27.93	$ 180.00						5,027.27					5,027.27
APACR99227	24-Mar-25	7-Apr-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR99227	24-Mar-25	7-Apr-25	Guidant Group | Contractor Staffing	4.75	$ 139.65							663.34				663.34
APACR99227	24-Mar-25	7-Apr-25	Guidant Group | Contractor Staffing	24.00	$ 135.03						3,240.70					3,240.70
Total March 2025						0.00	0.00	0.00	0.00	13,577.50	25,261.71	1,047.38	0.00	0.00	0.00	39,886.59
Total Actual Costs to Date						0.00	0.00	0.00	20,270.00	13,577.50	89,848.91	11,335.43	0.00	0.00	0.00	135,031.84
April 2025																
APACR02514	31-Mar-25	14-Apr-25	Guidant Group | Contractor Staffing	0.50	$ 139.65							69.83				69.83
APACR02514	31-Mar-25	14-Apr-25	Guidant Group | Contractor Staffing	24.00	$ 135.03						3,240.70					3,240.70
APACR04656	1-Apr-25	16-Apr-25	Concentric Energy Advisors | Rate of Return	5.50	$ 695.00					3,822.50						3,822.50
APACR05035	7-Apr-25	21-Apr-25	Guidant Group | Contractor Staffing	32.00	$ 135.03						4,320.95					4,320.95
APACR05528	7-Apr-25	21-Apr-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR05528	8-Apr-25	22-Apr-25	Guidant Group | Contractor Staffing	0.50	$ 139.65							69.83				69.83
APACR07281	14-Apr-25	28-Apr-25	Guidant Group | Contractor Staffing	4.50	$ 139.65							628.43				628.43

Duke Energy Kentucky, Inc.
Gas Rate Case Expense
Case No. 2025-0125
Account 0186119

Document/ Journal Entry No.	Invoice Date	Payment Date	Vendor Name / Description	Hours Worked	Rate Per Hour	Accounting	Engineering	Legal	Consultants: Depreciation Study	Consultants: Rate of Return	Consultants: Rate Case	Consultants: Lead Lag Study	Publish Legal Notices	Transport/ Lodging/Meals	Misc.	Total
APACR07281	14-Apr-25	28-Apr-25	Guidant Group | Contractor Staffing	32.00	$ 135.03						4,320.95					4,320.95
APACR07733	15-Apr-25	29-Apr-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR09185	20-Apr-25	2-May-25	Guidant Group | Contractor Staffing	16.00	$ 54.31						868.96					868.96
APACR09185	21-Apr-25	5-May-25	Guidant Group | Contractor Staffing	0.50	$ 139.65							69.83				69.83
APACR09185	21-Apr-25	5-May-25	Guidant Group | Contractor Staffing	32.00	$ 135.03						4,320.96					4,320.96
APACR11387	28-Apr-25	12-May-25	Guidant Group | Contractor Staffing	20.00	$ 54.31						1,086.20					1,086.20
APACR11387	28-Apr-25	12-May-25	Guidant Group | Contractor Staffing	40.00	$ 135.03						5,401.20					5,401.20
MISPRJ3950	28-Jan-25	6-Mar-25	Concentric Energy Advisors | Rate of Return	9.75	$ 675.00					6,581.25						6,581.25
MISPRJ3950	21-Feb-25	26-Mar-25	Concentric Energy Advisors | Lead Lag Study	6.75	$ 790.00							5,332.50				5,332.50
MISPRJ3950	21-Feb-25	26-Mar-25	Concentric Energy Advisors | Lead Lag Study	6.75	$ 575.00							3,881.25				3,881.25
MISPRJ3950	4-Mar-25	19-Mar-25	Concentric Energy Advisors | Rate of Return	14.50	$ 695.00					10,077.50						10,077.50
MISPRJ3950	4-Mar-25	19-Mar-25	Concentric Energy Advisors | Rate of Return	n/a	n/a					3,500.00						3,500.00
MISPRJ3950	24-Mar-25	8-Apr-25	Concentric Energy Advisors | Lead Lag Study	0.75	$ 790.00							592.50				592.50
MISPRJ3950	24-Mar-25	8-Apr-25	Concentric Energy Advisors | Lead Lag Study	12.00	$ 575.00							6,900.00				6,900.00
Total April 2025						0.00	0.00	0.00	0.00	23,981.25	25,732.32	17,544.17	0.00	0.00	0.00	67,257.74
Total Actual Costs to Date						0.00	0.00	0.00	20,270.00	37,558.75	115,581.23	28,879.60	0.00	0.00	0.00	202,289.58
May 2025																
APACR14408	22-Apr-25	23-May-25	Taft Stettinius & Hollister LLP | Professional Legal Services	[redacted]	[redacted]			[redacted]								[redacted]
APACR14408	5-May-25	19-May-25	Guidant Group | Contractor Staffing	0.50	$ 139.65							69.83				69.83
APACR14408	5-May-25	19-May-25	Guidant Group | Contractor Staffing	40.00	$ 135.03						5,401.20					5,401.20
APACR15187	6-May-25	20-May-25	Guidant Group | Contractor Staffing	8.00	$ 54.31						434.48					434.48
APACR15399	24-Mar-25	8-May-25	Gannett Fleming | Depreciation Consultants	17.00	$ 205.00				3,485.00							3,485.00
APACR15399	24-Mar-25	8-May-25	Gannett Fleming | Depreciation Consultants	8.50	$ 240.00				2,040.00							2,040.00
APACR15399	24-Mar-25	8-May-25	Gannett Fleming | Depreciation Consultants	8.00	$ 340.00				2,720.00							2,720.00
APACR15399	24-Mar-25	8-May-25	Gannett Fleming | Depreciation Consultants	6.00	$ 140.00				840.00							840.00
APACR15399	24-Mar-25	8-May-25	Gannett Fleming | Depreciation Consultants	2.00	$ 150.00				300.00							300.00
APACR15399	30-Apr-25	23-May-25	Gannett Fleming | Depreciation Consultants	13.00	$ 205.00				2,665.00							2,665.00

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01032234
Invoice Date: 08/05/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	18	$135.03	CONT_REG	$2,430.55
[redacted]					

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01038778
Invoice Date: 08/19/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	18	$135.03	CONT_REG	$2,430.55
[redacted]					

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01043978
Invoice Date: 08/28/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	18	$135.03	CONT_REG	$2,430.55
[redacted]					

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01044564
Invoice Date: 09/03/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	32	$135.03	CONT_REG	$4,320.95
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01047419
Invoice Date: 09/09/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	12.8	$135.03	CONT_REG	$1,728.38
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,160.48

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01050583
Invoice Date: 09/16/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$135.03	CONT_REG	$2,160.48
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $4,320.96

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01054306
Invoice Date: 09/24/2024

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	0.25	$139.65	CONT_REG	$34.91
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $593.51

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01054261
Invoice Date: 09/24/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$135.03	CONT_REG	$2,160.45
[redacted]					

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01057936
Invoice Date: 10/01/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.75	$139.65	CONT_REG	$104.74
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,675.80

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01069363
Invoice Date: 10/30/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.51	$139.65	CONT_REG	$71.22
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $139.65

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01079199
Invoice Date: 11/19/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.25	$139.65	CONT_REG	$34.91
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $174.56

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01083327
Invoice Date: 11/26/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	1.63	$139.65	CONT_REG	$227.63
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $349.13

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01071897
Invoice Date: 11/04/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$135.03	CONT_REG	$2,160.50
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01074029
Invoice Date: 11/05/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	2.75	$139.65	CONT_REG	$384.04
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $768.08

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01076768
Invoice Date: 11/12/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	3.63	$139.65	CONT_REG	$506.93
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $558.60

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01076685
Invoice Date: 11/12/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	8	$135.03	CONT_REG	$1,080.25
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01079199
Invoice Date: 11/19/2024

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	0.51	$139.65	CONT_REG	$71.22
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $174.56

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01079483
Invoice Date: 11/19/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	8	$135.03	CONT_REG	$1,080.25
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01081386
Invoice Date: 11/25/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	12	$135.03	CONT_REG	$1,620.35
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01083327
Invoice Date: 11/26/2024

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	0.38	$139.65	CONT_REG	$53.07
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $349.13

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01085899
Invoice Date: 12/03/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01085224
Invoice Date: 12/03/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	7.2	$135.03	CONT_REG	$972.21
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $3,240.72

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01086255
Invoice Date: 12/04/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.26	$139.65	CONT_REG	$36.31
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $69.83

GANNETT FLEMING

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160, Philadelphia, PA 19182-9160 Federal EIN: [redacted]
ACH/EFT Payment Information:
Account Name: Gannett Fleming Companies ABA [redacted]
Account No. [redacted]
Send Remit Info: [redacted]@gfnet.com
Send Audit Inquiries [redacted]@gfnet.com
All Other Inquires Contact the Project Team

Attention: [redacted]
Duke Energy Kentucky LLC
139 East Fourth Street/ 1303-Main
Cincinnati, OH 45202
UNITED STATES

Invoice : 0000044573
Invoice Date : 12/4/2024
Due Date: 1/3/2025
Project : 082369
Project Name : Duke Energy Kentucky-Gas 2025 Rate Case
Bill Term : 01

For Professional Services Rendered Through 11/29/2024

Duke Energy Kentucky - 2025 Gas Rate Case Filing - Case No. 2025-XXXXX

	Current Billings
000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing	3,395.00
Total :	3,395.00

Current Billings		3,395.00
Amount Due This Bill	**US**	3,395.00

[redacted]

Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **Invoice : 0000044573**

000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing

Rate Labor

Class	*Hours*	*Rate*	*Amount*
Associate Analyst	8.50	190.000	1,615.00
Asst. Project Manager - Depreciation	1.00	230.000	230.00
[redacted]	4.00	320.000	1,280.00
Senior Technician	1.00	130.000	130.00
Support Staff	1.00	140.000	140.00
Total Rate Labor	15.50		***3,395.00***

Total Bill Task : 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing **3,395.00**

Total Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **3,395.00**

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01086658
Invoice Date: 12/09/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01087130
Invoice Date: 12/09/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	12	$135.03	CONT_REG	$1,620.35
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01089683
Invoice Date: 12/16/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	18	$54.31	CONT_REG	$977.58
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,955.16

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01089972
Invoice Date: 12/16/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	5.5	$139.65	CONT_REG	$768.08

Sales Tax: $0.00
Misc: $0.00
Total: $768.08

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01089760
Invoice Date: 12/16/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	12	$135.03	CONT_REG	$1,620.35
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01092620
Invoice Date: 12/23/2024

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	16	$54.31	CONT_REG	$868.96

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01093132
Invoice Date: 12/23/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	2	$139.65	CONT_REG	$279.30

Sales Tax: $0.00
Misc: $0.00
Total: $279.30

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01093186
Invoice Date: 12/23/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$135.03	CONT_REG	$2,700.60
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01095370
Invoice Date: 12/30/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$54.31	CONT_REG	$868.96

Sales Tax: $0.00
Misc: $0.00
Total: $868.96

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01096879
Invoice Date: 12/31/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	2	$139.65	CONT_REG	$279.30

Sales Tax: $0.00
Misc: $0.00
Total: $279.30

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01096732
Invoice Date: 12/31/2024

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	24	$135.03	CONT_REG	$3,240.72

Sales Tax: $0.00
Misc: $0.00
Total: $3,240.72

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01097913
Invoice Date: 01/03/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	32	$54.31	CONT_REG	$1,737.92

Sales Tax: $0.00
Misc: $0.00
Total: $1,737.92

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01098477
Invoice Date: 01/06/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	5.5	$139.65	CONT_REG	$768.08

Sales Tax: $0.00
Misc: $0.00
Total: $768.08

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01099636
Invoice Date: 01/07/2025

	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	32	$135.03	CONT_REG	$4,320.96

Sales Tax: $0.00
Misc: $0.00
Total: $4,320.96

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01101302
Invoice Date: 01/13/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	6	$139.65	CONT_REG	$837.90

Sales Tax:	$0.00
Misc:	$0.00
Total:	$837.90

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01102754
Invoice Date: 01/14/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01102338
Invoice Date: 01/14/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	10	$135.03	CONT_REG	$1,350.30
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01103538
Invoice Date: 01/20/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	2.5	$139.65	CONT_REG	$349.13

Sales Tax: $0.00
Misc: $0.00
Total: $349.13

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01104805
Invoice Date: 01/21/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01106472
Invoice Date: 01/27/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$54.31	CONT_REG	$868.96
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,737.92

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01106758
Invoice Date: 01/27/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	2	$139.65	CONT_REG	$279.30

Sales Tax: $0.00
Misc: $0.00
Total: $279.30

GANNETT FLEMING

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160, Philadelphia, PA 19182-9160 Federal EIN: [redacted]
ACH/EFT Payment Information:
Account Name: Gannett Fleming Companies ABA: [redacted]
Account No.: [redacted]
Send Remit Info: [redacted]@gfnet.com
Send Audit Inquiries: [redacted]@gfnet.com
All Other Inquires Contact the Project Team

Attention: [redacted]
Duke Energy Kentucky LLC
139 East Fourth Street/ 1303-Main
Cincinnati, OH 45202
UNITED STATES

Invoice : 0000045372
Invoice Date : 12/20/2024
Due Date: 1/19/2025
Project : 082369
Project Name : Duke Energy Kentucky-Gas 2025 Rate Case
Bill Term : 01

For Professional Services Rendered For 11/30/2024 Through 12/13/2024

Duke Energy Kentucky - 2025 Gas Rate Case Filing - Case No. 2025-XXXXX

	Current Billings
000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing	655.00
Total :	655.00

Current Billings		655.00
Amount Due This Bill	**US**	655.00

[redacted]

Outstanding Receivables	Invoice Number	Date	Amount	Balance Due
	0000044573	12/4/2024	3,395.00	3,395.00
				3,395.00

Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **Invoice : 0000045372**

000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing
Rate Labor

Class	*Hours*	*Rate*	*Amount*
Associate Analyst	1.50	190.000	285.00
[redacted]	0.50	320.000	160.00
Support Staff	1.50	140.000	210.00
Total Rate Labor	3.50		***655.00***
Total Bill Task : 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing			**655.00**

Total Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **655.00**

GANNETT FLEMING

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160, Philadelphia, PA 19182-9160 Federal EIN: [redacted]
ACH/EFT Payment Information:
Account Name: Gannett Fleming Companies ABA [redacted]
Account No. [redacted]
Send Remit Info: [redacted]@gfnet.com
Send Audit Inquiries [redacted]@gfnet.com
All Other Inquires Contact the Project Team

Attention: [redacted]
Duke Energy Kentucky LLC
139 East Fourth Street/ 1303-Main
Cincinnati, OH 45202
UNITED STATES

Invoice : 0000046617
Invoice Date : 1/20/2025
Due Date: 2/19/2025
Project : 082369
Project Name : Duke Energy Kentucky-Gas 2025 Rate Case
Bill Term : 01

For Professional Services Rendered For 12/14/2024 Through 1/10/2025

Duke Energy Kentucky - 2025 Gas Rate Case Filing - Case No. 2025-XXXXX

	Current Billings
000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing	4,630.00
Total :	4,630.00

Current Billings		4,630.00
Amount Due This Bill	**US**	4,630.00

[redacted]

Outstanding Receivables	Invoice Number	Date	Amount	Balance Due
	0000045372	12/20/2024	655.00	655.00
				655.00

Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **Invoice : 0000046617**

000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing

Rate Labor

Class	*Hours*	*Rate*	*Amount*
Associate Analyst	14.50	190.000	2,755.00
Asst. Project Manager - Depreciation	3.50	230.000	805.00
[redacted]	1.50	320.000	480.00
Senior Technician	4.00	130.000	520.00
Support Staff	0.50	140.000	70.00
Total Rate Labor	24.00		***4,630.00***

Total Bill Task : 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing **4,630.00**

Total Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **4,630.00**

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01109292
Invoice Date: 01/30/2025

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	16.5	$54.31	CONT_REG	$896.12

Sales Tax: $0.00
Misc: $0.00
Total: $1,792.23

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01109464
Invoice Date: 02/03/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.5	$139.65	CONT_REG	$69.83

Sales Tax:	$0.00
Misc:	$0.00
Total:	$69.83

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01109558
Invoice Date: 02/03/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01114701
Invoice Date: 02/11/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01113764
Invoice Date: 02/11/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	11.5	$139.65	CONT_REG	$1,605.98

Sales Tax:	$0.00
Misc:	$0.00
Total:	$1,605.98

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01113559
Invoice Date: 02/11/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01115191
Invoice Date: 02/17/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01116442
Invoice Date: 02/17/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16.5	$139.65	CONT_REG	$2,304.23

Sales Tax: $0.00
Misc: $0.00
Total: $2,304.23

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01115433
Invoice Date: 02/17/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	12	$135.03	CONT_REG	$1,620.35
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01118396
Invoice Date: 02/24/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	8.75	$139.65	CONT_REG	$1,221.94

Sales Tax: $0.00
Misc: $0.00
Total: $1,221.94

GANNETT FLEMING

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160, Philadelphia, PA 19182-9160 Federal EIN: [redacted]
ACH/EFT Payment Information:
Account Name: Gannett Fleming Companies ABA [redacted]
Account No. [redacted]
Send Remit Info: [redacted]@gfnet.com
Send Audit Inquiries: [redacted]@gfnet.com
All Other Inquires Contact the Project Team

Attention: [redacted]
Duke Energy Kentucky LLC
139 East Fourth Street/ 1303-Main
Cincinnati, OH 45202
UNITED STATES

Invoice : 0000048023
Invoice Date : 2/19/2025
Due Date: 3/21/2025
Project : 082369
Project Name : Duke Energy Kentucky-Gas 2025 Rate Case
Bill Term : 01

For Professional Services Rendered For 1/11/2025 Through 2/7/2025

Duke Energy Kentucky - 2025 Gas Rate Case Filing - Case No. 2025-XXXXX

	Current Billings
000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing	11,590.00
Total :	11,590.00

Current Billings		11,590.00
Amount Due This Bill	**US**	11,590.00

[redacted]

Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **Invoice : 0000048023**

000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing

Rate Labor

Class	*Hours*	*Rate*	*Amount*
Associate Analyst	6.00	205.000	1,230.00
Asst. Project Manager - Depreciation	15.50	240.000	3,720.00
[redacted]	17.00	340.000	5,780.00
Senior Technician	4.00	140.000	560.00
Support Staff	2.00	150.000	300.00
Total Rate Labor	44.50		***11,590.00***

Total Bill Task : 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing **11,590.00**

Total Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **11,590.00**

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01133031
Invoice Date: 03/26/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01133240
Invoice Date: 03/31/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	18	$54.31	CONT_REG	$977.58
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,955.16

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01121818
Invoice Date: 03/03/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	1	$139.65	CONT_REG	$139.65

Sales Tax: $0.00
Misc: $0.00
Total: $139.65

Invoice

CONCENTRIC ENERGY ADVISORS

March 04, 2025
Engagement No: 100718.00
Invoice No: 0019505

[redacted]
Duke Energy Business Services LLC
526 South Church St
Charlotte, NC 28202

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Professional Services from January 01, 2025 to January 31, 2025

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President		14.50	695.00	10,077.50	
	Totals	14.50		10,077.50	
	Total Labor				**10,077.50**
ROE Model Analytical Support				3,500.00	
				3,500.00	**3,500.00**
			Total this Phase		**$13,577.50**
			Total this Invoice		**$13,577.50**

Billings to Date

	Current	Prior	Total
Labor	13,577.50	6,581.25	20,158.75
Totals	**13,577.50**	**6,581.25**	**20,158.75**

For billing inquiries or to request electronic payment instructions,
please contact us at [redacted]**@ceadvisors.com**

Taxpayer ID: [redacted]

Please note: we have no intention of changing our bank details, and any request to do so should be treated as suspicious.

Engagement 100718.00 2024-Duke Kentucky Gas ROE Invoice 0019505

Billing Backup

Tuesday, March 4, 2025

Concentric Energy Advisors, Inc. Invoice 0019505 Dated 3/4/2025 1:24:02 PM

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President					
[redacted]	1/2/2025	2.00	695.00	1,390.00	
Updates to ROE analysis					
[redacted]	1/6/2025	1.75	695.00	1,216.25	
Proxy group research					
[redacted]	1/9/2025	2.00	695.00	1,390.00	
Review research documents on subject company risks					
[redacted]	1/16/2025	3.50	695.00	2,432.50	
Edits to testimony					
[redacted]	1/22/2025	2.50	695.00	1,737.50	
Updates to ROE analysis					
[redacted]	1/28/2025	.75	695.00	521.25	
Prepare summary of updated analysis					
[redacted]	1/30/2025	2.00	695.00	1,390.00	
Edits to testimony					
Totals		14.50		10,077.50	
Total Labor					**10,077.50**
ROE Model Analytical Support				3,500.00	
				3,500.00	**3,500.00**
			Total this Phase		**$13,577.50**
			Total this Engagement		**$13,577.50**
			Total this Report		**$13,577.50**

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01124687
Invoice Date: 03/10/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	1.5	$139.65	CONT_REG	$209.48

Sales Tax:	$0.00
Misc:	$0.00
Total:	$209.48

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01124356
Invoice Date: 03/10/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01126970
Invoice Date: 03/13/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$54.31	CONT_REG	$868.96
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,737.92

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01126971
Invoice Date: 03/13/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01127244
Invoice Date: 03/17/2025

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	20	$54.31	CONT_REG	$1,086.20

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01127468
Invoice Date: 03/17/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.25	$139.65	CONT_REG	$34.91

Sales Tax:	$0.00
Misc:	$0.00
Total:	$34.91

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01127469
Invoice Date: 03/17/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

Shape the future with confidence

200 Plaza Drive
Secaucus NJ 07094
USA

Invoice

Duke Energy Corporation
[redacted]
525 South Tryon Street
Charlotte NC 28202
USA

Invoice No.: US01U001784800
Please reference this number on remittance.

Invoice Date:	March 12, 2025
Due Date:	May 11, 2025
Client No.:	0011415661
Engagement No.:	E-68938033
PO Ref No:	12291777

Remit To:
Ernst & Young US LLP
P.O. Box [redacted]
Pittsburgh, PA 15264-0382
EIN: [redacted]

Fees related to work performed for the Duke Energy's Customer Advocacy Regulatory Engagement & Support ("CARES") organization related to project management, communications, and stakeholder engagement to assist with the rate cases in February 2025.

	USD Amount
Fee	50,272.73
Professional Services	**50,272.73**

Total Fees & Expenses	Amount	Tax Amount	Total Amount
Taxable			
Total Exempt	50,272.73		50,272.73
Total Invoice amount	**50,272.73**	**0.00**	**50,272.73**

International Wire Transfer:
[redacted] Bank, NA
Bank Swift code: [redacted]
Account name: Ernst & Young U.S. LLP
Account number: [redacted]

Domestic Wire and ACH Transfer: (US based banks)
[redacted] Bank, NA
Bank ABA#: [redacted]
Account name: Ernst & Young U.S. LLP
Account number: [redacted]

To ensure proper application of your electronic payment,
please provide client and invoice number details directly to:
[redacted].ey.com or fax to [redacted]

INVOICE

Remit To
Corporate Employment Resources, Inc.
400 South Tryon Street Building - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01130173
Invoice Date: 03/24/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01130494
Invoice Date: 03/24/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	4.75	$139.65	CONT_REG	$663.34

Sales Tax: $0.00
Misc: $0.00
Total: $663.34

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01130460
Invoice Date: 03/24/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	24	$135.03	CONT_REG	$3,240.70
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01133509
Invoice Date: 03/31/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.5	$139.65	CONT_REG	$69.83

Sales Tax: $0.00
Misc: $0.00
Total: $69.83

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01133508
Invoice Date: 03/31/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	24	$135.03	CONT_REG	$3,240.70
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

Invoice

CONCENTRIC ENERGY ADVISORS

April 01, 2025
Engagement No: 100718.00
Invoice No: 0019644

[redacted]
Duke Energy Business Services LLC
526 South Church St
Charlotte, NC 28202

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Professional Services from February 01, 2025 to February 28, 2025

Phase 01 Up to filing

Professional Personnel

	Hours	Rate	Amount	
Vice President	5.50	695.00	3,822.50	
Totals	5.50		3,822.50	
Total Labor				**3,822.50**
			Total this Phase	**$3,822.50**
			Total this Invoice	**$3,822.50**

Outstanding Invoices

Number	Date	Balance
0019505	3/4/2025	-13,577.50
Total		**-13,577.50**

Billings to Date

	Current	Prior	Total
Labor	3,822.50	20,158.75	23,981.25
Totals	**3,822.50**	**20,158.75**	**23,981.25**

For billing inquiries or to request electronic payment instructions,
please contact us at **accounting@ceadvisors.com**

Taxpayer ID: [redacted]

Please note: we have no intention of changing our bank details, and any request to do so should be treated as suspicious.

Engagement	100718.00	2024-Duke Kentucky Gas ROE	Invoice	0019644

Billing Backup

Tuesday, April 1, 2025

Concentric Energy Advisors, Inc. Invoice 0019644 Dated 4/1/2025 9:09:58 AM

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President					
[redacted]	2/20/2025	1.00	695.00	695.00	
Updates to ROE analysis					
[redacted]	2/21/2025	2.50	695.00	1,737.50	
Updates to ROE analysis; edits to testimony					
[redacted]	2/28/2025	2.00	695.00	1,390.00	
Review updates to capital market conditions					
Totals		5.50		3,822.50	
Total Labor					**3,822.50**

Total this Phase	**$3,822.50**
Total this Engagement	**$3,822.50**
Total this Report	**$3,822.50**

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01136322
Invoice Date: 04/07/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	32	$135.03	CONT_REG	$4,320.95
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01137701
Invoice Date: 04/07/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01137741
Invoice Date: 04/08/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.5	$139.65	CONT_REG	$69.83

Sales Tax:	$0.00
Misc:	$0.00
Total:	$69.83

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01140125
Invoice Date: 04/14/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	4.5	$139.65	CONT_REG	$628.43

Sales Tax: $0.00
Misc: $0.00
Total: $628.43

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01139975
Invoice Date: 04/14/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	32	$135.03	CONT_REG	$4,320.95
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01141648
Invoice Date: 04/15/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01142137
Invoice Date: 04/20/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	16	$54.31	CONT_REG	$868.96
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,737.92

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01142300
Invoice Date: 04/21/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.5	$139.65	CONT_REG	$69.83

Sales Tax: $0.00
Misc: $0.00
Total: $69.83

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01142635
Invoice Date: 04/21/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	32	$135.03	CONT_REG	$4,320.96

Sales Tax: $0.00
Misc: $0.00
Total: $4,320.96

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01145170
Invoice Date: 04/28/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01146407
Invoice Date: 04/28/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

Invoice

CONCENTRIC ENERGY ADVISORS

January 28, 2025
Engagement No: 100718.00
Invoice No: 0019365

[redacted]
Duke Energy Business Services LLC
526 South Church St
Charlotte, NC 28202

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Professional Services from December 01, 2024 to December 31, 2024

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President		9.75	675.00	6,581.25	
	Totals	9.75		6,581.25	
	Total Labor				**6,581.25**
			Total this Phase		**$6,581.25**
			Total this Invoice		**$6,581.25**

Billings to Date

	Current	Prior	Total
Labor	6,581.25	0.00	6,581.25
Totals	**6,581.25**	**0.00**	**6,581.25**

For billing inquiries or to request electronic payment instructions,
please contact us at **accounting@ceadvisors.com**

Taxpayer ID: [redacted]

Please note: we have no intention of changing our bank details, and any request to do so should be treated as suspicious.

Engagement 100718.00 2024-Duke Kentucky Gas ROE Invoice 0019365

Billing Backup

Tuesday, January 28, 2025

Concentric Energy Advisors, Inc. Invoice 0019365 Dated 1/28/2025 9:40:13 AM

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President					
[redacted]	12/2/2024	1.50	675.00	1,012.50	
Testimony development					
[redacted]	12/6/2024	1.00	675.00	675.00	
Preliminary analysis					
[redacted]	12/19/2024	1.50	675.00	1,012.50	
Review recent rate decisions					
[redacted]	12/20/2024	2.00	675.00	1,350.00	
Testimony development					
[redacted]	12/23/2024	1.50	675.00	1,012.50	
Preliminary research and analysis					
[redacted]	12/30/2024	2.25	675.00	1,518.75	
Testimony development					
Totals		9.75		6,581.25	
Total Labor					**6,581.25**
			Total this Phase		**$6,581.25**
			Total this Engagement		**$6,581.25**
			Total this Report		**$6,581.25**

Invoice

CONCENTRIC ENERGY ADVISORS

February 21, 2025
Engagement No: 100720.00
Invoice No: 0019446

[redacted]
Duke Energy Business Services LLC
526 South Church St
Charlotte, NC 28202

Engagement 100720.00 2024-Confidential-Lead Lag Study

Professional Services from January 01, 2025 to January 31, 2025

Phase 01 Lead-Lag Study Prefiled Direct Testimony

Professional Personnel

	Hours	Rate	Amount	
President	6.75	790.00	5,332.50	
Assistant VP	6.75	575.00	3,881.25	
Totals	13.50		9,213.75	
Total Labor				**9,213.75**
			Total this Phase	**$9,213.75**
			Total this Invoice	**$9,213.75**

Outstanding Invoices

Number	Date	Balance
0019336	1/23/2025	3,071.25
Total		**3,071.25**

Billings to Date

	Current	Prior	Total
Labor	9,213.75	3,071.25	12,285.00
Totals	**9,213.75**	**3,071.25**	**12,285.00**

For billing inquiries or to request electronic payment instructions,
please contact us at [redacted]**@ceadvisors.com**

Taxpayer ID: [redacted]

Please note: we have no intention of changing our bank details, and any request to do so should be treated as suspicious.

Engagement	100720.00	2024-Confidential-Lead Lag Study	Invoice	0019446

Billing Backup

Thursday, February 20, 2025

Concentric Energy Advisors, Inc. | Invoice 0019446 Dated 2/21/2025 | 9:13:32 PM

Engagement 100720.00 2024-Confidential-Lead Lag Study

Phase 01 Lead-Lag Study Prefiled Direct Testimony

Professional Personnel

		Hours	Rate	Amount	
President					
[redacted]	1/3/2025	1.00	790.00	790.00	
Project planning					
[redacted]	1/7/2025	1.50	790.00	1,185.00	
Develop draft testimony					
[redacted]	1/8/2025	1.50	790.00	1,185.00	
Develop draft testimony					
[redacted]	1/24/2025	1.75	790.00	1,382.50	
Review client data; draft testimony					
[redacted]	1/28/2025	1.00	790.00	790.00	
Review documents; call with Duke team					
Assistant VP					
[redacted]	1/17/2025	2.25	575.00	1,293.75	
Download and review new data from Company; coordinate check in to review					
[redacted]	1/27/2025	3.00	575.00	1,725.00	
Review data received to-date from DEK, begin revenue lag modeling					
[redacted]	1/28/2025	1.50	575.00	862.50	
Prep for data review meeting, conduct meeting, follow up items including sending Dane interest expense testimony					
	Totals	13.50		9,213.75	
	Total Labor				**9,213.75**
			Total this Phase		**$9,213.75**
			Total this Engagement		**$9,213.75**
			Total this Report		**$9,213.75**

Invoice

CONCENTRIC ENERGY ADVISORS

March 04, 2025
Engagement No: 100718.00
Invoice No: 0019505

[redacted]
Duke Energy Business Services LLC
526 South Church St
Charlotte, NC 28202

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Professional Services from January 01, 2025 to January 31, 2025

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President		14.50	695.00	10,077.50	
	Totals	14.50		10,077.50	
	Total Labor				**10,077.50**
ROE Model Analytical Support				3,500.00	
				3,500.00	**3,500.00**
			Total this Phase		**$13,577.50**
			Total this Invoice		**$13,577.50**

Billings to Date

	Current	Prior	Total
Labor	13,577.50	6,581.25	20,158.75
Totals	**13,577.50**	**6,581.25**	**20,158.75**

For billing inquiries or to request electronic payment instructions,
please contact us at [redacted]**@ceadvisors.com**

Taxpayer ID: [redacted]

Please note: we have no intention of changing our bank details, and any request to do so should be treated as suspicious.

Engagement 100718.00 2024-Duke Kentucky Gas ROE Invoice 0019505

Billing Backup

Tuesday, March 4, 2025

Concentric Energy Advisors, Inc. Invoice 0019505 Dated 3/4/2025 1:24:02 PM

Engagement 100718.00 2024-Duke Kentucky Gas ROE

Phase 01 Up to filing

Professional Personnel

		Hours	Rate	Amount	
Vice President					
[redacted]	1/2/2025	2.00	695.00	1,390.00	
Updates to ROE analysis					
[redacted]	1/6/2025	1.75	695.00	1,216.25	
Proxy group research					
[redacted]	1/9/2025	2.00	695.00	1,390.00	
Review research documents on subject company risks					
[redacted]	1/16/2025	3.50	695.00	2,432.50	
Edits to testimony					
[redacted]	1/22/2025	2.50	695.00	1,737.50	
Updates to ROE analysis					
[redacted]	1/28/2025	.75	695.00	521.25	
Prepare summary of updated analysis					
[redacted]	1/30/2025	2.00	695.00	1,390.00	
Edits to testimony					
Totals		14.50		10,077.50	
Total Labor					**10,077.50**
ROE Model Analytical Support				3,500.00	
				3,500.00	**3,500.00**
			Total this Phase		**$13,577.50**
			Total this Engagement		**$13,577.50**
			Total this Report		**$13,577.50**

Invoice

CONCENTRIC ENERGY ADVISORS

March 24, 2025
Engagement No: 100720.00
Invoice No: 0019579

[redacted]
Duke Energy Business Services LLC
526 South Church St
Charlotte, NC 28202

Engagement 100720.00 2024-Confidential-Lead Lag Study

Professional Services from February 01, 2025 to February 28, 2025

Phase 01 Lead-Lag Study Prefiled Direct Testimony

Professional Personnel

	Hours	Rate	Amount
President	.75	790.00	592.50
Assistant VP	12.00	575.00	6,900.00
Totals	12.75		7,492.50
Total Labor			**7,492.50**

Total this Phase **$7,492.50**

Total this Invoice **$7,492.50**

Outstanding Invoices

Number	Date	Balance
0019336	1/23/2025	3,071.25
0019446	2/21/2025	9,213.75
Total		**12,285.00**

Billings to Date

	Current	Prior	Total
Labor	7,492.50	12,285.00	19,777.50
Totals	**7,492.50**	**12,285.00**	**19,777.50**

For billing inquiries or to request electronic payment instructions,
please contact us at **accounting@ceadvisors.com**

Taxpayer ID: [redacted]

Please note: we have no intention of changing our bank details, and any request to do so should be treated as suspicious.

Engagement 100720.00 2024-Confidential-Lead Lag Study Invoice 0019579

Billing Backup

Monday, March 24, 2025

Concentric Energy Advisors, Inc. Invoice 0019579 Dated 3/24/2025 9:52:24 AM

Engagement 100720.00 2024-Confidential-Lead Lag Study

Phase 01 Lead-Lag Study Prefiled Direct Testimony

Professional Personnel

		Hours	Rate	Amount	
President					
[redacted]	2/4/2025	.75	790.00	592.50	
Review O&M sample					
Assistant VP					
[redacted]	2/3/2025	1.00	575.00	575.00	
Download new data, communications with company, model fuel					
[redacted]	2/4/2025	3.00	575.00	1,725.00	
Develop initial sample, continue data reviews					
[redacted]	2/5/2025	2.50	575.00	1,437.50	
Other O&M sampling, data population analysis, discuss electric study with N. Souza, discuss other O&M analysis with [redacted], communications with DEK team					
[redacted]	2/6/2025	1.50	575.00	862.50	
Continue data analysis, exchange emails with DEK team about sampling					
[redacted]	2/7/2025	1.00	575.00	575.00	
Exchange emails with DEK team about sampling and customer deposits					
[redacted]	2/18/2025	.50	575.00	287.50	
Begin reviewing new data					
[redacted]	2/20/2025	1.00	575.00	575.00	
Lead-lag modeling					
[redacted]	2/26/2025	1.50	575.00	862.50	
Organize resources for invoice review, review new data					
Totals		12.75		7,492.50	
Total Labor					**7,492.50**

Total this Phase **$7,492.50**

Total this Engagement **$7,492.50**

Total this Report **$7,492.50**

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01148587
Invoice Date: 05/05/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.5	$139.65	CONT_REG	$69.83

Sales Tax: $0.00
Misc: $0.00
Total: $69.83

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01149029
Invoice Date: 05/05/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01150652
Invoice Date: 05/06/2025

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	8	$54.31	CONT_REG	$434.48
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

GANNETT FLEMING

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160, Philadelphia, PA 19182-9160 Federal EIN: [redacted]
ACH/EFT Payment Information:
Account Name: Gannett Fleming Companies ABA [redacted]
Account No. [redacted]
Send Remit Info: [redacted]@gfnet.com
Send Audit Inquiries [redacted]@gfnet.com
All Other Inquires Contact the Project Team

Attention: [redacted]
Duke Energy Kentucky LLC
139 East Fourth Street/ 1303-Main
Cincinnati, OH 45202
UNITED STATES

Invoice : 0000049356
Invoice Date : 3/24/2025
Due Date: 4/23/2025
Project : 082369
Project Name : Duke Energy Kentucky-Gas 2025 Rate Case
Bill Term : 01

For Professional Services Rendered For 2/8/2025 Through 3/7/2025

Duke Energy Kentucky - 2025 Gas Rate Case Filing - Case No. 2025-XXXXX

	Current Billings
000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing	9,385.00
Total :	9,385.00

Current Billings		9,385.00
Amount Due This Bill	**US**	9,385.00

[redacted]

Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **Invoice : 0000049356**

000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing
Rate Labor

Class	*Hours*	*Rate*	*Amount*
Associate Analyst	17.00	205.000	3,485.00
Asst. Project Manager - Depreciation	8.50	240.000	2,040.00
[redacted]	8.00	340.000	2,720.00
Senior Technician	6.00	140.000	840.00
Support Staff	2.00	150.000	300.00
Total Rate Labor	41.50		***9,385.00***

Total Bill Task : 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing **9,385.00**

Total Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **9,385.00**

GANNETT FLEMING

Check Payment Information:
Gannett Fleming Valuation and Rate Consultants, LLC
PO Box 829160, Philadelphia, PA 19182-9160 Federal EIN: [redacted]
ACH/EFT Payment Information:
Account Name: Gannett Fleming Companies ABA [redacted]
Account No.: [redacted]
Send Remit Info: [redacted]@gfnet.com
Send Audit Inquiries: [redacted]@gfnet.com
All Other Inquires Contact the Project Team

Attention: [redacted]
Duke Energy Kentucky LLC
139 East Fourth Street/ 1303-Main
Cincinnati, OH 45202
UNITED STATES

Invoice : 0000050800
Invoice Date : 4/30/2025
Due Date: 5/30/2025
Project : 082369
Project Name : Duke Energy Kentucky-Gas 2025 Rate Case
Bill Term : 01

For Professional Services Rendered For 3/8/2025 Through 4/11/2025

Duke Energy Kentucky - 2025 Gas Rate Case Filing - Case No. 2025-XXXXX

		Current Billings
000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing		11,441.49
	Total :	11,441.49

Current Billings		11,441.49
Amount Due This Bill	**US**	11,441.49

[redacted]

Outstanding Receivables	Invoice Number	Date	Amount	Balance Due
	0000049356	3/24/2025	9,385.00	9,385.00
				9,385.00

Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **Invoice : 0000050800**

000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing

Rate Labor

Class	*Hours*	*Rate*	*Amount*
Associate Analyst	13.00	205.000	2,665.00
Asst. Project Manager - Depreciation	4.50	240.000	1,080.00
[redacted]	9.50	340.000	3,230.00
Senior Technician	8.00	140.000	1,120.00
Support Staff	4.00	150.000	600.00
Total Rate Labor	39.00		***8,695.00***

Expenses

Account / Vendor	*Cost*	*Multiplier*	*Amount*
Lodging			
[redacted]	156.18	1.0000	156.18
[redacted]	156.18	1.0000	156.18
Meals and Meals Per Diem			
[redacted]	120.28	1.0000	120.28
[redacted]	18.93	1.0000	18.93
Other Transportation			
[redacted]	40.00	1.0000	40.00
Transportation - Airfare			
M & T BANK NA	2,176.72	1.0000	2,176.72
Transportation - Rental Car			
EAN SERVICES LLC	78.20	1.0000	78.20
Total Expenses			***2,746.49***

Total Bill Task : 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing **11,441.49**

Total Project : 082369 - Duke Energy Kentucky-Gas 2025 Rate Case **11,441.49**

Employee Expense Report

Backup

Employee: [redacted]

Expense Report: 421661 - Duke KY Gas Field Visit

Project: 082369 - Duke Energy Kentucky-Gas 2025 Rate Case

Backup For: 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing

Expense Report Dates: 2/4/2025 - 2/4/2025

Posting Date: 2/21/2025

Client: 36416616 - Duke Energy Kentucky LLC

Transaction Details

Sequence	Date	Category	Project	Task Hierarchy	Location	Receipt	Currency	Quantity	Amount
1	2/4/2025	Project- Lunch	082369	000	Camp Hill PA (West Building)	1	US		18.93
		Field review and management meeting re depreciation study, Erlanger, KY							
2	2/4/2025	Project- Lodging	082369	000	Camp Hill PA (West Building)	2	US		156.18
		Field review and management meeting re depreciation study, Erlanger, KY							
							Total		**175.11**

Audit Trail

Date / Time	User Name	Action	State	Comments
2/10/2025 2:37:44 PM	[redacted]	Submit	PendingFirstApproval	
2/11/2025 3:14:21 PM	[redacted]	Approve	PendingProcessing	
2/11/2025 3:14:22 PM	BSTServiceP	Process	Out	processor-invoked

Employee Expense Report
Backup

Employee: [redacted]
Expense Report: 423852 - February25expenses
Project: 082369 - Duke Energy Kentucky-Gas 2025 Rate Case
Backup For: 000 - Depreciation Consulting Services re 2025 Gas Rate Case Filing

Expense Report Dates: 1/31/2025 - 2/26/2025
Posting Date: 3/28/2025
Client: 36416616 - Duke Energy Kentucky LLC

Transaction Details

Sequence	Date	Category	Project	Task Hierarchy	Location	Receipt	Currency	Quantity	Amount
1	2/4/2025	Project- Other Food & Beverage	082369	000	Camp Hill PA (West Building)	1	US		1.50
		Field visit for Duke Energy Kentucky - Erlanger, KY							
2	2/4/2025	Project- Lunch	082369	000	Camp Hill PA (West Building)	2	US		17.91
		Field visit for Duke Energy Kentucky - Erlanger, KY							
2	2/5/2025	Project- Lunch	082369	000	Camp Hill PA (West Building)	5	US		56.68
		Field visit for Duke Energy Kentucky - Erlanger, KY - Lunch for [redacted])							
3	2/4/2025	Project- Dinner	082369	000	Camp Hill PA (West Building)	3	US		~~56.86~~ 44.19
		Field visit for Duke Energy Kentucky - Erlanger, KY - Dinner for [redacted]							
4	2/5/2025	Project- Rental Car Gas	082369	000	Camp Hill PA (West Building)	4	US		4.00
		Field visit for Duke Energy Kentucky - Erlanger, KY							
5	2/5/2025	Project- Parking	082369	000	Camp Hill PA (West Building)	6	US		36.00
		Field visit for Duke Energy Kentucky - Erlanger, KY							
6	2/5/2025	Project- Lodging	082369	000	Camp Hill PA (West Building)	7	US		156.18
		Field visit for Duke Energy Kentucky - Erlanger, KY							

Audit Trail

Date / Time	User Name	Action	State	Comments
3/11/2025 8:53:21 PM	[redacted]	Submit	PendingFirstApproval	
3/21/2025 4:03:42 PM	[redacted]	Approve	PendingProcessing	
3/21/2025 4:03:44 PM	BSTServiceP	Process	Out	processor-invoked

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01151324
Invoice Date: 05/12/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Zempleo, Inc.
Remote Contingent Worker - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01151411
Invoice Date: 05/12/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	0.75	$139.65	CONT_REG	$104.74

Sales Tax: $0.00
Misc: $0.00
Total: $104.74

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01152827
Invoice Date: 05/13/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01154290
Invoice Date: 05/19/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01156173
Invoice Date: 05/20/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	20	$54.31	CONT_REG	$1,086.20
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $2,172.40

INVOICE

Remit To
Corporate Employment Resources, Inc.
525 S Tryon St - Charlotte, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01157337
Invoice Date: 05/27/2025

#	Description	Qty	Unit Price	Units	Extended Price
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
1-3	Hours_Worked	10	$54.31	CONT_REG	$543.10
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Sales Tax: $0.00
Misc: $0.00
Total: $1,955.16

INVOICE

Remit To
Zempleo, Inc.
NC Regional Headquarters (Projects) - Raleigh, NC

Worker
[redacted]

Invoice Nbr: DUKEIN01157421
Invoice Date: 05/27/2025

#	Description	Qty	Unit Price	Units	Extended Price
1-2	Hours_Worked	40	$135.03	CONT_REG	$5,401.20

Sales Tax: $0.00
Misc: $0.00
Total: $5,401.20

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-012 CONFIDENTIAL ATTACHMENT 3

FILED UNDER SEAL

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-013

REQUEST:

Provide the following information with regard to uncollectible accounts for the three most recent calendar years for gas operations:

a. Reserve account balance at the beginning of the year;

b. Charges to the reserve account (accounts charged off);

c. Credits to reserve account;

d. Current year provision;

e. Reserve account balance at the end of the year; and

f. Percent of provision to total revenue.

RESPONSE:

Please see STAFF-DR-01-013 Attachment.

PERSON RESPONSIBLE: Linda L. Miller

DUKE ENERGY KENTUCKY, INC.
Reserve for Uncollectible Accounts - Account 144
Years 2022 through 2024

		2022	2023	2024
a.	Balance - Beginning of Year	$ -	$ -	$ -
b.	Charge Offs	$ -	$ -	$ 1,131,069
c.	Recoveries	$ -	$ -	$ (304,313)
d.	Provision	$ -	$ -	$ (1,374,006)
e.	Balance - End of Year	$ -	$ -	$ (547,250)
f.	Provision - Gas Operations	$ -	$ -	$ (1,374,006)
f.	Percent of Gas Revenue	0.000%	0.000%	-1.071%

Note:
(a) Prior to March 2024, all retail accounts receivable were sold to Cinergy Receivables LLC, therefore transferring the risk of collectability to the purchaser and eliminating the need for a reserve for uncollectible accounts on Duke Energy Kentucky.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-014

REQUEST:

Provide the amount of excess deferred federal income taxes resulting from the reductions in the corporate tax rate in 1986 and 2018, as of the end of the most recent calendar year. Show the amounts associated with each reduction separately.

RESPONSE:

As of 12/31/2024, the amount of excess deferred federal income taxes resulting from the reductions in the corporate tax rate in 1986 and 2018 are:

1986 Excess Deferred Income Tax (EDIT) - $0

2018 Excess Deferred Income Tax (EDIT) - $29,300,755

PERSON RESPONSIBLE: John R. Panizza

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-015

REQUEST:

Provide the following tax data for the most recent calendar year:

a. Income taxes:

(1) Federal operating income taxes deferred – accelerated tax depreciation.

(2) Federal operating income taxes deferred – other (explain).

(3) Federal income taxes – operating.

(4) Income credits resulting from prior deferrals of federal income taxes.

(5) Investment tax credit net.

(a) Investment credit realized.

(b) Investment credit amortized – Revenue Act of 1971.

(6) The information in Item 15a(1–4) for state income taxes.

(7) A reconciliation of book to federal taxable income as shown in Schedule D1 and a calculation of the book federal income tax expense for the base period using book taxable income as the starting point.

(8) A reconciliation of book to state taxable income as shown in Schedule D2 and a calculation of the book state income tax expense for the base period using book taxable income as the starting point.

b. An analysis of Kentucky Other Operating Taxes as shown in Schedule D3.

RESPONSE:

a. Please see STAFF-DR-01-015(a)(1-6) Attachment and STAFF-DR-01-015(a)(7-8) Attachment.

b. Please see STAFF-DR-01-015(b) Attachment.

PERSON RESPONSIBLE: John R. Panizza

Duke Energy Kentucky, Inc.
STAFF-DR-01-015(a)(1-6)
Federal and State Income Taxes
12 Months Ended December 31, 2024

		Amounts Reflect Operating Gas Taxes Only				
		15(a)(3) Current	15(a)(1)(2) Deferred	15(a)(6) Current	15(a)(6) Deferred	
Description		**Federal**	**Federal**	**Kentucky**	**State**	**Total**
Current Year Tax Provision		1,511,926	2,839,126	(31,610)	1,185,796	5,505,238
Provision to Tax Return True-Ups		6,298,496	(6,087,448)	1,356,599	(1,311,692)	255,955
Federal Excess Deferred Income Tax Amortization			(864,027)			(864,027)
State Excess Deferred Income Tax Amortization			48,505		(169,453)	(120,948)
Income Credits Resulting from Prior Deferrals	**15(a)(4)(6)**					-
Investment Tax Credit Amortization	**15(a)(5)(b)**					-
Total		**7,810,422**	**(4,063,844)**	**1,324,989**	**(295,349)**	**4,776,219**

Additional Information:

Investment Tax Credits Realized	**15(a)(5)(a)**	**NONE**

Note 1: Schedule M detail for items such as depreciation is shown in response DR-01-015(a)(7) - Tax Reconciliation

Duke Energy Kentucky, Inc.
STAFF-DR-01-015(a)(7)
Reconciliation of Book Net Income and Federal Taxable Income
12 Months Ended December 31, 2024

Line No.	Item (a)	Total Company (b)	Total Company Non-Operating (c)	Kentucky Retail (d)	Other Jurisdictional (e)
1	Net income per books	101,445,306	(29,028,186)	31,027,203	99,446,288
2	Add income taxes:	0			
3	Federal income tax - current	24,703,584	(2,240,816)	7,810,422	19,133,978
4	Federal income tax - deferred depreciation	0			
5	Federal income tax - deferred other	(5,492,816)	3,676,620	(4,063,844)	(5,105,592)
6	Investment tax credit adjustment	0	0	0	0
7	Federal income taxes charged to other income and deductions	0			
8	State income taxes	5,753,679	357,465	1,029,640	4,366,574
9	State income taxes charged to other income and deductions	0			
10	Total	126,409,753	(27,234,917)	35,803,422	117,841,248
11	Flow through items:	0			
12	Add (itemize)	0			
13	Deduct (itemize)	0		0	
14	Book taxable income	126,409,753	(27,234,917)	35,803,422	117,841,248
15	Differences between book taxable income and taxable income per tax return:				
16	Add (itemize)				
	State Income Tax Deduction	(2,523,690)	(620,105)	31,610	(1,935,195)
	Interest Reclass	0	38,897,701	(12,313,515)	(26,584,186)
	Bad Debts	2,773,466	0	615,996	2,157,470
	Book Depreciation	91,093,175	7,746,053	23,378,090	59,969,032
	Capitalized Hardware/Software	451,652	0	20,967	430,685
	Coal Ash Spend, Net of Capitalized Portion	3,489,960	0	0	3,489,960
	Contributions in Aid of Construction	968,917	0	262,493	706,424
	Deferred Revenue	880,114	0	0	880,114
	Demand Side Management Deferral	2,540,455	0	(507,836)	3,048,291
	Lobbying	360,000	360,000	0	0
	Loss on Reacquired Debt	79,507	0	27,120	52,387
	Meals & Entertainment	190,000	190,000	0	0
	Penalties	2,521	2,521	0	0
	Regulatory Asset - Carbon Management	199,996	0	0	199,996
	Regulatory Asset - Deferred Plant Costs	4,215,791	0	0	4,215,791
	Regulatory Asset - Non-AMI Meters	368,588	0	0	368,588
	Regulatory Liability - RSLI & Other Misc Dfd Costs	289,602	0	289,602	0
	Storm Cost Deferral	210,211	0	0	210,211
	Tax Interest Capitalized	3,523,700	0	1,441,372	2,082,328
	Transportation Benefits	24,000	24,000	0	0
	Deferred Costs - Customer Connect	124,047	0	124,047	0
	Non-Cash Overhead Basis Adjustment	490,294	0	(151,362)	641,656
	Capitalized 174 R&D	2,000,000	0	2,000,000	0
	Extra Facility Lighting	7,193	0	0	7,193
	Benefits Accruals	3,320,881	0	1,300,752	2,020,129
	Mark to Market	54,334	(412,426)	0	466,760
	Regulatory Asset - ESM Deferral	1,302,849	0	0	1,302,849
	Gas Supplier Refunds	76,398	0	76,398	0
	Lease Adjustments	0	0	56,267	(56,267)
	Regulatory Asset - Deferred Revenue	612,405	0	0	612,405
	Regulatory Liability - Outage Costs	2,025,745	0	0	2,025,745
	Total Additions	119,152,111	46,187,744	16,652,001	56,312,366
17	Deduct (itemize)				
	AFUDC Equity Income	(4,611,595)	(4,611,595)	0	0
	AFUDC Interest	(2,480,607)	(2,480,607)	0	0
	Asset Retirement Obligation	(100,250)	0	(96,353)	(3,897)

Duke Energy Kentucky, Inc.
STAFF-DR-01-015(a)(7)
Reconciliation of Book Net Income and Federal Taxable Income
12 Months Ended December 31, 2024

Line No.	Item (a)	Total Company (b)	Total Company Non-Operating (c)	Kentucky Retail (d)	Other Jurisdictional (e)
	Cost of Removal	(15,295,563)	0	(5,014,496)	(10,281,067)
	Environmental Reserve	(6,952)	0	0	(6,952)
	Equipment/T&D Repairs	(56,796,503)	0	(11,055,906)	(45,740,597)
	Regulatory Asset/Liability - Rate Case Expenses	(101,502)	0	12,805	(114,307)
	Regulatory Asset - Transition from MISO to PJM	(218,194)	0	0	(218,194)
	Tax Depreciation/Amortization	(86,100,000)	0	(30,600,000)	(55,500,000)
	Tax Gains/Losses	(4,250,000)	0	(1,150,000)	(3,100,000)
	Property Tax Reserves	(7,094,148)	0	(1,249,882)	(5,844,266)
	Rate Refunds	(5,730)	0	(5,730)	0
	Regulatory Asset - FAS 158	(3,098,864)	0	(334,429)	(2,764,435)
	Charitable Contribution Carryover	(63,337)	0	(18,285)	(45,052)
	Regulatory Liability - Overcollection of Revenue Refund Adj	(1,505,572)	0	(1,505,572)	0
	Emissions Allowance Expense	(737)	0	0	(737)
	Regulatory Asset - Vacation Carryover	(57,345)	0	(35,698)	(21,647)
	Unbilled Revenue - Fuel	(1,976,841)	0	(1,976,841)	0
	Severance Reserve - LT	(627,867)	0	0	(627,867)
	Workers Com Reserve	(106,131)	0	(29,642)	(76,489)
	Total Deductions	(184,497,738)	(7,092,202)	(53,060,029)	(124,345,507)
18	Taxable income per return	61,064,126	11,860,625	(604,606)	49,808,107

Computation of Tax:				
Provision for Federal Income Tax at 21%	12,823,466	2,490,731	(126,967)	10,459,702
True Up Entries	240,669	(4,731,547)	6,025,868	(1,053,652)
Net Operating Loss	(42,461)	-	(12,258)	(30,203)
Corporate Alternative Minimum Tax	12,910,000	-	2,194,700	10,715,300
Other Adjustments	(1,228,090)	-	(270,921)	(957,169)
Total Federal Income Tax Provision	24,703,584	(2,240,816)	7,810,422	19,133,978

Note: (1) Provide a calculation of the amount shown on Lines 3 through 7 above.
(2) Provide a workpaper supporting each calculation including the depreciation for straight-line tax and accelerated tax depreciation.
(3) Provide a schedule setting forth the basis of allocation of each item of revenue or cost allocated above.

Duke Energy Kentucky, Inc.
STAFF-DR-01-015(a)(8)
Reconciliation of Book Net Income and State Taxable Income
12 Months Ended December 31, 2024

Line No.	Item	Total Company	Total Company Non-Operating	Kentucky Retail	Other Jurisdictional
	(a)	(b)	(c)	(d)	(e)
1	Net income per books	101,445,306	(29,028,186)	31,027,203	99,446,288
2	Add income taxes:	0			
3	Federal income tax - current	24,703,584	(2,240,816)	7,810,422	19,133,978
4	Federal income tax - deferred depreciation	0			
5	Federal income tax - deferred other	(5,492,817)	3,676,620	(4,063,845)	(5,105,592)
6	Investment tax credit adjustment	0	0	0	0
7	Federal income taxes charged to other income and deductions	0			
8	State income taxes	5,753,679	357,465	1,029,640	4,366,574
9	State income taxes charged to other income and deductions	0			
10	Total	126,409,752	(27,234,917)	35,803,421	117,841,248
11	Flow through items:	0			
12	Add (itemize)	0			
13	Deduct (itemize)	0		0	
14	Book taxable income	126,409,752	(27,234,917)	35,803,421	117,841,248
15	Differences between book taxable income and taxable income per tax return:	0			
16	Add (itemize)	0			
	Interest Reclass	0	38,897,701	(12,313,515)	(26,584,186)
	Bad Debts	2,773,466	0	615,996	2,157,470
	Book Depreciation	91,093,175	7,746,053	23,378,090	59,969,032
	Capitalized Hardware/Software	451,652	0	20,967	430,685
	Coal Ash Spend, Net of Capitalized Portion	3,489,960	0	0	3,489,960
	Contributions in Aid of Construction	968,917	0	262,493	706,424
	Deferred Revenue	880,114	0	0	880,114
	Demand Side Management Deferral	2,540,455	0	(507,836)	3,048,291
	Lobbying	360,000	360,000	0	0
	Loss on Reacquired Debt	79,507	0	27,120	52,387
	Meals & Entertainment	190,000	190,000	0	0
	Penalties	2,521	2,521	0	0
	Regulatory Asset - Carbon Management	199,996	0	0	199,996
	Regulatory Asset - Deferred Plant Costs	4,215,791	0	0	4,215,791
	Regulatory Asset - Non-AMI Meters	368,588	0	0	368,588
	Regulatory Liability - RSLI & Other Misc Dfd Costs	289,602	0	289,602	0
	Storm Cost Deferral	210,211	0	0	210,211
	Tax Interest Capitalized	3,523,700	0	1,441,372	2,082,328
	Transportation Benefits	24,000	24,000	0	0
	Deferred Costs - Customer Connect	124,047	0	124,047	0
	Non-Cash Overhead Basis Adjustment	490,294	0	(151,362)	641,656
	Capitalized 174 R&D	2,000,000	0	2,000,000	0
	Extra Facility Lighting	7,193	0	0	7,193
	Benefits Accruals	3,320,881	0	1,300,752	2,020,129
	Mark to Market	54,334	(412,426)	0	466,760
	Regulatory Asset - ESM Deferral	1,302,849	0	0	1,302,849
	Gas Supplier Refunds	76,398	0	76,398	0
	Lease Adjustments	0	0	56,267	(56,267)
	Regulatory Asset - Deferred Revenue	612,405	0	0	612,405
	Regulatory Liability - Outage Costs	2,025,745	0	0	2,025,745
	Total Additions	121,675,801	46,807,849	16,620,391	58,247,561
17	Deduct (itemize)				
	Kentucky Bonus Depreciation Adjustment	(12,794,023)	0	0	(12,794,023)
	AFUDC Equity Income	(4,611,595)	(4,611,595)	0	0
	AFUDC Interest	(2,480,607)	(2,480,607)	0	0
	Asset Retirement Obligation	(100,250)	0	(96,353)	(3,897)
	Cost of Removal	(15,295,563)	0	(5,014,496)	(10,281,067)
	Environmental Reserve	(6,952)	0	0	(6,952)
	Equipment/T&D Repairs	(56,796,503)	0	(11,055,906)	(45,740,597)

Duke Energy Kentucky, Inc.
STAFF-DR-01-015(a)(8)
Reconciliation of Book Net Income and State Taxable Income
12 Months Ended December 31, 2024

Line No.	Item	Total Company	Total Company Non-Operating	Kentucky Retail	Other Jurisdictional
	(a)	(b)	(c)	(d)	(e)
	Regulatory Asset/Liability - Rate Case Expenses	(101,502)	0	12,805	(114,307)
	Regulatory Asset - Transition from MISO to PJM	(218,194)	0	0	(218,194)
	Tax Depreciation/Amortization	(86,100,000)	0	(30,600,000)	(55,500,000)
	Tax Gains/Losses	(4,250,000)	0	(1,150,000)	(3,100,000)
	Property Tax Reserves	(7,094,148)	0	(1,249,882)	(5,844,266)
	Rate Refunds	(5,730)	0	(5,730)	0
	Regulatory Asset - FAS 158	(3,098,864)	0	(334,429)	(2,764,435)
	Charitable Contribution Carryover	(63,337)	0	(18,285)	(45,052)
	Regulatory Liability - Overcollection of Revenue Refund Adj	(1,505,572)	0	(1,505,572)	0
	Emissions Allowance Expense	(737)	0	0	(737)
	Regulatory Asset - Vacation Carryover	(57,345)	0	(35,698)	(21,647)
	Unbilled Revenue - Fuel	(1,976,841)	0	(1,976,841)	0
	Severance Reserve - LT	(627,867)	0	0	(627,867)
	Workers Com Reserve	(106,131)	0	(29,642)	(76,489)
	Total Deductions	(197,291,761)	(7,092,202)	(53,060,029)	(137,139,530)
18	Taxable income per return	50,793,792	12,480,730	(636,217)	38,949,279
	Computation of Tax:				
	Apportionment Percentage	99.3700%	99.3700%	99.3700%	99.3700%
	Allocable Income	50,473,791	12,402,102	(632,209)	38,703,898
	State Income Tax Rate	5.0000%	5.0000%	5.0000%	5.0000%
	Current State Income Tax Expense	2,523,690	620,105	(31,610)	1,935,195
	True Up Entries	411,453	(1,177,990)	1,356,599	232,844
	Total State Income Tax Provision	2,935,143	(557,885)	1,324,989	2,168,039

Note: (1) Provide a calculation of the amount shown on Lines 3 through 7 above.
(2) Provide a workpaper supporting each calculation including the depreciation for straight-line tax and accelerated tax depreciation.
(3) Provide a schedule setting forth the basis of allocation of each item of revenue or cost allocated above.

Duke Energy Kentucky, Inc.
STAFF-DR-01-015(b)
Analysis of Other Operating Taxes
12 Months Ended December 31, 2024

		DR(CR) 236				
Line No.	Item (a)	Charged Expense (b)	Charged to Construction (c)	Charged to Other Accounts[1] (d)	Amounts Accrued[2] (e)	Amount Paid (f)
1	Kentucky Retail					
	(a) State income	(1,324,989)	0	0	(620,044)	(5,827,758)
	(b) Franchise fees	2,383	0	0	0	(2,383)
	(c) Ad valorem	(4,858,320)	(160,985)	0	(5,233,068)	3,889,500
	(d) Payroll (employers portion)	(1,939)	0	0	12,837	4,406
	(e) Other taxes					
2	Total Retail [L1(a) through L1(e)]	(6,182,865)	(160,985)	0	(5,840,275)	(1,936,235)
3	Other jurisdictions	(9,955,139)	(3,076,182)	0	(15,227,740)	19,350,756
	Total per books (L2 and L3)	(16,138,004)	(3,237,167)	0	(21,068,015)	17,414,521

(1) Explain items in this Column.

(2) Column (e) represents the ending 236 taxes payable balance for each respective tax type.

CONFIDENTIAL STAFF-DR-01-016
(As to Attachments only)

REQUEST:

Provide a copy of federal and state income tax returns for the most recent tax year, including supporting schedules.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachments only)

Please see STAFF-DR-01-016 Confidential Attachments 1 and 2, for the 2023 federal and state income tax returns, respectively, for Duke Energy Kentucky. The Kentucky Corporation Income Tax Return is filed on a unitary combined basis with Duke Energy Kentucky's affiliated companies including all of Duke Energy Corporation's affiliated entities except insurance entities.

PERSON RESPONSIBLE: John R. Panizza

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-016 CONFIDENTIAL ATTACHMENTS 1 & 2

FILED UNDER SEAL

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-017

REQUEST:

Provide a schedule of franchise fees paid to cities, towns, or municipalities, including the basis of these fees.

RESPONSE:

Please see STAFF-DR-01-017 Attachment.

PERSON RESPONSIBLE: John R. Panizza

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue	
2024	1	CITY OF BELLEVUE	28,088	802,517	
2024	1	CITY OF BROMLEY	2,145	214,466	
2024	1	CITY OF COVINGTON	191,008	6,366,927	
2024	1	CITY OF CRESCENT SPRINGS	18,666	622,192	
2024	1	CITY OF CRESTVIEW HILLS	20,750	691,660	
2024	1	CITY OF CRITTENDEN	10,932	364,403	
2024	1	CITY OF DAYTON	21,590	616,847	
2024	1	CITY OF DRY RIDGE	6,450	128,991	
2024	1	CITY OF EDGEWOOD	31,014	1,632,298	
2024	1	CITY OF ELSMERE	20,882	696,076	
2024	1	CITY OF ERLANGER	76,599	2,553,286	
2024	1	CITY OF FORT MITCHELL KY	33,029	1,100,972	
2024	1	CITY OF FORT THOMAS	5,087	NA	[1]
2024	1	CITY OF GLENCOE	207	6,886	
2024	1	CITY OF HIGHLAND HEIGHTS	23,439	781,285	
2024	1	CITY OF INDEPENDENCE	55,576	1,634,586	
2024	1	CITY OF LUDLOW	23,093	769,767	
2024	1	CITY OF NEWPORT	70,906	2,363,540	
2024	1	CITY OF SOUTHGATE	15,385	512,834	
2024	1	CITY OF TAYLOR MILL	24,084	802,786	
2024	1	CITY OF UNION	29,406	980,183	
2024	1	CITY OF VILLA HILLS	28,825	960,832	
2024	1	CITY OF WILDER	23,699	789,981	
2024	1	CITY OF WILLIAMSTOWN	2,578	85,931	
2024	1	CITY OF WOODLAWN	630	20,989	
2024	2	CITY OF BELLEVUE	37,607	1,074,494	
2024	2	CITY OF BROMLEY	1,756	175,639	
2024	2	CITY OF COVINGTON	234,723	7,824,085	
2024	2	CITY OF CRESCENT SPRINGS	22,556	751,859	
2024	2	CITY OF CRESTVIEW HILLS	27,880	929,324	
2024	2	CITY OF CRITTENDEN	11,003	366,758	
2024	2	CITY OF DAYTON	25,922	740,623	
2024	2	CITY OF DRY RIDGE	6,301	126,022	
2024	2	CITY OF EDGEWOOD	36,882	1,941,138	
2024	2	CITY OF ELSMERE	41,081	1,369,366	
2024	2	CITY OF ERLANGER	85,842	2,861,409	
2024	2	CITY OF FORT MITCHELL KY	43,312	1,443,726	
2024	2	CITY OF FORT THOMAS	5,075	NA	[1]
2024	2	CITY OF GLENCOE	362	12,076	
2024	2	CITY OF HIGHLAND HEIGHTS	31,369	1,045,639	
2024	2	CITY OF INDEPENDENCE	71,667	2,107,862	
2024	2	CITY OF LUDLOW	20,310	676,994	
2024	2	CITY OF NEWPORT	96,085	3,202,841	
2024	2	CITY OF SOUTHGATE	14,813	493,769	
2024	2	CITY OF TAYLOR MILL	31,612	1,053,726	
2024	2	CITY OF UNION	39,514	1,317,130	
2024	2	CITY OF VILLA HILLS	33,009	1,100,307	

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue	
2024	2	CITY OF WILDER	19,913	663,756	
2024	2	CITY OF WILLIAMSTOWN	5,187	172,906	
2024	2	CITY OF WOODLAWN	894	29,815	
2024	3	CITY OF BELLEVUE	37,961	1,084,589	
2024	3	CITY OF BROMLEY	1,517	151,692	
2024	3	CITY OF COVINGTON	216,507	7,216,893	
2024	3	CITY OF CRESCENT SPRINGS	20,592	686,407	
2024	3	CITY OF CRESTVIEW HILLS	22,519	750,636	
2024	3	CITY OF CRITTENDEN	8,922	297,384	
2024	3	CITY OF DAYTON	28,645	818,417	
2024	3	CITY OF DRY RIDGE	6,497	129,942	
2024	3	CITY OF EDGEWOOD	28,425	1,496,050	
2024	3	CITY OF ELSMERE	36,920	1,230,668	
2024	3	CITY OF ERLANGER	90,869	3,028,951	
2024	3	CITY OF FORT MITCHELL KY	36,334	1,211,150	
2024	3	CITY OF FORT THOMAS	5,101	NA	[1]
2024	3	CITY OF GLENCOE	243	8,106	
2024	3	CITY OF HIGHLAND HEIGHTS	36,068	1,202,260	
2024	3	CITY OF INDEPENDENCE	69,775	2,052,196	
2024	3	CITY OF LUDLOW	16,538	551,269	
2024	3	CITY OF NEWPORT	99,411	3,313,703	
2024	3	CITY OF SOUTHGATE	13,686	456,212	
2024	3	CITY OF TAYLOR MILL	29,221	974,042	
2024	3	CITY OF UNION	40,609	1,353,620	
2024	3	CITY OF VILLA HILLS	25,637	854,569	
2024	3	CITY OF WILDER	20,484	682,801	
2024	3	CITY OF WILLIAMSTOWN	3,674	122,460	
2024	3	CITY OF WOODLAWN	879	29,300	
2024	4	CITY OF BELLEVUE	25,703	734,382	
2024	4	CITY OF BROMLEY	1,828	182,791	
2024	4	CITY OF COVINGTON	175,992	5,866,384	
2024	4	CITY OF CRESCENT SPRINGS	15,298	509,935	
2024	4	CITY OF CRESTVIEW HILLS	17,574	585,797	
2024	4	CITY OF CRITTENDEN	6,927	230,898	
2024	4	CITY OF DAYTON	19,046	544,175	
2024	4	CITY OF DRY RIDGE	4,579	91,579	
2024	4	CITY OF EDGEWOOD	23,011	1,211,094	
2024	4	CITY OF ELSMERE	29,615	987,152	
2024	4	CITY OF ERLANGER	65,677	2,189,242	
2024	4	CITY OF FORT MITCHELL KY	27,711	923,711	
2024	4	CITY OF FORT THOMAS	40,083	2,004,126	
2024	4	CITY OF GLENCOE	194	6,464	
2024	4	CITY OF HIGHLAND HEIGHTS	21,880	729,343	
2024	4	CITY OF INDEPENDENCE	43,675	1,284,550	
2024	4	CITY OF LUDLOW	11,957	398,576	
2024	4	CITY OF NEWPORT	71,352	2,378,410	
2024	4	CITY OF SOUTHGATE	10,202	340,068	

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue
2024	4	CITY OF TAYLOR MILL	21,602	720,057
2024	4	CITY OF UNION	29,602	986,745
2024	4	CITY OF VILLA HILLS	20,062	668,742
2024	4	CITY OF WILDER	16,739	557,980
2024	4	CITY OF WILLIAMSTOWN	3,159	105,298
2024	4	CITY OF WOODLAWN	622	20,719
2024	5	CITY OF BELLEVUE	21,691	619,736
2024	5	CITY OF BROMLEY	1,025	102,504
2024	5	CITY OF COVINGTON	130,170	4,338,986
2024	5	CITY OF CRESCENT SPRINGS	13,069	435,645
2024	5	CITY OF CRESTVIEW HILLS	16,498	549,929
2024	5	CITY OF CRITTENDEN	6,082	202,749
2024	5	CITY OF DAYTON	15,270	436,272
2024	5	CITY OF DRY RIDGE	2,613	52,255
2024	5	CITY OF EDGEWOOD	21,872	1,151,153
2024	5	CITY OF ELSMERE	22,045	734,830
2024	5	CITY OF ERLANGER	57,396	1,913,209
2024	5	CITY OF FORT MITCHELL KY	22,949	764,981
2024	5	CITY OF FORT THOMAS	33,717	1,685,871
2024	5	CITY OF GLENCOE	109	3,633
2024	5	CITY OF HIGHLAND HEIGHTS	27,891	929,698
2024	5	CITY OF INDEPENDENCE	47,722	1,403,594
2024	5	CITY OF LUDLOW	9,972	332,394
2024	5	CITY OF NEWPORT	60,893	2,029,774
2024	5	CITY OF SOUTHGATE	8,568	285,591
2024	5	CITY OF TAYLOR MILL	19,064	635,471
2024	5	CITY OF UNION	25,979	865,960
2024	5	CITY OF VILLA HILLS	15,831	527,702
2024	5	CITY OF WILDER	13,307	443,566
2024	5	CITY OF WILLIAMSTOWN	1,689	56,304
2024	5	CITY OF WOODLAWN	490	16,342
2024	6	CITY OF BELLEVUE	19,812	566,048
2024	6	CITY OF BROMLEY	1,297	129,731
2024	6	CITY OF COVINGTON	134,561	4,485,359
2024	6	CITY OF CRESCENT SPRINGS	15,038	501,283
2024	6	CITY OF CRESTVIEW HILLS	17,506	583,542
2024	6	CITY OF CRITTENDEN	6,569	218,978
2024	6	CITY OF DAYTON	14,346	409,879
2024	6	CITY OF DRY RIDGE	1,858	37,152
2024	6	CITY OF EDGEWOOD	24,126	1,269,782
2024	6	CITY OF ELSMERE	22,096	736,527
2024	6	CITY OF ERLANGER	58,494	1,949,788
2024	6	CITY OF FORT MITCHELL KY	22,931	764,373
2024	6	CITY OF FORT THOMAS	30,806	1,540,306
2024	6	CITY OF GLENCOE	87	2,901
2024	6	CITY OF HIGHLAND HEIGHTS	24,399	813,289
2024	6	CITY OF INDEPENDENCE	43,162	1,269,462

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue
2024	6	CITY OF LUDLOW	10,277	342,570
2024	6	CITY OF NEWPORT	56,561	1,885,377
2024	6	CITY OF SOUTHGATE	8,583	286,094
2024	6	CITY OF TAYLOR MILL	19,374	645,812
2024	6	CITY OF UNION	24,215	807,165
2024	6	CITY OF VILLA HILLS	18,137	604,569
2024	6	CITY OF WILDER	14,754	491,813
2024	6	CITY OF WILLIAMSTOWN	1,242	41,389
2024	6	CITY OF WOODLAWN	691	23,030
2024	7	CITY OF BELLEVUE	19,066	544,746
2024	7	CITY OF BROMLEY	1,426	142,615
2024	7	CITY OF COVINGTON	120,676	4,022,541
2024	7	CITY OF CRESCENT SPRINGS	14,395	479,821
2024	7	CITY OF CRESTVIEW HILLS	13,173	439,083
2024	7	CITY OF CRITTENDEN	6,227	207,572
2024	7	CITY OF DAYTON	14,711	420,307
2024	7	CITY OF DRY RIDGE	1,739	34,776
2024	7	CITY OF EDGEWOOD	20,576	1,082,943
2024	7	CITY OF ELSMERE	18,291	609,713
2024	7	CITY OF ERLANGER	52,041	1,734,715
2024	7	CITY OF FORT MITCHELL KY	24,687	822,898
2024	7	CITY OF FORT THOMAS	28,599	1,429,935
2024	7	CITY OF GLENCOE	76	2,535
2024	7	CITY OF HIGHLAND HEIGHTS	22,220	740,662
2024	7	CITY OF INDEPENDENCE	35,472	1,043,304
2024	7	CITY OF LUDLOW	11,174	372,478
2024	7	CITY OF NEWPORT	47,592	1,586,408
2024	7	CITY OF SOUTHGATE	8,068	268,938
2024	7	CITY OF TAYLOR MILL	14,296	476,542
2024	7	CITY OF UNION	20,467	682,246
2024	7	CITY OF VILLA HILLS	18,158	605,268
2024	7	CITY OF WILDER	13,405	446,838
2024	7	CITY OF WILLIAMSTOWN	843	28,102
2024	7	CITY OF WOODLAWN	457	15,228
2024	8	CITY OF BELLEVUE	30,042	858,353
2024	8	CITY OF BROMLEY	1,022	102,228
2024	8	CITY OF COVINGTON	190,357	6,345,239
2024	8	CITY OF CRESCENT SPRINGS	16,990	566,326
2024	8	CITY OF CRESTVIEW HILLS	25,327	844,226
2024	8	CITY OF CRITTENDEN	8,167	272,222
2024	8	CITY OF DAYTON	18,962	541,781
2024	8	CITY OF DRY RIDGE	1,432	28,638
2024	8	CITY OF EDGEWOOD	31,311	1,647,966
2024	8	CITY OF ELSMERE	29,673	989,086
2024	8	CITY OF ERLANGER	74,452	2,481,729
2024	8	CITY OF FORT MITCHELL KY	30,684	1,022,804
2024	8	CITY OF FORT THOMAS	43,018	2,150,920

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue
2024	8	CITY OF GLENCOE	75	2,489
2024	8	CITY OF HIGHLAND HEIGHTS	29,124	970,788
2024	8	CITY OF INDEPENDENCE	53,670	1,578,521
2024	8	CITY OF LUDLOW	13,476	449,211
2024	8	CITY OF NEWPORT	79,701	2,656,697
2024	8	CITY OF SOUTHGATE	10,790	359,681
2024	8	CITY OF TAYLOR MILL	28,849	961,649
2024	8	CITY OF UNION	33,295	1,109,848
2024	8	CITY OF VILLA HILLS	22,634	754,456
2024	8	CITY OF WILDER	18,146	604,855
2024	8	CITY OF WILLIAMSTOWN	885	29,502
2024	8	CITY OF WOODLAWN	330	10,999
2024	9	CITY OF BELLEVUE	26,476	756,460
2024	9	CITY OF BROMLEY	1,508	150,759
2024	9	CITY OF COVINGTON	164,277	5,475,901
2024	9	CITY OF CRESCENT SPRINGS	17,399	579,970
2024	9	CITY OF CRESTVIEW HILLS	18,646	621,541
2024	9	CITY OF CRITTENDEN	7,304	243,462
2024	9	CITY OF DAYTON	19,282	550,912
2024	9	CITY OF DRY RIDGE	1,760	35,197
2024	9	CITY OF EDGEWOOD	25,624	1,348,628
2024	9	CITY OF ELSMERE	24,583	819,427
2024	9	CITY OF ERLANGER	61,149	2,038,296
2024	9	CITY OF FORT MITCHELL KY	30,677	1,022,554
2024	9	CITY OF FORT THOMAS	39,341	1,967,027
2024	9	CITY OF GLENCOE	72	2,387
2024	9	CITY OF HIGHLAND HEIGHTS	29,055	968,488
2024	9	CITY OF INDEPENDENCE	44,676	1,313,999
2024	9	CITY OF LUDLOW	12,834	427,803
2024	9	CITY OF NEWPORT	68,740	2,291,323
2024	9	CITY OF SOUTHGATE	10,355	345,160
2024	9	CITY OF TAYLOR MILL	21,412	713,731
2024	9	CITY OF UNION	29,754	991,814
2024	9	CITY OF VILLA HILLS	22,301	743,354
2024	9	CITY OF WILDER	17,735	591,160
2024	9	CITY OF WILLIAMSTOWN	830	27,651
2024	9	CITY OF WOODLAWN	582	19,390
2024	10	CITY OF BELLEVUE	22,098	631,363
2024	10	CITY OF BROMLEY	1,146	114,598
2024	10	CITY OF COVINGTON	129,008	4,300,273
2024	10	CITY OF CRESCENT SPRINGS	11,969	398,962
2024	10	CITY OF CRESTVIEW HILLS	15,409	513,632
2024	10	CITY OF CRITTENDEN	5,162	172,066
2024	10	CITY OF DAYTON	14,425	412,156
2024	10	CITY OF DRY RIDGE	1,367	27,334
2024	10	CITY OF EDGEWOOD	21,565	1,135,009
2024	10	CITY OF ELSMERE	20,192	673,051

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue
2024	10	CITY OF ERLANGER	53,683	1,789,449
2024	10	CITY OF FORT MITCHELL KY	21,991	733,040
2024	10	CITY OF FORT THOMAS	33,177	1,658,866
2024	10	CITY OF GLENCOE	72	2,404
2024	10	CITY OF HIGHLAND HEIGHTS	25,320	844,001
2024	10	CITY OF INDEPENDENCE	37,758	1,110,539
2024	10	CITY OF LUDLOW	9,197	306,568
2024	10	CITY OF NEWPORT	61,667	2,055,562
2024	10	CITY OF SOUTHGATE	9,663	322,089
2024	10	CITY OF TAYLOR MILL	17,807	593,572
2024	10	CITY OF UNION	28,201	940,018
2024	10	CITY OF VILLA HILLS	14,371	479,036
2024	10	CITY OF WILDER	16,508	550,260
2024	10	CITY OF WILLIAMSTOWN	837	27,901
2024	10	CITY OF WOODLAWN	522	17,403
2024	11	CITY OF BELLEVUE	19,666	561,898
2024	11	CITY OF BROMLEY	1,178	117,826
2024	11	CITY OF COVINGTON	128,113	4,270,443
2024	11	CITY OF CRESCENT SPRINGS	13,060	435,322
2024	11	CITY OF CRESTVIEW HILLS	15,076	502,540
2024	11	CITY OF CRITTENDEN	5,997	199,886
2024	11	CITY OF DAYTON	13,738	392,503
2024	11	CITY OF DRY RIDGE	1,785	35,699
2024	11	CITY OF EDGEWOOD	17,606	926,607
2024	11	CITY OF ELSMERE	8,171	272,355
2024	11	CITY OF ERLANGER	49,178	1,639,280
2024	11	CITY OF FORT MITCHELL KY	22,054	735,120
2024	11	CITY OF FORT THOMAS	28,314	1,415,710
2024	11	CITY OF GLENCOE	99	3,283
2024	11	CITY OF HIGHLAND HEIGHTS	23,643	788,090
2024	11	CITY OF INDEPENDENCE	37,708	1,109,051
2024	11	CITY OF LUDLOW	9,410	313,659
2024	11	CITY OF NEWPORT	52,648	1,754,948
2024	11	CITY OF SOUTHGATE	8,672	289,068
2024	11	CITY OF TAYLOR MILL	17,557	585,239
2024	11	CITY OF UNION	22,845	761,484
2024	11	CITY OF VILLA HILLS	15,366	512,190
2024	11	CITY OF WILDER	12,420	414,007
2024	11	CITY OF WILLIAMSTOWN	978	32,587
2024	11	CITY OF WOODLAWN	341	11,362
2024	12	CITY OF BELLEVUE	18,852	538,629
2024	12	CITY OF BROMLEY	1,377	137,674
2024	12	CITY OF COVINGTON	128,171	4,272,373
2024	12	CITY OF CRESCENT SPRINGS	13,374	445,814
2024	12	CITY OF CRESTVIEW HILLS	15,141	504,695
2024	12	CITY OF CRITTENDEN	5,813	193,770
2024	12	CITY OF DAYTON	14,036	401,033

Duke Energy Kentucky, Inc.
STAFF-DR-01-017
Schedule of Franchise Fees Paid - Gas & Electric
12 Months Ended December 31, 2024

Year	Month	Vendor Name JD	Tax Paid	Taxable Revenue
2024	12	CITY OF DRY RIDGE	2,745	54,893
2024	12	CITY OF EDGEWOOD	21,324	1,122,334
2024	12	CITY OF ELSMERE	20,745	691,497
2024	12	CITY OF ERLANGER	51,968	1,732,264
2024	12	CITY OF FORT MITCHELL KY	23,125	770,825
2024	12	CITY OF FORT THOMAS	29,293	1,464,671
2024	12	CITY OF GLENCOE	155	5,170
2024	12	CITY OF HIGHLAND HEIGHTS	22,997	766,582
2024	12	CITY OF INDEPENDENCE	39,213	1,153,313
2024	12	CITY OF LUDLOW	10,540	351,328
2024	12	CITY OF NEWPORT	53,580	1,786,016
2024	12	CITY OF SOUTHGATE	8,681	289,351
2024	12	CITY OF TAYLOR MILL	16,822	560,737
2024	12	CITY OF UNION	24,561	818,713
2024	12	CITY OF VILLA HILLS	16,879	562,627
2024	12	CITY OF WILDER	14,393	479,754
2024	12	CITY OF WILLIAMSTOWN	1,732	57,737
2024	12	CITY OF WOODLAWN	503	16,770
			8,168,070	278,562,105

1	January	764,065	25,500,236
2	February	944,675	31,481,263
3	March	897,032	29,703,318
4	April	704,090	24,258,218
5	May	595,913	20,518,151
6	June	590,922	20,406,217
7	July	527,836	18,240,214
8	August	792,413	27,340,213
9	September	696,368	24,046,394
10	October	573,115	19,809,152
11	November	525,621	18,080,158
12	December	556,021	19,178,569
		8,168,070	278,562,105

[1] During January - March of 2024, the City of Fort Thomas Franchise Fee was based on a fixed amount

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-018

REQUEST:

Provide the journal entries relating to the purchase of utility plant acquired as an operating unit or system by purchase, merger, consolidation, liquidation, or otherwise currently included in rate base. Also, provide a schedule showing the calculation of the acquisition adjustment at the date of purchase for each item of utility plant, the amortization period, and the unamortized balance at the beginning of the base period.

RESPONSE:

No utility plant was acquired as an operating unit or system by purchase, merger, consolidation, liquidation, or otherwise since the last base rate case.

PERSON RESPONSIBLE: Sharif S. Mitchell

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-019

REQUEST:

Provide Duke Kentucky's rate base, capital structure, and statement of income for the most recent 12 months preceding the base period and for the base period. Provide a reconciliation with detailed explanations.

RESPONSE:

Please see STAFF-DR-01-019 Attachment.

PERSON RESPONSIBLE: Linda L. Miller
Jefferson "Jay" P. Brown

DUKE ENERGY KENTUCKY, INC.
GAS JURISDICTIONAL RATE BASE

LINE NO.	RATE BASE COMPONENT	SUPPORTING SCHEDULE REFERENCE	AS OF 8/31/2024	BASE PERIOD	VARIANCE	
1	Adjusted Jurisdictional Plant in Service	B-2	$ 990,016,162	$ 901,535,332	$ (88,480,830)	(1)
2	Accumulated Depreciation and Amortization	B-3 / B-3.2	(209,943,816)	(238,499,918)	(28,556,102)	(1)
3	Net Plant in Service (Line 1 + Line 2)		780,072,346	663,035,414	(117,036,932)	
4	Construction Work in Progress	B-4	-	-	-	
5	Cash Working Capital Allowance	B-5	2,824,655	460,861	(2,363,794)	(2)
6	Other Working Capital Allowances	B-5	3,389,369	2,440,832	(948,537)	
7	Other Items:					
8	Customers' Advances for Construction	B-6	(2,528,681)	(1,801,940)	726,741	
9	Investment Tax Credits	B-6	-	-	-	
10	Deferred Income Taxes	B-6	(106,454,971)	(91,641,963)	14,813,008	(3)
11	Excess Deferred Income Taxes	B-6	(30,522,510)	(27,220,455)	3,302,055	(4)
12	Other Rate Base Adjustments	B-6	817,218	1,536,717	719,499	
13	Jurisdictional Rate Base (Line 3 through Line 12)		$ 647,597,426	$ 546,809,466	$ (100,787,960)	

(1) These variances are driven by adjustments made to the base period. Per Schedules B-2.2 and B-3.1, adjustments were made to eliminate ARO, PMM Assets, and assets devoted to non Duke Energy Kentucky customers. Also, additions to plant in service and accumulated depreciation during the period are offsetting these adjustments.
(2) The cash working capital for August 2024 is based on 1/8 O&M and the base period is based on the lead lag study.
(3) These variances are driven by adjustments made to the base period. Per Schedule B-6 adjustments were made to eliminate liberalized depreciation related to facilities devoted to non DE-Kentucky customers and ADIT for items not included in rate base.
(4) These variances are driven by adjustments made to the base period. Per Schedule B-6 adjustments were made to eliminate liberalized depreciation related to facilities devoted to non DE-Kentucky customers.

DUKE ENERGY KENTUCKY, INC.
CAPITAL STRUCTURE

LINE NO.	CLASS OF CAPITAL	REFERENCE	AS OF 8/31/2024	BASE PERIOD	VARIANCE	
1	**Total Company**					
2	Common Equity		$ 1,213,386,708	$ 1,167,693,555	$ (45,693,153)	(1)
3	Long-Term Debt	J-3	928,845,651	788,806,405	(140,039,246)	(2)
4	Short-Term Debt	J-2	-	165,113,616	165,113,616	(3)
5						
6	Total Capital		$ 2,142,232,359	$ 2,121,613,576	$ (20,618,783)	
7						
8	**Gas Jurisdictional**					
9	Common Equity		$ 406,989,885	$ 328,291,329	$ (78,698,556)	(1)
10	Long-Term Debt		311,550,325	221,769,378	(89,780,947)	(2)
11	Short-Term Debt		-	46,421,845	46,421,845	(3)
12						
13	Total Jurisdictional Gas Capital		$ 718,540,210	$ 596,482,552	$ (122,057,658)	

(1) The variance in common equity is primarily driven by a distribution of $140 million to Duke Energy Ohio in September 2024 partially offset by net income during the period.
(2) The variance in long-term debt is primary due to the reclassification of $95 million (3.23% due 10/1/2025) in October 2024 and $45 million (3.42% due 1/15/2026) in January 2025 to current maturities.
(3) The variance primarily due to the reclassification of $95 million (3.23% due 10/1/2025) in October 2024 and $45 million (3.42% due 1/15/2026) in January 2025 to current maturities, and $25 million of short-term money pool borrowings in the base period ($0 at 8/31/2024).

DUKE ENERGY KENTUCKY, INC.
GAS INCOME STATEMENT

LINE NO.	DESCRIPTION	ENDING 8/31/2024	BASE PERIOD	VARIANCE	
1	OPERATING REVENUE	130,489,361	149,565,657	19,076,296	(1)
2					
3	OPERATING EXPENSES				
4	Operation and Maintenance Expenses				
5	Production Expenses				
6	Liquefied Petroleum Gas	0	0	0	
7	Other	3,458	1,627	(1,831)	
8	Total Production Expense	3,458	1,627	(1,831)	
9					
10	Other Gas Supply Expenses				
11	Purchased Gas	45,820,547	56,979,326	11,158,779	(2)
12	Other	536,295	640,605	104,310	
13	Total Other Gas Supply Expenses	46,356,842	57,619,931	11,263,089	
14	Transmission Expense	338,515	(362,391)	(700,906)	
15	Distribution Expense	7,601,690	8,491,894	890,204	
16	Customer Accounts Expense	4,912,021	4,429,496	(482,525)	
17	Customer Service & Information Expense	748,424	712,867	(35,557)	
18	Sales Expense	40,321	65,836	25,515	
19	Administrative & General Expense	7,796,964	7,797,164	200	
20	Other	619,551	(1,657,848)	(2,277,399)	(3)
21	Total Operation and Maintenance Expense	68,417,786	77,098,576	8,680,790	
22					
23	Depreciation Expense	22,688,430	23,774,518	1,086,088	(4)
24					
25	Taxes Other Than Income Taxes				
26	Other Federal Taxes	381,157	168,698	(212,459)	
27	State and Other Taxes	6,970,994	3,671,461	(3,299,533)	(5)
28	Total Taxes Other Than Income Taxes	7,352,151	3,840,159	(3,511,992)	
29					
30	State Income Taxes				
31	State Income Tax - Current	(2,917,438)	1,964,983	4,882,421	
32	Provision for Deferred Income Taxes - Net	3,941,191	(484,843)	(4,426,034)	
33	Total State Income Tax Expense	1,023,753	1,480,140	456,387	
34					
35	Federal Income Taxes				
36	Federal Income Tax - Current	(8,480,577)	9,142,847	17,623,424	
37	Provision for Deferred Income Taxes - Net	13,034,662	(3,391,629)	(16,426,291)	
38	Amortization of Investment Tax Credit	0	0	0	
39	Total Federal Income Tax Expense	4,554,085	5,751,218	1,197,133	
40					
41	Total Operating Expenses and Taxes	104,036,205	111,944,611	7,908,406	
42					
43	Net Operating Income	26,453,156	37,621,046	11,167,890	

(1) The variance is due to higher sales volumes and PMM Revenue in the Base Period.
(2) The variance is due to higher volumes in the Base Period.
(3) The variance is due to the under collection true-up in the Base Period for Rider PMM.
(4) The variance is due to higher plant in service during the base period, not including adjustments.
(5) The primary driver is related to one-time property tax reductions relating to both prior and current years as well as adjustments to property tax accruals recorded in the actual portion of the base period.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-020

REQUEST:

Provide the capital structure at the end of the five most recent calendar years and each of the other periods shown in Schedule E1 and Schedule E2.

RESPONSE:

Please see STAFF-DR-01-020 Attachment.

PERSON RESPONSIBLE: Linda L. Miller

Schedule 20a

Duke Energy Kentucky, Inc.

Case No. 2025-00125

Calculation of Capital Structure

12 Months Ended December 2020 - December 2024

Dollars In Thousands

Line No.	Type of Capital	2020		2021		2022		2023		2024	
		Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio
1.	Long Term Debt [1,3]	$ 728,796	47.9%	$ 729,221	44.1%	$ 779,157	44.8%	$ 704,562	36.5%	$ 928,924	45.6%
2.	Short-Term Debt	75,472	5.0%	102,596	6.2%	81,232	4.7%	92,903	4.8%	-	0.0%
3.	Preferred & Preference Stock	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
4.	Common Equity [2]	718,237	47.2%	821,642	49.7%	880,194	50.6%	1,130,357	58.6%	1,107,516	54.3%
5.	Total Capitalization	$ 1,522,505	100.1%	$ 1,653,459	100.0%	$ 1,740,583	100.1%	$ 1,927,822	99.9%	$ 2,036,440	99.9%

(1) Includes current portion of Long Term Debt

(2) Includes Common Stock, Additional Paid in Capital, Other Comprehensive Income, Retained Earnings and Noncontrolling Interest

(3) 2020 and forward amounts include the unamortized debt expense amounts, in accordance with updated GAAP guidance

Instructions: If the applicant is a member of an affiliated group, the above data is to be provided for the applicant as shown.
On a separate schedule, the same data should also be provided for the parent company and the entire system on a consolidated basis.

Schedule 20b

Duke Energy Kentucky, Inc.

Case No. 2025-00125
Calculation of Capital Structure
12 Months Ended December 2024
Dollars In Thousands

Line No.	Item	Total Capital	Long-term Debt [1]	Short-term Debt	Preferred Stock	Common Stock [2]	Retained Earnings	Total Common Equity
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1	Balance at the beginning of Jan 1, 2024	$ 1,927,822	704,562	92,903	-	486,274	644,083	1,130,357
2	1st Month	1,880,098	704,590	33,806	-	486,274	655,428	1,141,702
3	2nd Month	1,885,834	704,617	28,866	-	486,274	666,077	1,152,351
4	3rd Month	1,898,084	704,645	30,860	-	486,274	676,305	1,162,579
5	4th Month	1,904,096	704,673	32,385	-	486,274	680,764	1,167,038
6	5th Month	1,923,059	704,701	30,268	-	501,991	686,099	1,188,090
7	6th Month	2,127,171	928,780	-	-	501,991	696,400	1,198,391
8	7th Month	2,135,201	928,809	-	-	501,991	704,401	1,206,392
9	8th Month	2,142,232	928,846	-	-	501,991	711,395	1,213,386
10	9th Month	2,008,530	928,882	-	-	501,991	577,657	1,079,648
11	10th Month	2,013,411	928,851	-	-	501,991	582,569	1,084,560
12	11th Month	2,019,624	928,887	-	-	501,991	588,746	1,090,737
13	12th Month	2,036,439	928,924	-	-	501,991	605,524	1,107,515
group, the	Total (L1 through L13)	25,901,601	10,729,767	249,088	-	6,447,298	8,475,448	14,922,746
ed for the pa	Average Balance (L14 / 13)	$ 1,992,431	$ 825,367	$ 19,161	$ -	$ 495,946	$ 651,958	$ 1,147,904
16	Average Capitalization Ratio	100.00%	41.43%	0.96%	0.00%	24.89%	32.72%	57.61%
17	End-of-period capitalization Ratio	100.00%	45.62%	0.00%	0.00%	24.65%	29.73%	54.38%

(1) Includes current portion of Long Term Debt
(2) Includes Common Stock, Additional Paid in Capital, Other Comprehensive Income and Noncontrolling Interest

Instructions:
1. If applicable , provide an additional schedule in the above format excluding common equity in subsidiaries from the total company capital structure.
Show the amount of common equity excluded.
2. Include premium class of stock.

Schedule 20a

Duke Energy Corp.

Case No. 2025-00125

Calculation of Capital Structure

12 Months Ended December 2020 - December 2024

Dollars In Millions

Line No.	Type of Capital	2020		2021		2022		2023		2024	
		Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio	Amount	Ratio
1.	Long Term Debt [1,3]	$ 59,863	53.5%	$ 63,835	54.0%	$ 69,751	55.6%	$ 75,252	58.0%	$ 80,688	59.5%
2.	Short-Term Debt	2,873	2.6%	$ 3,304	2.8%	3,952	3.1%	4,288	3.3%	3,584	2.6%
3.	Preferred & Preference Stock	1,962	1.8%	$ 1,962	1.7%	1,962	1.6%	1,962	1.5%	972	0.7%
4.	Common Equity [2]	47,222	42.2%	$ 49,175	41.6%	49,892	39.7%	48,226	37.2%	50,284	37.2%
5.	Total Capitalization	$ 111,920	100.1%	$ 118,276	100.1%	$ 125,557	100.0%	$ 129,728	100.0%	$ 135,528	100.0%

(1) Includes current portion of Long Term Debt

(2) Includes Common Stock, Additional Paid in Capital, Other Comprehensive Income, Retained Earnings and Noncontrolling Interest

(3) 2020 and forward amounts include the unamortized debt expense amounts, in accordance with updated GAAP guidance

Instructions: If the applicant is a member of an affiliated group, the above data is to be provided for the applicant as shown.
On a separate schedule, the same data should also be provided for the parent company and the entire system on a consolidated basis.

Schedule 20b

Duke Energy Corp.

Case No. 2025-00125
Calculation of Capital Structure
12 Months Ended December 2024
Dollars In Millions

Line No.	Item	Total Capital	Long-term Debt [1]	Short-term Debt	Preferred Stock	Common Stock [2]	Retained Earnings	Total Common Equity
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1	Balance at the beginning of Jan 1, 2024	$ 129,728	75,252	4,288	1,962	45,991	2,235	48,226
2	1st Month	130,139	76,492	3,824	1,962	45,998	1,863	47,861
3	2nd Month	130,599	76,456	3,919	1,962	46,031	2,231	48,262
4	3rd Month	132,046	77,253	4,155	1,962	46,135	2,541	48,676
5	4th Month	132,207	77,071	4,320	1,962	46,144	2,710	48,854
6	5th Month	131,706	77,050	4,331	1,962	46,155	2,208	48,363
7	6th Month	133,255	78,779	3,670	1,962	46,209	2,635	48,844
8	7th Month	133,093	78,744	3,865	1,962	46,214	2,308	48,522
9	8th Month	133,541	80,114	2,525	1,962	46,233	2,707	48,940
10	9th Month	134,317	80,121	3,947	972	46,225	3,052	49,277
11	10th Month	133,255	80,117	3,495	972	46,230	2,441	48,671
12	11th Month	134,024	80,312	3,649	972	46,247	2,844	49,091
13	12th Month	135,528	80,688	3,584	972	46,853	3,431	50,284
group, the	Total (L1 through L13)	1,723,438	1,018,449	49,572	21,546	600,665	33,206	633,871
ed for the pa	Average Balance (L14 / 13)	$ 132,572	$ 78,342	$ 3,813	$ 1,657	$ 46,205	$ 2,554	$ 48,759
16	Average Capitalization Ratio	100.00%	59.09%	2.88%	1.25%	34.85%	1.93%	36.78%
17	End-of-period capitalization Ratio	100.00%	59.54%	2.64%	0.72%	34.57%	2.53%	37.10%

(1) Includes current portion of Long Term Debt
(2) Includes Common Stock, Additional Paid in Capital, Other Comprehensive Income and Noncontrolling Interest

Instructions:
1. If applicable , provide an additional schedule in the above format excluding common equity in subsidiaries from the total company capital structure.
Show the amount of common equity excluded.
2. Include premium class of stock.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-021

REQUEST:

Provide the following:

a. A list of all outstanding issues of long-term debt as of the end of the latest calendar year together with the related information as shown in Schedule F1.

b. An analysis of short-term debt as shown in Schedule F2 as of the end of the latest calendar year.

RESPONSE:

a. Please see STAFF-DR-01-021(a) Attachment.

b. Please see STAFF-DR-01-021(b) Attachment.

PERSON RESPONSIBLE: Thomas J. Heath, Jr.

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
Schedule of Outstanding Long-Term Debt
For The Period Ended December 31, 2024

Line No.	Type of Debt Issue (a)	Date of Issue (b)	Date of Maturity (c)	Amount Outstanding [1] (d)	Coupon Interest Rate [2] (e)	Cost Rate At Issue [3] (f)	Cost Rate to Maturity [4] (g)	Bond Rating at Time of Issue [5] S&P (h)	Bond Rating at Time of Issue [5] Moody's (h)	Type of Obligation (i)	Annualized Cost Col. (d) x Col. (g) (j)
1	Unamortized Loss on Reacquired Debt:										
2	7.65 due July 2025			(34,455)							34,455
3	Variable Rate PCB, due August 2027			(40,219)							15,569
4	Long-Term Debt:										
5	Long-Term Notes Payable		16-Mar-29	25,000,000	4.692%	4.692%	4.692%	A-2	P-2	Long Term Commercial Paper	1,173,000
7	Debentures	12-Oct-21	01-Aug-27	49,788,049	3.700%	3.700%	3.881%	BBB+	Baa1	Pollution Control Bond	1,932,045
6	Debentures	27-Jun-22	01-Aug-27	26,668,686	3.750%	3.750%	3.832%	A+/A-1	Aa3	Pollution Control Bond	1,021,973
8	Debentures	07-Mar-06	10-Mar-36	64,618,938	6.200%	6.232%	6.289%	BBB	Baa1	Unsecured Debenture	4,064,049
9	Debentures	05-Jan-16	15-Jan-26	44,975,263	3.420%	3.420%	3.475%	Not Rated	Not Rated	Unsecured Debenture	1,562,811
10	Debentures	05-Jan-16	15-Jan-46	49,813,471	4.450%	4.450%	4.484%	Not Rated	Not Rated	Unsecured Debenture	2,233,866
11	Debentures	07-Sep-17	15-Sep-29	29,951,280	3.350%	3.350%	3.390%	Not Rated	Not Rated	Unsecured Debenture	1,015,354
12	Debentures	07-Sep-17	15-Sep-47	29,905,861	4.110%	4.110%	4.137%	Not Rated	Not Rated	Unsecured Debenture	1,237,146
13	Debentures	07-Sep-17	15-Sep-57	29,898,281	4.260%	4.260%	4.285%	Not Rated	Not Rated	Unsecured Debenture	1,281,110
14	Debentures	03-Oct-18	15-Oct-28	39,940,893	4.180%	4.180%	4.225%	Not Rated	Not Rated	Unsecured Debenture	1,687,600
15	Debentures	12-Dec-18	15-Dec-48	34,887,023	4.620%	4.620%	4.648%	Not Rated	Not Rated	Unsecured Debenture	1,621,716
16	Debentures	17-Jul-19	15-Jul-49	39,839,374	4.320%	4.320%	4.354%	Not Rated	Not Rated	Unsecured Debenture	1,734,546
17	Debentures	26-Sep-19	01-Oct-25	94,948,235	3.230%	3.230%	3.286%	Not Rated	Not Rated	Unsecured Debenture	3,120,265
18	Debentures	26-Sep-19	01-Oct-29	74,841,057	3.560%	3.560%	3.612%	Not Rated	Not Rated	Unsecured Debenture	2,703,462
19	Debentures	15-Sep-20	15-Sep-30	34,927,378	2.650%	2.650%	2.692%	Not Rated	Not Rated	Unsecured Debenture	940,228
20	Debentures	15-Sep-20	15-Sep-50	34,890,937	3.660%	3.660%	3.684%	Not Rated	Not Rated	Unsecured Debenture	1,285,243
21	Debentures	28-Jun-24	15-Jul-31	79,657,324	5.900%	5.900%	5.991%	Not Rated	Not Rated	Unsecured Debenture	4,772,406
22	Debentures	28-Jun-24	15-Jul-34	94,592,551	6.000%	6.000%	6.071%	Not Rated	Not Rated	Unsecured Debenture	5,742,715
23	Debentures	28-Jun-24	15-Jul-39	49,779,707	6.170%	6.170%	6.228%	Not Rated	Not Rated	Unsecured Debenture	3,100,152
21	MCF Fees			(472,793)						MCF Fees	112,347
22	Other Fees									Other Fees	632,449
	Current Maturities:										
	Debentures	26-Sep-19	01-Oct-25	(94,948,235)	3.230%	3.230%	3.286%	Not Rated	Not Rated	Unsecured Debenture	(3,120,265)
23				833,428,605							39,904,240
24	Annualized Cost Rate [total										
25	Col. (j) / Total col. (d)]										4.788%

26 (1) Represents Carrying Value
27 (2) Nominal Rate
28 (3) Nominal Rate Plus Discount or Premium Amortization
29 (4) Nominal Rate Plus Discount or Premium Amortization, and Issuance Cost
30 (5) Standard & Poor's, Moody, etc.

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
Schedule of Short-Term Debt
For The Period Ended December 31, 2024

Line No.	Type of Debt Issue (a)	Date of Issue (b)	Date of Maturity (c)	Amount Outstanding (d)	Nominal Interest Rate (e)	Effective Interest Rate (f)	Annualized Interest Cost Col. (f) x Col. (d) (g)
1	Notes Payable to Associated Companies:						
2	Notes Payable - Money Pool			-			-
3	Current Maturities						
4	Unsecured - Private due 2025			95,000,000	3.230%	3.286%	3,120,265
5	Total Short-Term Debt			95,000,000			3,120,265
6	Annualized Cost Rate [Total Col. (g) / Total Col. (d)]						3.284%
7	Actual Interest Paid or Accrued on Short-Term						
8	Debt during the Test Year [report in Col. (g) of this schedule]						$ 2,167,890
9	Average Short-Term Debt - Format 3, Schedule 2, Line 15 Col. (d) [Report in Col. (g) of this Schedule]						$ 46,177,756
10	Test-Year Interest Cost Rate [Actual Interest /						
11	Average Short-Term Debt] [Report in Col. (f) of this schedule]					4.695%	

Note: In all instances where the Effective Interest Cost Rate is different from the Nominal Interest Rate, provide a calculation of the effective Interest Cost Rate in sufficient detail to show the items of costs that cause the difference.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-022

REQUEST:

Provide a reconciliation and detailed explanation of each difference, if any, in Duke Kentucky's capitalization and net investment rate base for the base period and forecast period.

RESPONSE:

Please see STAFF-DR-01-022 Attachment for the base period reconciliation and Filing Requirement 16(6)(f) filed with the Application, Volume 1, Tab 20 for the forecasted period reconciliation.

PERSON RESPONSIBLE: Jefferson "Jay" P. Brown

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
RECONCILIATION OF CAPITALIZATION AND RATE BASE
AS OF AUGUST 31, 2025

DATA: "X" BASE PERIOD FORECASTED PERIOD
TYPE OF FILING: "X" ORIGINAL UPDATED REVISED
WORK PAPER REFERENCE NO(S).:

STAFF-DR-01-022
PAGE 1 OF 5
WITNESS RESPONSIBLE:
J. P. BROWN

Line No.	Description	Source	Amount
1	Capitalization Allocated to Gas Operations	Page 2 of 5	639,076,310
2	Adjustments to Plant in Service	Sch. B-2.2 & B-3.1	(157,884,776)
3	Assets per Books not included in Rate Base:		
4	Other Property and Investments	Schedule B-8	(5,954,175)
5	CWIP	Schedule B-4	(51,438,834)
6	Cash	Schedule B-8	6,439,108
7	Other Current Assets	Schedule B-8	(36,932,889)
8	Other Regulatory Assets	Schedule B-8	(29,069,778)
9	Other Deferred Debits	Schedule B-8	12,329,790
10	Subtotal		(104,626,778)
11	Liabilities per Books not included in Rate Base:		
12	Other Current liabilities	Schedule B-8	24,659,268
13	Other Non-current liabilities	Schedule B-8	9,756,931
14	Deferred Credits	Schedule B-8	13,989,971
15	Subtotal		48,406,170
16	Items included in Rate Base:		
17	Cash Working Capital Formula	Sch.B-5	460,861
18	Capitalization / Rate Base Differences		121,377,678
19	Subtotal		121,838,539
20	Total Variance		(92,266,844)
21	Gas Rate Base	Schedule B-1	546,809,466

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
RECONCILIATION OF CAPITALIZATION AND RATE BASE
AS OF AUGUST 31, 2025

STAFF-DR-01-022
PAGE 2 OF 5
WITNESS RESPONSIBLE:
J. P. BROWN

Line No.	Description		Capitalization Total	Capitalization Gas
1	Total Base Period Capitalization	(1)	2,121,613,576	
2				
3	Less:			
4	Electric Non-jurisdictional Rate Base	(2)	(4,264,917)	
5	Non-jurisdictional Rate Base	(2)	(21,050,353)	
6				
7	Jurisdictional Capitalization		2,146,928,846	
8				
9	Gas Jurisdictional Rate Base Allocation %	(2)	29.767%	639,076,310
10				
11	Plus: Jurisdictional Gas ITC	(3)		0
12				
13	Total Allocated Capitalization			639,076,310

Notes:
(1) Schedule J-1, page 1.
(2) Page 3 of 5.
(3) Schedule B-6, page 1.

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
RECONCILIATION OF CAPITALIZATION AND RATE BASE
AS OF AUGUST 31, 2025

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PAGE 3 OF 5
WITNESS RESPONSIBLE:
J. P. BROWN

Line No.	Description	Schedule Reference	Total Company	Gas Excl. of Facil Dev. to Other Than DE-Ky Custs.		Gas Non-Juris.		Electric Jurisdictional	Electric Non-Juris.	Non-Jurisdictional
1	Total Utility Plant in Service (Accts 101 & 106) (A)	Sch B-2, (C)	3,562,148,383	901,535,332		165,179,329		2,495,433,722	0	0
2										
3	Additions:									
4	Construction Work in Progress (Account 107)	Sch B-4, (C)	131,859,240	51,438,834		0		80,420,406	0	0
5										
6	Fuel Inventory	Sch B-5	24,788,993	0		0		24,788,993	0	
7										
8	Materials & Supplies -									
9	Propane Inventory (Account 151) (A)	WPB-5.1a	0	0		0		0	0	0
10	Other Material and Supplies (Accts. 154 & 163) (A)	WPB-5.1b	24,943,403	630,182		0		24,313,221	0	0
11	Total Materials & Supplies		24,943,403	630,182		0		24,313,221	0	0
12										
13	Gas Stored Underground (Account 164) (A)	WPB-5.1e	1,610,670	1,610,670		0		0	0	0
14										
15	Prepayments (Account 165) (A)	WPB-5.1d	2,317,086	199,980		201,815		1,044,504	870,787	0
16										
17	Emission Allowances (Account 158)	WPB-5.1h	0	0		0		0	0	0
18										
19	Cash Working Capital Allowance	Sch B-5.1	460,861	460,861		0		0	0	0
20										
21	Other Rate Base Items	WPB-1.1a	1,536,717	1,536,717		0		0	0	0
22	Total Additions		187,516,970	55,877,244		201,815		130,567,124	870,787	0
23										
24	Deductions:									
25	Reserve for Accumulated Depreciation (Acct 108) (A)	Sch B-3, (C)	1,222,826,231	238,499,918		7,294,553		977,031,760	0	0
26										
27	Accum. Deferred Income Taxes (Accts 190, 282, & 283) (A)	Sch B-6, WPB-6a	346,925,466	100,507,695	(A)	12,857,358	(B)	212,510,060	0	21,050,353
28										
29	Customer Advances for Construction (Account 252)	WPB-6a	1,801,940	1,801,940		0		0	0	0
30										
31	Total Regulatory Liability - Excess Deferred Taxes (Acct 254)	Sch B-6	74,311,872	26,943,889		2,138,706	(B)	45,229,277	0	0
32										
33	Investment Tax Credits	Sch B-6	5,135,704	0		0		0	5,135,704	0
34	Total Deductions		1,651,001,213	367,753,442		22,290,617		1,234,771,097	5,135,704	21,050,353
35										
36	Net Original Cost Rate Base		2,098,664,140	589,659,134		143,090,527		1,391,229,749	(4,264,917)	(21,050,353)
37										
38	Jurisdictional Rate Base Ratio		100.000%	28.097%		6.818%		66.291%	-0.203%	-1.003%
39										
40	Jurisdictional Rate Base Ratio - Excluding Non-Jurisdictional		100.000%	29.767%				70.233%		

Notes:
(A) Adjusted for non-jurisdictional gas plant.
(B) Staff-DR-01-015, page 4.
(C) Company records.

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
RECONCILIATION OF CAPITALIZATION AND RATE BASE
AS OF AUGUST 31, 2025

STAFF-DR-01-022
PAGE 4 OF 5
WITNESS RESPONSIBLE:
J. P. BROWN

LINE NO.	Description	WPB-6a	Allocation % (A)	To Be Eliminated (Col. 1 * Col. 2)
		(1)	(2)	(3)
1	Investment tax Credit - 3%	0	19.23%	0
2				
3	Liberalized Depreciation	(70,566,518)	19.23%	(13,569,941)
4				
5	Excess Deferred Taxes	(28,784,740)	7.43%	(2,138,706)

(A) Source: STAFF-DR-01-22, page 5 of 5.

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2025-00125
RECONCILIATION OF CAPITALIZATION AND RATE BASE
COMPUTATION OF RATIO OF PLANT DEVOTED TO OTHER THAN
DE-KENTUCKY CUSTOMERS & EXCLUDED RIDER PMM TO TOTAL PLANT FOR ELIMINATION PURPOSES
AS OF AUGUST 31, 2025

STAFF-DR-01-022
PAGE 5 OF 5
WITNESS RESPONSIBLE:
J. P. BROWN

Line No.	Description		Amount (1)
1	Total Net Gas Plant before Adjustments		
2	of Facilities Devoted to Other	Original Cost	$ 1,066,714,661
3	Than DE-Kentucky Customers & Rider PMM	Accum Depr.	245,794,471
4		Net Plant	$ 820,920,190
5			
6	Total Net Gas Plant Devoted to	Original Cost	$ 165,179,329
7	Other Than DE-Kentucky Customers & exclud. Rider PMM	Accum Depr.	7,294,553
8		Net Plant	$ 157,884,776
9			
10			
11	Ratio of Plant Devoted to Other Than		
12	DE-Kentucky Customers & Excluded Rider PMM to Total Plant	(Line 8 / Line 4)	19.23%
13			
14			
15			
16			
17	Total Net Gas Plant before Adjustment		
18	of Facilities Devoted to Other	Original Cost	$ 1,066,714,661
19	Than DE-Kentucky Customers	Accum Depr.	245,794,471
20		Net Plant	$ 820,920,190
21			
22	Total Net Gas Plant Devoted to	Original Cost	$ 66,930,941
23	Other Than DE-Kentucky Customers	Accum Depr.	5,923,765
24		Net Plant	$ 61,007,176
25			
26			
27	Ratio of Plant Devoted to Other Than		
28	DE-Kentucky Customers to Total Plant	(Line 24/ Line 20)	7.43%

(1) Company Records.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-023

REQUEST:

Provide the information shown in Schedule G for each construction project in progress, or planned to be in progress, during the 12 months preceding the base period, the base period, and the forecasted test period.

RESPONSE:

Please see STAFF-DR-01-023 Attachment 1 for information as of August 31, 2024.

Please see STAFF-DR-01-023 Attachment 2 for information as of August 31, 2025.

Please see STAFF-DR-01-023 Attachment 3 for information as of December 31, 2026.

Please note the company's construction forecasting is performed at a summarized level; therefore, the same level of detail is not available for future periods as historical periods.

As outlined on Schedule B-1, the Company is not requesting to include recovery of CWIP in base rates.

PERSON RESPONSIBLE: Sharif S. Mitchell – a.
Claire C. Hudson – b., c.

DUKE ENERGY KENTUCKY
CASE NO. 2025-00125
CONSTRUCTION PROJECTS
AS OF AUGUST 31, 2024

SCHEDULE G

Line No. (A)	Project No. (B)	Description of Project (C)	Accumulated Costs				Estimated Physical Percent Complete
			Construction Amount (D)	AFUDC Capitalized (E)	Indirect Costs Other (F)	Total Cost (G=D+E+F)	
1	04000156	04000156 - DEE EAM NEXTGEN GIS	356,233	7,304	26,995	390,532	Various
2	107GASCK	107GASCK - GAS CAPITAL OVERHEAD	41,576,128	-	(38,235,844)	3,340,284	Various
3	315986HW6	315986HW6 - CUSTOMER CONNECT- HARDWARE PROJ 4	(6,243)	599	5,646	2	Various
4	315986HW7	315986HW7 - CUSTOMER CONNECT - HARDWARE PROJ 5	(2,505)	294	2,216	5	Various
5	315986HW8	315986HW8 - CUSTOMER CONNECT- HARDWARE PROJ 6	(3,479)	284	3,183	(12)	Various
6	344598001	344598001 - DUKE CUSTOMER IVR REPLACEMENT	(19,912)	3,505	17,422	1,016	Various
7	349472021	349472021 - FMA ENHANCEMENTS	8,837	834	77	9,748	Various
8	349472028	349472028 - NEW FMA ENHANCEMENTS	17,393	951	1,133	19,477	Various
9	349472029	349472029 - MAXIMO INTEGRATIONS AND OTHER ENHAN	29,179	1,454	2,237	32,871	Various
10	349472032	349472032 - EAM - ARGUS ENHANCEMENTS	5,460	126	1,009	6,595	Various
11	349472033	349472033 - EAM MOBILEMAX & LIGHTING SUPPORT	8,029	107	325	8,460	Various
12	349472034	349472034 - EAM DATA PRODUCTS MADE	2,676	70	928	3,675	Various
13	400055029	400055029 - IVR VOICE AUTHENTICATION	53,292	3,081	989	57,363	Various
14	400055030	400055030 - SAP & BUSINESS CUSTOMER WEB PORTAL	25,984	728	9,902	36,613	Various
15	400055031	400055031 - D-E.COM/MY ACCOUNT WEB	10,535	364	3,596	14,494	Various
16	400055032	400055032 - CUSTOMER - MOBILE APPLICATION	36,193	1,288	9,800	47,280	Various
17	400055038	400055038 - CONTACT CENTER PLATFORM MODERNIZATI	8,318	-	4,342	12,660	Various
18	400055039	400055039 - NUANCE LICENSES	21,583	192	-	21,775	Various
19	400055040	400055040 - MODERN CUSTOMER AUTHENTICATION	912	-	200	1,112	Various
20	400055041	400055041 - NEW MYACCOUNT PLATFORM	6,457	-	1,562	8,019	Various
21	400109M	400109M - MY ACCOUNT MODERNIZATION	7,025	683	7,331	15,039	Various
22	400149HW2	400149HW2 - ESCA - ITOT CYBER CARBON BLACK HW	1,506	71	372	1,949	Various
23	400149SW2	400149SW2 - ESCA - ITOT CYBER CARBON BLACK SW	1,435	44	155	1,635	Various
24	400154001	400154001 - MIDWEST GAS UPLIFT - KENTUCKY	39,633	560	3,427	43,619	Various
25	400161002	400161002 - CISCO LICENSE SPA 2024	25,766	119	-	25,885	Various
26	43848219	43848219 - LAND - CHARTER - PATTY LN	2,466	120	716	3,302	Various
27	AW0938	AW0938 - HMI WORK STATION ERLANGER	2,216	855	(4,808)	(1,737)	Various
28	AW3186	AW3186 - STA 0948 THIRD & CRESCENT	550,429	34,957	47,800	633,187	Various
29	AW3192	AW3192 - STA 0941 GUBSER MILL	465,141	59,754	77,978	602,872	Various
30	AW3224	AW3224 - REG 0427 EMPIRE DR	723,404	96,679	93,496	913,579	Various
31	AW3227	AW3227 - STA 0949 DAYTON VALVE HOUSE	1,261,629	159,005	73,169	1,493,804	Various
32	AW3230	AW3230 - STA 0948 THIRD & CRESCENT LAND	49,716	3,616	1,256	54,589	Various
33	AW3246	AW3246 - REG 0427 EMPIRE DR LAND	74,886	10,915	14,329	100,129	Various
34	AW3250	AW3250 - STA 0949 DAYTON VALVE HOUSE LAND	23,173	1,205	2,232	26,610	Various
35	AW3690	AW3690 - STA 0941 GUBSER MILL LAND	41,874	4,927	3,583	50,384	Various
36	AW4685	AW4685 - LINE AM07 PIPELINE REPLACEMENT PHAS	26,850,501	937,749	3,220,513	31,008,763	Various
37	AW4691	AW4691 - CGI UPGRADE KENTUCKY	330,193	15,919	-	346,112	Various
38	AW4778	AW4778 - ROW - HARRIS PIKE UL45 EXT	119,654	11,663	31,900	163,217	Various
39	AW4796	AW4796 - HARRIS PIKE UL45 EXT - PRESSURE IMP	526,963	68,349	118,412	713,723	Various
40	AW5064	AW5064 - KENTUCKY - CORROSION REMEDIATION	177,391	22,251	38,106	237,747	Various
41	AW5957	AW5957 - CANCEL_LINE AM07 PHASE 2 - STATION	30,311	137,440	(122,025)	45,726	Various
42	AW6146	AW6146 - CANCEL_ROW LAKELAND PARK DR; LIM	3,167	296	985	4,448	Various
43	AW6387	AW6387 - LINE AM07 - PIPE REPLACEMENT - PH 3	2,075,419	73,604	413,491	2,562,514	Various
44	AW6388	AW6388 - LINE AM07 PHASE 3 - LAND	1,329,116	18,919	60,458	1,408,494	Various
45	AW6415	AW6415 - CANCEL-TBC ROW MEA-DECLARATION DR	4,903	480	1,357	6,739	Various
46	AW6482	AW6482 - CANCEL_LIS RD; CONSTANCE; 6" PL	3,238	136	802	4,176	Various
47	AW6483	AW6483 - CANCEL_CRESTVW HL; VILLA MADONNA DR	3,145	130	953	4,227	Various
48	AW6484	AW6484 - CANCEL_OLD LEXINGTON PIKE_RICHWOOD	488	20	167	675	Various
49	AW6694	AW6694 - CANCEL_ROW MEA - MANHATTAN BLVD-	2,144	95	530	2,770	Various
50	AW6846	AW6846 - KENTUCKY - CORROSION REMEDIATION	261,839	14,241	97,625	373,706	Various
51	AW7013	AW7013 - ROW - PIPELINE REPLACEMENT - PH2	264,960	13,893	55,389	334,243	Various
52	AW7772	AW7772 - LINE AM07 PHASE 3 - STATION	487,241	8,988	50,639	546,868	Various
53	AW78502	AW78502 - EMERGENCY CHARTER 24" AMO7 CUT OUT	118,224	476	40,511	159,210	Various
54	AW7866	AW7866 - LINE AM07 PHASE 4 - PIPE	309,140	5,893	46,160	361,192	Various
55	AW8410	AW8410 - OC-REG 0149 - ERLANGER M&R 149 UPGR	1,875,854	18,395	194,433	2,088,682	Various
56	CGRREPLA	CGRREPLA - CGR REPLACE DEK GAS	26,064	-	28,966	55,031	Various
57	G0224	G0224 - CANCEL STA 809 - WATERWORKS RD- STA	482	-	-	482	Various
58	GASKYIND	GASKYIND - INDIRECT POOL	823	-	-	823	Various
59	GCPBUDKY	GCPBUDKY - BUDGET ONLY - KENT GAS CAP	9,713	-	3,645	13,358	Various
60	GCTA30062	GCTA30062 - INTGO_PI SCADA DATA IMPLEMENTATION	(8,898)	-	(1,721)	(10,619)	Various
61	IT2200160	IT2200160 - NGBU-AI FRAMEWORK	(21,346)	6,152	36,811	21,617	Various
62	IT2200165	IT2200165 - NGBU TRACEABILITY PLATFORM	1,925	2,366	3,461	7,752	Various
63	IT2300096	IT2300096 - TIMP DATA INTEGRATION AND ALIGNMENT	1,291	25	603	1,919	Various
64	IT2300097	IT2300097 - TEMPORARY GAS ORDER ENTRY SYSTEM (T	7,357	86	423	7,865	Various
65	IT2300098	IT2300098 - MAJOR PROJECTS DIGITAL INSPECTION	2,304	43	431	2,778	Various
66	IT2300102	IT2300102 - GTIS 3-YEAR PLAN / EDI PLATFORM	53,796	1,650	3,066	58,512	Various
67	IT2300103	IT2300103 - NGBU DATA FABRICS BUILD	10,483	235	1,096	11,814	Various
68	IT2400006	IT2400006 - PCS INSPECTION TOOL REPLACEMENT	147	3	51	201	Various
69	IT2400022	IT2400022 - SAP CUSTOMER SYSTEM CHANGES	7,193	60	242	7,494	Various
70	IT2400024	IT2400024 - BEACON PLUME INVESTIGATION WORK	3,031	23	1,713	4,767	Various
71	KYWSREF24	KYWSREF24 - KY WORKSTATION REFRESH 2024	382,249	3,214	1,820	387,282	Various
72	LTHGIRFS	LTHGIRFS - LIGHTHOUSE: GAS IRIS	452,098	26,628	69,156	547,883	Various
73	LTHNGBUDP	LTHNGBUDP - LIGHTHOUSE INITIATIVE: NGBU	40,675	650	8,254	49,579	Various
74	MDTGAS20	MDTGAS20 - INSTALL WIN 7 PANASONIC TOUGHBOOKS	(39,116)	10,341	29,144	369	Various
75	MX0356982	MX0356982 - CHARTER-KYTC- 162.10 BRISTOW RD FRO	105,226	2,166	30,885	138,276	Various
76	MX1322454	MX1322454 - CHARTER-KYTC-162.40-BRISTOW RD-STI-	457,084	17,617	68,264	542,966	Various
77	MX1415972	MX1415972 - HOPEFUL CHURCH RD. PRI, FLORENCE 13	1,014,608	31,784	193,065	1,239,457	Various
78	MX2217622	MX2217622 - STATION 873 - 5TH & PHILADELPHIA	342,736	38,781	54,996	436,513	Various
79	MX2334412	MX2334412 - KYTC STI-SHORLAND RR XING-WALTON	4,353	90	2,013	6,457	Various
80	MX2532997	MX2532997 - CHARTER-RICHARD KNOCK HWY-PIMP-8" P	22,568	1,937	3,296	27,801	Various
81	MX2781786	MX2781786 - CANCEL_KYTC 19-9001 I-275 GRAVES RD	(22,644)	-	22,105	(539)	Various
82	MX3119117	MX3119117 - CARPENTER RD-MAE-2"PL-200'	4,237	68	1,045	5,351	Various
83	MX3471260	MX3471260 - DOLWICK DR - MAE - 4" PL - 275' - 1	1,692	7	557	2,256	Various
84	MX3584545	MX3584545 - NARROWS RD-STI-8"PL-2,145'	62,980	415	3,505	66,900	Various
85	MX3848219	MX3848219 - CHARTER - PATTY LN-RPL-2" & 4"PL-87	5,587	22	1,779	7,388	Various
86	MX4669122	MX4669122 - HEBRON LOOP PH 2 PRESSURE IMPROVEME	118,588	12,665	30,387	161,640	Various
87	MX6650945	MX6650945 - CHARTER-AMSTERDAM RD- VILLA HILLS-P	598,763	15,376	182,307	796,445	Various
88	MX7281845	MX7281845 - CANCEL -REG 0057 SARATOGA 11TH - OR	-	-	(60)	(60)	Various
89	MX8175168	MX8175168 - CANCEL BUTTERMILK PIKE STR IMPROV	(1)	-	-	(1)	Various
90	MX9219249	MX9219249 - RICHARDSON RD PRESSURE IMP 7300' OF	71,719	5,205	18,510	95,434	Various
91	OMGPCVNTN	OMGPCVNTN - MGP RESERVE - COVINGTON	225	-	-	225	Various
92	OMGPNWPRT	OMGPNWPRT - MGP RESERVE - NEWPORT	270	-	-	270	Various
93	PH2ASPAHW	PH2ASPAHW - ESCA-OT ASSET,PATCH & VULNERABILITY	1,330	43	387	1,761	Various
94	PH2ASPASW	PH2ASPASW - ESCA-OT ASSET,PATCH & VULNERABILITY	41,858	1,489	2,147	45,495	Various
95	R8822	R8822 - STA 10055288 WAITS & KELLOGG	161	-	16	177	Various
96	SG489SW	SG489SW - SG DEE OPENWAY AMI SCALE - 489	(4,147)	1,406	2,787	47	Various
97	SG781SW	SG781SW - SG DEE PPM PIMS PHASE 2 BUILD OUT	(3,153)	1,962	1,334	144	Various
98	T9338	T9338 - CANCEL STA 809 WATERWORKS DR - STA	2,511	548	276	3,335	Various
99	V8967	V8967 - ERLANGER MODULAR COMPLEX	(65,893)	8,126	54,969	(2,798)	Various

DUKE ENERGY KENTUCKY, INC.
Construction Projects

	As of August 31, 2025
Government Relocations	1,519,726
Measurement & Regulation	1,616,091
New Business	4,791,233
System Infrastructure - Harris Pike	2,133,249
System Infrastructure	1,299,321
Transmission Integrity Line AM07	36,829,988
Maintenance & Other	3,249,226
	51,438,834

DUKE ENERGY KENTUCKY, INC.
Construction Projects
End Bal: CWIP

	As of December 31, 2026
Government Relocations	1,251,280
Measurement & Regulation	(102,861)
New Business	6,325,382
System Infrastructure - Harris Pike	16,247,197
System Infrastructure	(2,490,751)
Transmission Integrity Line AM07	7,667,343
Maintenance & Other	7,947,044
	36,844,634

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-024

REQUEST:

Provide, in the format provided in Schedule H, an analysis of Duke Kentucky's Construction Work in Progress (CWIP) as defined in the Uniform System of Accounts for each project identified in Schedule G.

RESPONSE:

Please see STAFF-DR-01-024 Attachment for the requested information as of August 31, 2024. For the base period and forecasted test period this data is not available because our construction forecasting is performed at a summarized level, as noted in response to STAFF-DR-01-023.

As outlined on Schedule B-1, the Company is not requesting to include recovery of CWIP in base rates.

PERSON RESPONSIBLE: Claire C. Hudson
Sharif S. Mitchell

	DUKE ENERGY KENTUCKY							SCHEDULE H
	CASE NO. 2022-00125							
	CONSTRUCTION WORK IN PROGRESS - PERCENT COMPLETE							
	AS OF AUGUST 31, 2024							
Line No. (A)	Project No. (B)	Date Construction Work Began (C)	Estimated Project Completion Date (D)	Percent of Elapsed Time (E)	Original Budget Estimate (F)	Most Recent Budget Estimate (G)	Total Project Expenditures (H)	Percent of Total Expenditures (I) = (H/G)
1	04000156	1/1/2023	12/31/2026	42%	599,758	599,758	390,532	65%
2	107GASCK	7/1/2008	12/31/2050	38%	-	-	3,340,284	
3	315986HW6	3/1/2020	3/15/2021	100%	21,350	70,340	2	0%
4	315986HW7	4/1/2021	12/31/2021	100%	62,454	62,454	5	0%
5	315986HW8	10/1/2021	6/30/2022	100%	67,100	37,341	(12)	0%
6	344598001	4/1/2018	1/28/2020	100%	197,081	151,374	1,016	1%
7	349472021	6/1/2022	3/31/2026	59%	3,263	4,713	9,748	207%
8	349472028	4/1/2023	3/31/2026	47%	3,108	9,670	19,477	201%
9	349472029	4/1/2023	3/31/2026	47%	7,238	19,914	32,871	165%
10	349472032	2/1/2024	3/31/2026	27%	8,290	8,290	6,595	80%
11	349472033	1/1/2024	3/31/2026	30%	5,175	4,834	8,460	175%
12	349472034	2/1/2024	3/31/2026	27%	20,523	31,355	3,675	12%
13	400055029	10/1/2023	6/29/2025	53%	77,856	77,856	57,363	74%
14	400055030	11/1/2023	9/30/2025	43%	196,273	212,277	36,613	17%
15	400055031	11/1/2023	6/29/2025	50%	22,654	22,654	14,494	64%
16	400055032	11/1/2023	7/30/2025	48%	42,720	42,720	47,280	111%
17	400055038	5/1/2024	3/31/2026	17%	573,597	573,597	12,660	2%
18	400055039	7/1/2024	9/29/2024	68%	21,907	21,907	21,775	99%
19	400055040	6/1/2024	3/31/2026	14%	49,003	49,003	1,112	2%
20	400055041	6/1/2024	3/31/2026	14%	109,160	109,160	8,019	7%
21	400109M	6/1/2023	3/31/2025	68%	135,363	3,630	15,039	414%
22	400149HW2	8/1/2023	3/31/2026	41%	2,282	2,282	1,949	85%
23	400149SW2	1/1/2024	3/31/2026	30%	4,067	4,067	1,635	40%
24	400154001	1/1/2024	12/29/2025	33%	97,995	97,995	43,619	45%
25	400161002	6/1/2024	1/30/2025	37%	28,490	28,490	25,885	91%
26	43848219	7/1/2022	3/31/2026	58%	40,000	40,000	3,302	8%
27	AW0938	10/1/2019	3/2/2021	100%	64,259	108,082	(1,737)	-2%
28	AW3186	11/1/2021	11/27/2025	70%	948,400	948,400	633,187	67%
29	AW3192	9/1/2021	12/30/2025	69%	538,800	538,800	602,872	112%
30	AW3224	7/1/2021	10/30/2025	73%	732,000	732,000	913,579	125%
31	AW3227	11/1/2021	10/30/2025	71%	1,062,400	1,062,400	1,493,804	141%
32	AW3230	8/1/2021	11/27/2025	71%	82,500	82,500	54,589	66%
33	AW3246	4/1/2021	3/31/2026	68%	82,500	82,500	100,129	121%
34	AW3250	6/1/2021	11/29/2025	72%	82,500	82,500	26,610	32%
35	AW3690	6/1/2021	10/25/2025	74%	82,500	82,500	50,384	61%
36	AW4685	11/1/2021	2/28/2025	85%	33,015,500	45,768,732	31,008,763	68%
37	AW4691	12/1/2021	6/30/2022	100%	120,000	120,000	346,112	288%
38	AW4778	7/1/2022	11/30/2026	49%	926,800	926,800	163,217	18%
39	AW4796	2/1/2022	11/30/2026	53%	7,884,400	7,884,400	713,723	9%
40	AW5064	8/1/2022	9/30/2025	66%	272,000	272,000	237,747	87%
41	AW5957	10/1/2022	2/28/2025	79%	9,656,000	9,656,000	45,726	0%
42	AW6146	10/1/2022	12/31/2023	100%	25,000	25,000	4,448	18%
43	AW6387	1/1/2023	12/31/2025	56%	40,828,200	40,828,200	2,562,514	6%
44	AW6388	9/1/2023	12/31/2025	43%	4,060,000	4,060,000	1,408,494	35%
45	AW6415	1/1/2023	7/14/2023	100%	25,000	25,000	6,739	27%
46	AW6482	2/1/2023	8/25/2023	100%	25,000	25,000	4,176	17%
47	AW6483	2/1/2023	4/28/2023	100%	25,000	25,000	4,227	17%
48	AW6484	2/1/2023	10/13/2023	100%	25,000	25,000	675	3%
49	AW6694	3/1/2023	6/9/2023	100%	25,000	25,000	2,770	11%
50	AW6846	7/1/2023	9/30/2025	52%	180,000	180,000	373,706	208%
51	AW7013	9/1/2023	4/18/2025	61%	4,284,600	4,284,600	334,243	8%
52	AW7772	1/1/2024	12/31/2025	33%	4,905,200	4,905,200	546,868	11%
53	AW78502	8/1/2024	12/5/2024	24%	99,000	99,000	159,210	161%
54	AW7866	2/1/2024	3/30/2027	18%	60,559,700	60,559,700	361,192	1%
55	AW8410	7/1/2024	3/31/2026	10%	11,169,500	11,169,500	2,088,682	19%
56	CGRREPLA	4/1/2023	12/31/2050	5%	-	-	55,031	
57	G0224	8/1/2010	10/1/2018	100%	99	482	482	100%
58	GASKYIND	7/1/2008	12/31/2050	38%	-	-	823	
59	GCPBUDKY	5/1/2023	12/31/2050	5%	-	-	13,358	
60	GCTA30062	9/1/2017	10/30/2019	100%	133,026	133,026	(10,619)	-8%
61	IT2200160	1/1/2023	3/30/2027	39%	76,081	185,732	21,617	12%
62	IT2200165	1/1/2023	3/31/2026	51%	57,231	125,985	7,752	6%
63	IT2300096	1/1/2024	6/29/2026	27%	75,811	75,811	1,919	3%
64	IT2300097	3/1/2024	3/31/2025	46%	15,803	15,803	7,865	50%
65	IT2300098	1/1/2024	5/28/2025	47%	41,810	41,810	2,778	7%
66	IT2300102	1/1/2024	6/29/2026	27%	336,772	336,772	58,512	17%
67	IT2300103	2/1/2024	3/31/2027	18%	229,894	229,894	11,814	5%
68	IT2400006	2/1/2024	3/31/2025	50%	50,039	50,039	201	0%
69	IT2400022	5/1/2024	6/29/2025	29%	33,919	33,919	7,494	22%
70	IT2400024	6/1/2024	4/30/2025	27%	22,730	22,730	4,767	21%
71	KYWSREF24	6/1/2024	2/28/2026	14%	200,000	200,000	387,282	194%

72	LTHGIRFS	6/1/2020	3/1/2025	90%	-	218,641	547,883	251%
73	LTHNGBUDP	1/1/2024	2/28/2025	57%	91,438	91,438	49,579	54%
74	MDTGAS20	12/1/2019	3/31/2021	100%	403,995	403,995	369	0%
75	MX0356982	2/1/2024	2/5/2026	29%	278,045	278,045	138,276	50%
76	MX1322454	10/1/2022	10/29/2025	62%	786,870	1,018,418	542,966	53%
77	MX1415972	2/1/2023	6/26/2025	66%	2,073,615	4,037,204	1,239,457	31%
78	MX2217622	10/1/2017	11/30/2025	85%	87,907	87,907	436,513	497%
79	MX2334412	3/1/2024	11/6/2025	30%	-	-	6,457	
80	MX2532997	2/1/2024	6/26/2025	41%	143,363	190,970	27,801	15%
81	MX2781786	6/1/2021	11/22/2023	100%	70,083	50,204	(539)	-1%
82	MX3119117	5/1/2024	2/20/2025	41%	33,685	72,085	5,351	7%
83	MX3471260	8/1/2024	1/13/2025	18%	23,780	38,815	2,256	6%
84	MX3584545	6/1/2024	4/13/2025	29%	131,449	477,776	66,900	14%
85	MX3848219	5/1/2024	10/2/2025	24%	540,783	540,783	7,388	1%
86	MX4669122	3/1/2021	3/4/2027	58%	765	765	161,640	21120%
87	MX6650945	2/1/2023	2/27/2025	76%	251,700	1,114,429	796,445	71%
88	MX7281845	7/1/2020	3/31/2021	100%	44,954	5,000	(60)	-1%
89	MX8175168	11/1/2019	3/31/2021	100%	62,696	62,696	(1)	0%
90	MX9219249	11/1/2022	3/12/2026	55%	765	765	95,434	12470%
91	OMGPCVNTN	8/1/2012	12/31/2026	84%	-	-	225	
92	OMGPNWPRT	8/1/2012	3/31/2051	31%	-	-	270	
93	PH2ASPAHW	10/1/2023	3/31/2026	37%	3,196	3,196	1,761	55%
94	PH2ASPASW	9/1/2023	3/31/2026	39%	323,116	323,116	45,495	14%
95	R8822	5/1/2016	8/1/2017	100%	67,178	67,178	177	0%
96	SG489SW	11/1/2016	12/31/2018	100%	16,065	16,065	47	0%
97	SG781SW	7/1/2018	3/31/2021	100%	76,874	78,061	144	0%
98	T9338	9/1/2017	9/1/2018	100%	116,007	116,007	3,335	3%
99	V8967	6/1/2019	10/30/2020	100%	244,738	381,377	(2,798)	-1%

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-025

REQUEST:

Concerning Duke Kentucky's construction projects:

a. For each project started during the last five calendar years, provide the information requested in the format contained in Schedule I1. For each project, include the amount of any cost variance and delay encountered, and explain in detail the reasons for such variances and delays.

b. Using the data included in Schedule I1, calculate the annual "Slippage Factor" associated with those construction projects. The Slippage Factor should be calculated as shown in Schedule I2.

c. In determining the capital additions reflected in the base period and forecasted test period, explain whether Duke Kentucky recognized a Slippage Factor.

RESPONSE:

a. Please see STAFF-DR-01-025(a) Attachment for requested data associated with projects started during the last five calendar years (*i.e.*, projects started in 2020 and forward). Please note that the Company does not maintain annual budgets at the detailed project level.

b. Please see STAFF-DR-01-025(b) Attachment. The slippage factor is calculated by comparing actual annual capital spend to budgeted annual capital spend for the electric operations of Duke Energy Kentucky, regardless of the year the project started.

c. Duke Energy Kentucky did not recognize a Slippage Factor for capital additions in either the base period or forecasted test period. Duke Energy Kentucky intends that the dollars budgeted for capital construction projects will be spent in the year budgeted and this is supported by the 5-year average slippage factor calculation.

PERSON RESPONSIBLE: Sharif S. Mitchell – a.
Claire C. Hudson – b., c.

Duke Energy Kentucky Natural Gas
Year 2020

Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	FARCOSSW	ARCOS21	ARCOS21 - ARCOS RENEWAL	59,327		59,327			$ 59,327	59,327	(0)	12/17/2020	9/30/2021	12/1/2020	4/25/2021
75086	FENABLES	MOBS	MOBS - ENABLE MOBILITY SOFTWARE	(6)		(6)			$ 729,170	649,497	79,673	3/30/2015	10/31/2017	5/1/2015	11/7/2017
75086	FMDT2017	MDTKE17	MDTKE17 - CF53 PURCHASES FOR MDT REPLAC	275		275			$ 30,923	33,851	(2,928)	2/7/2018	6/1/2020	2/1/2018	5/1/2020
75086	FMDT2020	MDTGAS20	MDTGAS20 - INSTALL WIN 7 PANASONIC TOUGHBOOKS	160,649		160,649			$ 464,844	403,995	60,849	10/10/2019	3/31/2021	12/1/2019	3/31/2021
75086	FP647	V5213	V5213 - AM07 CASING REM 647 ERLANGER RD	39,887		39,887			$ 114,175	115,207	(1,032)	8/22/2018	3/30/2019	9/1/2018	11/23/2018
75086	FPIT	338802003	338802003 - EAM PLATFORM OPTIMIZATION	485		485			$ 40,925	147,321	(106,396)	4/25/2018	5/30/2020	6/1/2018	3/31/2020
75086	FPIT	338802004	338802004 - MOBILE DURABLE TEAM	26,077		26,077			$ 127,364	52,783	74,581	9/17/2018	5/28/2020	10/1/2018	5/28/2020
75086	FPIT	338802005	338802005 - MAXIMO DURABLE TEAM	2,416		2,416			$ 163,191	33,459	129,732	9/13/2018	5/28/2020	10/1/2018	5/28/2020
75086	FPIT	338802006	338802006 - SMALLWORLD/MYWORLD DURABLE TEAM	(333)		(333)			$ 11	48,911	(48,900)	9/6/2018	5/28/2020	10/1/2018	11/10/2020
75086	FPIT	338802008	338802008 - ECOSYS DURABLE TEAM ACCIUNTING	(431)		(431)			$ 1,197	52,026	(50,829)	9/13/2018	3/30/2020	9/1/2018	3/30/2020
75086	FPIT	338802HW3	338802HW3 - EAM PLATFORM OPTIMIZATION	4		4			$ 4	59,872	(59,868)	4/25/2018	10/31/2019	7/1/2020	3/31/2020
75086	FPIT	349472HW1	349472HW1 - MULTI-INSTANCE OF SERVICE SUITE	5,096		5,096			$ 5,096	13,125	(8,029)	3/6/2020	11/29/2020	3/1/2020	11/29/2020
75086	FPIT	349472SW1	349472SW1 - MULTI-INSTANCE OF SERVICE SUITE	17,547		17,547			$ 17,547	36,419	(18,872)	3/6/2020	11/29/2020	3/1/2020	11/29/2020
75086	FPIT	359990001	359990001 - FIELD TEST EQUIPMENT CALIBRATION SO	439		439			$ 67,644	60,858	6,786	2/26/2019	12/29/2019	3/1/2019	12/1/2019
75086	FPIT	CC2000001	CC2000001 - NGBU COMMUNICATIONS PLATFORM	24,951		24,951			$ 24,951	1,242,489	(1,217,538)	3/30/2020	3/31/2022	4/1/2020	3/31/2022
75086	FPIT	GCTA30060	GCTA30060 - CONSOLIDATED SCADA APP ANALYSIS	54,018		54,018			$ 277,625	149,205	128,420	4/11/2017	6/30/2020	4/1/2017	6/30/2020
75086	FPIT	GCTA3006K	GCTA3006K - INTGO_PI SCADA DATA IMPLEMENTATION	992		992			$ 89,187	133,026	(43,839)	11/15/2019	3/17/2022	11/1/2019	3/1/2022
75086	FPIT	GCTA30073	GCTA30073 - PROJECT 2 GAS SUPPLY SYSTEM	57,554		57,554			$ 742,884	853,149	(110,265)	3/30/2017	3/31/2021	7/1/2017	3/31/2021
75086	FPIT	GCTA30114	GCTA30114 - SALES FORCE AUTOMATION CONSO STRATE	54,387		54,387			$ 263,901	-	263,901	6/21/2017	11/30/2020	10/1/2017	11/10/2020
75086	FPIT	GCTA30391	GCTA30391 - INTGO_GAS MAJOR PROJECTS MGMT	59,028		59,028			$ 83,440	224,469	(141,029)	12/18/2018	12/30/2020	1/1/2019	12/31/2020
75086	FPIT	GCTA30436	GCTA30436 - INTGO_GAS SCADA CONSOLIDATION PROGR	(733)		(733)			$ 607,214	513,619	93,595	5/21/2018	12/29/2019	6/1/2018	12/1/2019
75086	FPIT	GCTA33039	GCTA33039 - INTGO_CONSOLIDATED CAD TOOLS	51		51			$ 56,440	120,205	(63,765)	6/19/2018	9/24/2020	8/1/2018	3/31/2020
75086	FPIT	GCTA47001	GCTA47001 - INTGO_MATERIALS TRACEABILITY	57,724		57,724			$ 101,558	120,205	(18,647)	12/6/2018	3/31/2022	1/1/2019	5/31/2020
75086	FPIT	GCTA4700B	GCTA4700B - INTGO_TRACEABILITY FORM FDC	23,696		23,696			$ 105,920	215,691	(109,771)	12/6/2018	3/31/2021	12/1/2018	3/14/2021
75086	FPIT	IT1900021	IT1900021 - GIS ALIGNMENT FOR PCS - MIDWEST	120,582		120,582			$ 237,430	485,841	(248,411)	8/1/2019	1/31/2021	9/1/2019	1/17/2021
75086	FPIT	IT1900065	IT1900065 - GDPM PHASE 2	69,069		69,069			$ 69,069	87,832	(18,763)	2/7/2020	3/31/2021	2/1/2020	3/31/2021
75086	FPIT	IT1900067	IT1900067 - ARM TO MAXIMO INTEGRATION	1,053		1,053			$ 1,053	-	1,053	10/12/2020	7/31/2021	10/1/2020	7/27/2021
75086	FPIT	IT1900069	IT1900069 - TRG - WAM MEASUREMENT PROJECT	27,545		27,545			$ 27,545	65,041	(37,496)	2/21/2020	12/31/2021	3/1/2020	
75086	FPIT	IT1900073	IT1900073 - EAM 2020 MOBILE DURABLE TEAM	73,237		73,237			$ 73,237	36,572	36,665	1/20/2020	5/30/2021	1/1/2020	6/8/2021
75086	FPIT	IT1900074	IT1900074 - EAM 2020 MAXIMO DURABLE TEAM	184,717		184,717			$ 184,717	229,288	(44,571)	1/20/2020	5/30/2021	1/1/2020	6/8/2021
75086	FPIT	LTHWOOPS	LTHWOOPS - LIGHTHOUSE:WO OPTIMIZATION GAS- SW	(3,270)		(3,270)			$ 28,418	24,900	3,518	3/12/2019	12/29/2019	3/1/2019	9/30/2019
75086	FPIT	V5136	V5136 - COMMUNICATION RADIO INSTALL	240		240			$ 27,590	23,120	4,470	8/20/2018	12/31/2018	8/1/2018	7/31/2019
75086	FUNCTOHKY	107GASCK	107GASCK - GAS CAPITAL OVERHEAD	316,383		316,383			$ 531,208	-	531,208	7/1/2008	12/31/2050	7/1/2008	
75086	G71373	AW0856	AW0856 - 1373 US 27 BRIDGE ATTACHMENT	(3,554)		(3,554)			$ 67,521	91,770	(24,249)	7/30/2019	2/25/2020	11/1/2019	3/30/2020
75086	G7237BEAV	MX7783733	MX7783733 - BEAVER RD INSTALL REPLACEMENT PROJE	15,891		15,891			$ 15,891	48,085	(32,194)	8/17/2020	10/30/2020	8/1/2020	1/10/2021
75086	G73701	V8405	V8405 - BRIDGE ATTACH 3701 NARROWS RD	(508)		(508)			$ 12,718	11,496	1,222	2/18/2019	2/25/2020	9/1/2019	12/18/2019
75086	G73MILES	T1437	T1437 - STA 249: THREE MILE RD	11,898,464		11,898,464			$ 25,443,362	15,406,228	10,037,134	1/5/2017	8/28/2020	1/1/2017	9/15/2020
75086	G73MILES	T1437LAND	T1437LAND - 3 MILE STATION (LAND)	17,707		17,707			$ 20,326	40,000	(19,674)	6/22/2018	7/28/2020	9/1/2018	9/15/2020
75086	G73MILES	T4422	T4422 - AM07 BARLEYCORNS	(3,189)		(3,189)			$ 218,356	190,195	28,161	3/22/2017	7/28/2020	4/1/2017	12/1/2019
75086	G7AM07CUT	AW1330	AW1330 - AM07 CUTOUT FIDELITY	1,298,962		1,298,962			$ 1,607,710	1,236,780	370,930	10/23/2019	12/30/2019	10/1/2019	2/2/2020
75086	G7AM07DIG	V8815	V8815 - LINE AM07 INTEGRITY DIGS	63,305		63,305			$ 1,306,990	923,350	383,640	4/2/2019	12/30/2019	6/1/2019	12/31/2019
75086	G7AM07ILI	0233100	0233100 - LINE AM07 PIPELINE REPLACEMENT PHAS	1,433		1,433			$ 1,433	37,717,000	(37,715,567)	12/9/2020	12/31/2023	12/1/2020	3/18/2024
75086	G7ASDD	MX5515912	MX5515912 - AMAZON SOUTHWEST DELIVERY DIST. PRO	56,388		56,388			$ 56,388	307,485	(251,097)	4/16/2020	10/11/2020	5/1/2020	4/4/2021
75086	G7ASRP	CMSP70	CMSP70 - ASRP CURB TO METER 3" OR LESS	8,101		8,101			$ 8,879,433	20,388,002	(11,508,569)	3/4/2015	12/31/2019	7/1/2015	
75086	G7ASRP	LCMSP70	LCMSP70 - ASRP GREATER THAN 2" C-M INSTALL	74,283		74,283			$ (184,759)	10,000,000	(10,184,759)	1/13/2016	12/31/2019	7/1/2016	
75086	G7ASRP	MCSP70	MCSP70 - ASRP MAIN TO CURB 3" OR LESS	670,517		670,517			$ 41,392,311	19,954,384	21,437,927	3/4/2015	12/31/2019	7/1/2015	
75086	G7CAS106	V7737	V7737 - CASING#106 AM07 & MARTHA LAYNE	(187,024)		(187,024)			$ 1,989,733	1,749,344	240,389	11/28/2018	12/30/2019	12/1/2018	1/23/2020
75086	G7CAS106	V7738	V7738 - CASING#106 AM07 & MARTHA LAYNE(LAND	16,857		16,857			$ 113,350	10,000	103,350	11/28/2018	12/30/2019	1/1/2019	1/23/2020
75086	G7CAS112	V4266	V4266 - CASING 112 LINE AM07	9,734		9,734			$ 263,443	257,083	6,360	8/2/2018	12/30/2018	8/1/2018	1/22/2019
75086	G7CAS22	V4278	V4278 - CASING 22 LINE AM07	9,638		9,638			$ 251,559	311,445	(59,886)	8/2/2018	12/30/2018	8/1/2018	1/1/2019
75086	G7CAS42	V7739	V7739 - CASING#42 ABANDON- AM07 & HULBERT	(16,774)		(16,774)			$ 1,698,134	1,939,294	(241,160)	11/28/2018	11/30/2019	12/1/2018	11/15/2019
75086	G7CAS49	V7902	V7902 - CASING #49 ABANDON - AM07 & I-75	354,156		354,156			$ 7,336,064	6,131,715	1,204,349	12/14/2018	2/28/2020	1/1/2019	2/23/2020
75086	G7CAS53	V5417	V5417 - CASING 53 LINE AM07	2,349		2,349			$ 88,814	409,578	(320,764)	8/29/2018	12/30/2018	10/1/2018	3/1/2019
75086	G7CAS717	V7904	V7904 - CASING #717 LINE AM07 -US RT 50	9,389		9,389			$ 410,519	2,072,166	(1,661,647)	12/14/2018	7/25/2019	1/1/2019	8/21/2019
75086	G7CAS717	V8640	V8640 - CASING #717 LINEAM074-USRT50 LAND	11,229		11,229			$ 11,229	15,000	(3,771)	3/14/2019	9/25/2020	2/1/2020	8/21/2019
75086	G7ECOMPLX	V8967	V8967 - ERLANGER MODULAR COMPLEX	185,878		185,878			$ 206,915	244,738	(37,823)	4/17/2019	10/30/2020	6/1/2019	1/30/2022
75086	G7EPROPAN	V9131	V9131 - ERLANGER OPP	11,124		11,124			$ 323,088	954,131	(631,043)	5/3/2019	3/30/2020	8/1/2019	10/31/2020
75086	G7EQUIP	V8884	V8884 - KET NGBU EQUIPMENT	15,878		15,878			$ 33,333	150,768	(117,435)	4/11/2019	3/30/2020	6/1/2019	2/29/2020
75086	G7ERLCP	AW1656	AW1656 - ERLANGER MAG ANODES	485,979		485,979			$ 485,979	2,442,882	(1,956,903)	1/21/2020	12/31/2026	4/1/2020	
75086	G7ERLCP19	V9157	V9157 - 2019 ERLANGER OPS MAG ANODES	39,695		39,695			$ 390,344	350,812	39,533	5/8/2019	7/30/2020	5/1/2019	9/8/2020
75086	G7ERLREC	AW1547	AW1547 - ERLANGER RECTIFIER REMOTE MONITOR I	56,424		56,424			$ 56,424	60,320	(3,897)	12/11/2019	12/31/2020	2/1/2020	9/8/2020
75086	G7EUL06	V5625	V5625 - ECDA LINE UL06	25,761		25,761			$ 327,140	494,420	(167,280)	9/10/2018	3/30/2019	10/1/2018	3/17/2019
75086	G7EUL47	V6391	V6391 - LINE UL47 SCHEDULED DIGS	957		957			$ 989,423	724,400	265,023	10/10/2018	3/30/2019	10/1/2018	3/14/2019
75086	G7FRAME	G9421	G9421 - FRAME RELAY KENTUCKY	(1,001)		(1,001)			$ 47,575	190,203	(142,628)	2/1/2013	6/30/2014	2/1/2013	12/1/2014
75086	G7HMISTAT	AW0938	AW0938 - HMI WORK STATION ERLANGER	83,933		83,933			$ 88,911	64,259	24,652	8/9/2019	3/2/2021	10/1/2019	8/15/2021
75086	G7IMPRPL	MX1996777	MX1996777 - AM07 EXPOSURE-HORSEBRANCH RD. SEGME	(14,795)		(14,795)			$ 797,515	436,475	361,040	9/11/2017	7/31/2019	10/1/2017	9/10/2019
75086	G7IMPRPL	R0978	R0978 - AM07 PRESSURE TEST WP18	(1,848)		(1,848)			$ 2,871,251	105,162	2,766,090	7/6/2015	1/1/2018	9/1/2015	10/8/2017
75086	G7IMPRPL	R0981	R0981 - WP23 "AM07" PRESSURE TEST	140		140			$ 841,318	98,207	743,111	7/6/2015	2/28/2017	2/1/2016	10/20/2016
75086	G7IMPRPL	R4858	R4858 - AM-09 SEGMENT 3700 MAIN RPL	3,692		3,692			$ 1,573,982	367,589	1,206,393	12/2/2015	12/15/2016	12/1/2015	2/1/2017
75086	G7INTDIG	AW2017	AW2017 - LINE UL06 INTEGRITY DIGS	1,388,558		1,388,558			$ 1,388,558	2,024,700	(636,142)	4/9/2020	1/30/2021	4/1/2020	1/5/2021
75086	G7INTDIG	AW2018	AW2018 - LINE UL47 INTEGRITY DIGS	837,382		837,382			$ 837,382	748,000	89,382	4/9/2020	1/30/2021	4/1/2020	10/9/2020
75086	G7LGMR	B8625	B8625 - REG-9 IMPROVEMENTS/CWA	(848)		(848)			$ (848)	-	(848)	7/11/2004	12/31/2050	8/1/2004	1/14/2006
75086	G7LGMR	D3747	D3747 - REG 112K-WATERWORKS/CWA	(5,400)		(5,400)			$ 32,562	-	32,562	6/26/2008	12/31/2050	7/1/2008	3/31/2009
75086	G7LGMR	E0472	E0472 - STA 795 SANDMAN DR	(1,140)		(1,140)			$ 71,391	71,874	(483)	8/12/2008	12/31/2050	9/1/2008	1/15/2009
75086	G7LGMR	E4533	E4533 - REG 111K - 5TH & CRAIG	(856)		(856)			$ 94,852	103,681	(8,829)	2/24/2009	2/23/2014	3/1/2009	3/8/2010
75086	G7LGMR	E4592	E4592 - REG 108K - HWY & DAVID	(3,472)		(3,472)			$ 55,609	96,097	(40,488)	2/27/2009	2/24/2014	4/1/2009	1/28/2010
75086	G7LGMR	F2907	F2907 - STA 804 LOOKAWAY DRIVE	9,841		9,841			$ 68,370	39,821	28,549	12/9/2009	6/30/2012	12/1/2009	6/24/2011
75086	G7LGMR	G0224	G0224 - STA 809 - WATERWORKS RD- STATION	(5,657)		(5,657)			$ 482	99	383	7/7/2010	10/1/2018	8/1/2010	
75086	G7LGMR	G2537	G2537 - RPL SCADA RADIO EQUIP KY	(12,437)		(12,437)			$ 267,111	120,750	146,361	3/4/2011	7/31/2014	3/1/2011	3/15/2013
75086	G7LGMR	G6976	G6976 - CONCRETE STAIRWELL RPL	(834)		(834)			$ 13,127	18,898	(5,771)	3/7/2012	3/10/2013	7/1/2012	11/1/2012
75086	G7LGMR	H0264	H0264 - REG 118K INLET & OUTLET PIPING	(812)		(812)			$ 79,429	48,939	30,490	6/14/2013	6/30/2016	10/1/2014	1/25/2016
75086	G7LGMR	H0350	H0350 - STA 535K1 (UL33 TO HP) MODIFICATION	(693)		(693)			$ 22,604	19,578	3,027	7/2/2013	6/30/2015	11/1/2013	2/20/2015

Duke Energy Kentucky Natural Gas
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Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	G7LGMR	MX0573301	MX0573301 - REG 17 - FOOTE & FAIRFIELD DOWNSIZE	(248)		(248)			$ 10,612	31,486	(20,874)	11/19/2018	2/28/2019	4/1/2019	7/19/2019
75086	G7LGMR	MX0573477	MX0573477 - REG 95 - BAUM & BURNET DOWNSIZE	(231)		(231)			$ 9,541	26,609	(17,068)	11/19/2018	2/28/2019	4/1/2019	7/11/2019
75086	G7LGMR	MX0671045	MX0671045 - REG 101 - COVERT RUN & TAYLOR	(2,344)		(2,344)			$ 167,976	81,443	86,534	12/6/2018	8/30/2019	3/1/2019	10/27/2019
75086	G7LGMR	MX2218039	MX2218039 - INSTALL SCADA EQ-THREE MILE RD STA	322,616		322,616			$ 548,543	411,228	137,315	9/21/2017	7/10/2020	10/1/2017	9/15/2020
75086	G7LGMR	MX2335804	MX2335804 - STA 872 - OAKLAND VALVE HOUSE	538,294		538,294			$ 13,791,597	4,268,943	9,522,655	10/6/2017	8/15/2019	11/1/2017	9/19/2019
75086	G7LGMR	MX2386654	MX2386654 - STA 901 - MARY GRUBBS	(7,702)		(7,702)			$ 310,586	357,835	(47,249)	6/24/2019	10/31/2019	6/1/2019	2/19/2020
75086	G7LGMR	MX6693835	MX6693835 - REGULATOR 412 - 9TH & OVERTON	21,619		21,619			$ 59,231	106,314	(47,083)	12/15/2017	3/31/2021	2/1/2018	
75086	G7LGMR	MX6828172	MX6828172 - REG 420 BELAIR AND SPICEWOOD	573		573			$ 29,054	139,842	(110,788)	4/4/2018	3/31/2021	1/1/2019	
75086	G7LGMR	MX8672523	MX8672523 - REG 119 BRISTOW AND RICHARDSON	134		134			$ 40,674	262,006	(221,332)	3/21/2019	8/31/2020	5/1/2019	
75086	G7LGMR	R2900	R2900 - COX RD STATION RPL	(828)		(828)			$ 29,571	171,480	(141,910)	9/10/2015	8/1/2017	2/1/2016	4/11/2017
75086	G7LGMR	R3460	R3460 - STATION 577 (KY-17 & US-27)	(15,060)		(15,060)			$ 222,105	79,638	142,467	10/5/2015	6/15/2016	10/1/2015	3/17/2016
75086	G7LGMR	S7568	S7568 - STA 822 COX RD OUTLET	(423)		(423)			$ 29,416	25,055	4,361	6/8/2016	8/1/2017	8/1/2016	4/11/2017
75086	G7LGMR	S7572	S7572 - STA 822 COX RD INLET	(960)		(960)			$ 66,835	25,055	41,780	6/8/2016	8/1/2017	8/1/2016	4/11/2017
75086	G7LGMR	T1465	T1465 - STA 855 TAYLOR MILL RD - STATION	(2,296)		(2,296)			$ 202,527	83,247	119,280	1/6/2017	4/19/2018	3/1/2017	4/24/2018
75086	G7LGMR	T5473	T5473 - SCAD 21012299 PRESSURE TRANSMIITTER	5,764		5,764			$ 56,269	91,501	(35,232)	3/31/2017	12/1/2018	6/1/2017	9/30/2017
75086	G7LGMR	T9338	T9338 - STA 809 WATERWORKS DR - STATION	(482)		(482)			$ 3,335	116,007	(112,672)	7/14/2017	9/1/2018	9/1/2017	
75086	G7LNLP03	V5652	V5652 - LINE LP03	11		11			$ 886,878	1,325,999	(439,121)	9/11/2018	2/28/2019	10/1/2018	2/15/2019
75086	G7LNUL57	AW0832	AW0832 - LINE UL57 MONOLITHIC INSULATORS	1,026,789		1,026,789			$ 1,026,789	564,646	462,143	7/26/2019	12/25/2020	3/1/2020	12/3/2020
75086	G7LP3	LP3LAND	LP3LAND - CANCEL EMERGENCY LINE LP-3 (LAND)	(11)		(11)			$ -	110,000	(110,000)	6/22/2018	11/30/2018	12/1/2018	11/29/2018
75086	G7LUL02	AW2880	AW2880 - LINE UL02 - MAOP REPLACEMENT	21,358		21,358			$ 21,358	1,717,200	(1,695,842)	10/7/2020	3/31/2022	10/1/2020	1/5/2022
75086	G7MAINS	E0469	E0469 - STA 795 INLET PIPING	(242)		(242)			$ 6,363	6,569	(206)	8/12/2008	12/31/2050	9/1/2008	1/15/2009
75086	G7MAINS	MEAPJT70	MEAPJT70 - JOINT TRENCH PLASITC MAIN EXTENSION	785,143		785,143			$ 3,750,563	10,000,000	(6,249,437)	1/13/2016	12/31/2050	2/1/2016	
75086	G7MAINS	MX0270903	MX0270903 - FARM TAP PROJ. 3 MILE RD	6,486		6,486			$ 414,221	365,845	48,377	3/21/2019	10/19/2019	4/1/2019	12/21/2019
75086	G7MAINS	MX0556249	MX0556249 - FARM TAP PROJ; CALIFORNIA CROSSROAD	3,083		3,083			$ 277,359	123,394	153,965	1/14/2019	10/24/2019	5/1/2019	1/3/2020
75086	G7MAINS	MX0579746	MX0579746 - JT-G-RIVERS POINTE ESTATES PHASE 1	25,270		25,270			$ 25,270	109,259	(83,989)	3/9/2020	9/24/2020	11/1/2020	6/13/2021
75086	G7MAINS	MX0590999	MX0590999 - FARM TAP; E LOW GAP RD ALEXANDRIA	58,283		58,283			$ 372,791	359,351	13,441	7/31/2019	10/19/2022	8/1/2019	5/21/2020
75086	G7MAINS	MX0602140	MX0602140 - FARM TAP PROJ; ENZWEILER RD	7,227		7,227			$ 7,227	83,366	(76,139)	9/1/2020	10/17/2021	9/1/2020	10/6/2021
75086	G7MAINS	MX0602571	MX0602571 - FARM TAP PROJ; JOHNS HILL RD	232		232			$ 16,055	112,221	(96,166)	7/16/2019	12/12/2019	7/1/2019	6/2/2020
75086	G7MAINS	MX1130180	MX1130180 - FARM TAP PROJ; MARTHA LAYNE COLLINS	940		940			$ 74,540	62,901	11,639	2/7/2019	4/3/2019	3/1/2019	3/17/2020
75086	G7MAINS	MX1296075	MX1296075 - INSTALL GAS ONLY APPROACH MAIN - NE	3,331		3,331			$ 41,780	73,555	(31,775)	7/24/2019	1/19/2020	8/1/2019	3/13/2020
75086	G7MAINS	MX1304901	MX1304901 - FARM TAP PROJ; WAGONER RD CALIFORNI	2,255		2,255			$ 35,106	46,479	(11,374)	6/26/2019	11/14/2019	7/1/2019	1/22/2020
75086	G7MAINS	MX1307140	MX1307140 - FARM TAP PROJ; BARRS BRANCH / E MAI	118,173		118,173			$ 389,064	346,753	42,311	9/11/2019	3/29/2020	9/1/2019	5/15/2020
75086	G7MAINS	MX1356700	MX1356700 - FARM TAP PROJ; WINTERS LN HIGHLAND	3,685		3,685			$ 258,523	147,466	111,057	6/27/2019	12/26/2019	7/1/2019	3/11/2020
75086	G7MAINS	MX1370091	MX1370091 - FARM TAP PROJ; MARY INGLES HWY	253,724		253,724			$ 510,245	515,675	(5,430)	10/25/2019	5/28/2020	10/1/2019	7/20/2020
75086	G7MAINS	MX1957438	MX1957438 - FARM TAP PROJ; GRANDVIEW RD	51,623		51,623			$ 51,623	161,979	(110,356)	9/29/2020	12/16/2021	9/1/2020	1/10/2022
75086	G7MAINS	MX1958084	MX1958084 - FARM TAP PROJ; FLAGG SPRINGS PIKE	581,074		581,074			$ 581,074	541,626	39,448	2/5/2020	5/22/2020	2/1/2020	10/30/2020
75086	G7MAINS	MX2142600	MX2142600 - FARM TAP PROJ; THORNTON RD	2,387		2,387			$ 28,086	54,542	(26,456)	7/18/2019	12/19/2019	7/1/2019	1/26/2020
75086	G7MAINS	MX2143073	MX2143073 - FARM TAP PROJ; REIDLIN RD	413		413			$ 37,156	43,438	(6,281)	5/21/2019	10/31/2019	6/1/2019	1/22/2020
75086	G7MAINS	MX2271880	MX2271880 - MEA ~800 FT; 494 JONES RD	28,148		28,148			$ 242,750	163,070	79,680	7/30/2019	2/27/2020	8/1/2019	5/13/2020
75086	G7MAINS	MX2335879	MX2335879 - CANCEL STA 872 - OAKLAND VALVE -IN	(444,345)		(444,345)			$ -	380,442	(380,442)	1/5/2018	8/30/2019	5/1/2018	9/19/2019
75086	G7MAINS	MX2335908	MX2335908 - CANCEL OAKLAND VALVE HOUSE OUTLET	(84,169)		(84,169)			$ -	515,779	(515,779)	3/8/2019	6/28/2019	3/1/2019	9/19/2019
75086	G7MAINS	MX2424919	MX2424919 - MEA ~550 FT; 2000 GATEWAY BLVD	408		408			$ 32,354	50,616	(18,262)	7/2/2019	12/12/2019	7/1/2019	1/18/2020
75086	G7MAINS	MX2562222	MX2562222 - MEA ~600 FT - 400 KENTON LANDS RD	106,384		106,384			$ 192,207	205,184	(12,977)	10/4/2019	3/11/2020	11/1/2019	5/15/2020
75086	G7MAINS	MX2568722	MX2568722 - MEA ~230 FT; 500 S MAIN ST	100,718		100,718			$ 147,092	60,768	86,323	8/27/2019	3/18/2020	9/1/2019	6/8/2020
75086	G7MAINS	MX2626372	MX2626372 - ~675 FT MEA; 2344 AMSTERDAM RD	47,209		47,209			$ 52,023	60,345	(8,322)	11/19/2019	4/23/2020	12/1/2019	5/31/2020
75086	G7MAINS	MX2834473	MX2834473 - MEA ~640 FT; 8519 US RT 42	607		607			$ 55,531	77,219	(21,688)	9/30/2019	1/19/2020	10/1/2019	3/11/2020
75086	G7MAINS	MX2848811	MX2848811 - INDEPENDENCE RD MEA -	241		241			$ 5,552	35,185	(29,633)	9/30/2019	1/30/2020	10/1/2019	2/2/2020
75086	G7MAINS	MX2866813	MX2866813 - JT-G-ARCADIA PHASE I	9,202		9,202			$ 9,202	57,563	(48,361)	12/18/2019	3/31/2020	3/1/2020	8/19/2020
75086	G7MAINS	MX3354938	MX3354938 - ~MEA 450 FT; 3845 TURFWAY RD	(525)		(525)			$ 35,816	51,275	(15,459)	8/28/2019	1/5/2020	9/1/2019	3/26/2020
75086	G7MAINS	MX3444104	MX3444104 - MEA ~970 FT; ASHLEY DR	(1,155)		(1,155)			$ 49,045	93,363	(44,318)	9/13/2019	12/29/2019	9/1/2019	2/25/2020
75086	G7MAINS	MX3745351	MX3745351 - MEA ~200 FT; LEE LN	316		316			$ 14,418	34,346	(19,928)	10/18/2019	2/2/2020	10/1/2019	4/2/2020
75086	G7MAINS	MX4018013	MX4018013 - JOHNS HILL RD MEA	192,865		192,865			$ 209,964	73,344	136,620	11/13/2019	1/3/2020	11/1/2019	6/18/2020
75086	G7MAINS	MX4086064	MX4086064 - MEA ~1400 FT; 479 ORPHANGE RD	89,838		89,838			$ 94,080	95,523	(1,443)	12/2/2019	4/22/2020	12/1/2019	8/16/2020
75086	G7MAINS	MX4108387	MX4108387 - MEA ~ 270 FT; 950 WENSTRUP LN	16,718		16,718			$ 18,581	41,217	(22,636)	12/2/2019	4/2/2021	12/1/2019	6/18/2020
75086	G7MAINS	MX4125743	MX4125743 - 2,000 FT MEA; DAMASCUS	142,605		142,605			$ 142,605	152,669	(10,064)	1/29/2020	6/10/2020	2/1/2020	12/16/2020
75086	G7MAINS	MX4146445	MX4146445 - MEA ~ 25 FT; 411 COACHLIGHT DR	1,101		1,101			$ 3,285	13,325	(10,040)	10/1/2019	2/13/2020	11/1/2019	1/20/2020
75086	G7MAINS	MX4210795	MX4210795 - JT-G-BALLYSHANNON SECTION 5 PHASE 6	37,526		37,526			$ 37,526	52,790	(15,264)	12/19/2019	12/31/2020	1/1/2020	8/21/2020
75086	G7MAINS	MX4321381	MX4321381 - JT-G-STEEPLECHASE SECTION 18	6,862		6,862			$ 6,862	51,469	(44,607)	11/19/2019	1/11/2021	2/1/2020	8/2/2020
75086	G7MAINS	MX4355391	MX4355391 - ~1,600 FT MEA; 300 RICHARD KNOCK HW	251,266		251,266			$ 251,266	225,972	25,294	5/27/2020	8/25/2020	6/1/2020	11/30/2020
75086	G7MAINS	MX4769285	MX4769285 - ~985 FT MEA; OAKRIDGE DR	67,068		67,068			$ 67,068	116,703	(49,635)	2/17/2020	4/24/2020	2/1/2020	8/12/2020
75086	G7MAINS	MX4837396	MX4837396 - JT-G-PARK POINTE	298		298			$ 298	81,024	(80,726)	2/24/2020	2/24/2021	3/1/2020	7/14/2021
75086	G7MAINS	MX4861864	MX4861864 - TERMINAL DR MEA-CVG CONRAC PROJECT	159,154		159,154			$ 159,154	166,549	(7,395)	6/12/2020	12/17/2020	6/1/2020	1/12/2021
75086	G7MAINS	MX4875568	MX4875568 - FARM TAP PROJECT; E ALEXANDRIA / CA	943,847		943,847			$ 943,847	1,255,100	(311,253)	3/3/2020	9/11/2020	3/1/2020	12/26/2020
75086	G7MAINS	MX5040349	MX5040349 - GLENRIDGE DRIVE - MEA	100,239		100,239			$ 100,239	114,071	(13,832)	4/23/2020	7/10/2020	5/1/2020	11/24/2020
75086	G7MAINS	MX5373035	MX5373035 - ~350 FT MEA; 390 MEIJER DR	57,402		57,402			$ 57,402	44,298	13,104	4/3/2020	10/21/2020	6/1/2020	11/27/2020
75086	G7MAINS	MX5652554	MX5652554 - FARM TAP PROJ; MASON RD MEA	5,001		5,001			$ 5,001	237,226	(232,225)	12/16/2020	9/24/2021	12/1/2020	
75086	G7MAINS	MX5653109	MX5653109 - FARM TAP PROJ; CROSBY PKWY/MAGELLAN	778		778			$ 778	194,197	(193,419)	9/29/2020	7/13/2023	10/1/2020	11/15/2023
75086	G7MAINS	MX6180533	MX6180533 - 440 FT MEA; MEDICAL VILLAGE DR	104,236		104,236			$ 104,236	74,687	29,549	7/29/2020	10/16/2020	8/1/2020	1/25/2021
75086	G7MAINS	MX6243694	MX6243694 - ~400 FT MEA; DOLWICK DR	59,485		59,485			$ 59,485	104,176	(44,691)	6/18/2020	9/29/2020	7/1/2020	4/7/2021
75086	G7MAINS	MX6245365	MX6245365 - ~425 FT MEA; SARAH LN	10,581		10,581			$ 10,581	26,840	(16,259)	8/31/2020	11/15/2020	9/1/2020	2/10/2021
75086	G7MAINS	MX6684040	MX6684040 - ~1825 FTMEA; WRIGHT BLVD	49,899		49,899			$ 49,899	117,730	(67,831)	10/2/2020	12/18/2020	10/1/2020	3/8/2021
75086	G7MAINS	MX6835553	MX6835553 - JT-G-SOUTHWICK PHASE B PART 1	58		58			$ 58	46,989	(46,931)	11/23/2020	8/19/2021	12/1/2020	7/25/2021
75086	G7MAINS	MX6842755	MX6842755 - MAIN EXTENSION AARON DR-85 FT 2 IN-	5,099		5,099			$ 5,099	25,737	(20,638)	7/9/2020	8/28/2020	8/1/2020	12/15/2020
75086	G7MAINS	MX6891268	MX6891268 - AMAZON SOUTHWEST DELIVERY DIST PROJ	275,739		275,739			$ 275,739	319,190	(43,451)	5/22/2020	3/31/2021	5/1/2020	
75086	G7MAINS	MX7078370	MX7078370 - CANCEL INVESTMENT WAY MEA	255		255			$ 255	39,282	(39,027)	8/14/2020	10/16/2020	8/1/2020	
75086	G7MAINS	MX7122512	MX7122512 - 100 FT MEA; 10009 INDIAN HILL DR	26,072		26,072			$ 26,072	21,630	4,442	9/22/2020	11/27/2020	10/1/2020	3/12/2021
75086	G7MAINS	MX7231229	MX7231229 - STONEWATER APPROACH MAIN	4,612		4,612			$ 4,612	201,666	(197,054)	12/15/2020	12/18/2021	12/1/2020	8/14/2021
75086	G7MAINS	MX7488442	MX7488442 - SANCTUARY VILLAGE PHASE 1 PART 3	116		116			$ 116	44,181	(44,065)	9/23/2020	3/22/2023	10/1/2020	
75086	G7MAINS	MX7752227	MX7752227 - INSTALL GAS ONLY APPROACH MAIN - NE	395		395			$ 5,055	3,767	1,288	8/27/2018	11/20/2018	8/1/2018	12/26/2018
75086	G7MAINS	MX8030455	MX8030455 - CAMP ERNST AND SOLOMON MAE	32,949		32,949			$ 32,949	42,779	(9,830)	10/19/2020	4/12/2021	11/1/2020	4/26/2021
75086	G7MAINS	MX8059955	MX8059955 - ~440 FT MEA; 2 IN PL HP	2,481		2,481			$ 2,481	29,426	(26,945)	12/1/2020	5/11/2021	12/1/2020	5/6/2021
75086	G7MAINS	MX8377762	MX8377762 - JT-G-TRIPLE CROWN SECTION 18 PHASE	13,339		13,339			$ 20,163	57,033	(36,870)	9/28/2018	1/25/2019	11/1/2019	7/6/2020

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75086	G7MAINS	MX8451945	MX8451945 - INVESTMENT WAY MEA	26,815		26,815			$ 26,815	16,225	10,591	10/16/2020	12/30/2020	11/1/2020	2/2/2021
75086	G7MAINS	MX8505395	MX8505395 - ~350 FT MEA; 351 KENTON LANDS	453		453			$ 453	32,684	(32,231)	12/1/2020	2/28/2021	12/1/2020	6/28/2021
75086	G7MAINS	MX8574441	MX8574441 - GAS MAIN EXTENSION - 10177 BIG BONE	1,281		1,281			$ 101,535	80,516	21,019	8/22/2018	10/19/2018	8/1/2018	6/2/2019
75086	G7MAINS	MXA350358	MXA350358 - FARM TAP PROJ; THOMAS MORE PKWY	143,322		143,322			$ 143,322	131,212	12,110	12/12/2019	6/11/2020	1/1/2020	8/5/2020
75086	G7MREG118	MX2217622	MX2217622 - STATION 873 - 5TH & PHILADELPHIA	13,061		13,061			$ 25,442	87,907	(62,465)	9/22/2017	11/30/2025	10/1/2017	
75086	G7MRUPG	AW1568	AW1568 - STATION 338 MR UPGRADE	68,189		68,189			$ 68,189	190,631	(122,442)	12/18/2019	3/30/2022	2/1/2020	
75086	G7MRUPG	AW1569	AW1569 - STATION 286 RILEY ROAD MR UPGRADE	45,326		45,326			$ 45,326	190,631	(145,305)	12/18/2019	3/30/2022	2/1/2020	
75086	G7MSCPRD	L4115	L4115 - REPLACE CONTROL VALVES AT CONSTANCE	(1,281)		(1,281)			$ 31,357	58,753	(27,396)	5/13/2014	6/30/2015	6/1/2014	11/1/2014
75086	G7MSCPRD	M6102	M6102 - REPLACE COMPRESS 6&7 OIL LUBE SYS	(3,834)		(3,834)			$ 48,949	30,641	18,308	6/11/2014	6/30/2016	9/1/2014	1/14/2015
75086	G7MSCPRD	P8054	P8054 - REPLACE BTU MEASUREMENT AT ERLANGER	(1,261)		(1,261)			$ 52,327	49,804	2,522	3/12/2015	4/30/2016	7/1/2015	1/30/2016
75086	G7PHMSA	V7283	V7283 - PHMSA CRM PLAN	407,569		407,569			$ 1,844,152	416,794	1,427,358	11/14/2018	9/30/2020	12/1/2018	3/30/2021
75086	G7PRESIM	MX1640159	MX1640159 - ELIJAH CREEK PRESSURE IMPROVEMENT P	(27,117)		(27,117)			$ 861,605	760,042	101,563	6/4/2019	2/26/2020	6/1/2019	1/15/2020
75086	G7PUBIMP	30323	30323 - GRANDVIEW/GJH	25		25			$ 25	-	25	4/13/2000	1/31/2004	2/1/1997	3/31/1997
75086	G7PUBIMP	C9131	C9131 - PP620440/JOHN BETSCH	(337)		(337)			$ 27,300	-	27,300	1/18/2007	12/31/2012	1/1/2007	7/16/2007
75086	G7PUBIMP	D3299	D3299 - PP 978761/LLM	(263)		(263)			$ 90,039	-	90,039	4/15/2008	12/31/2050	4/1/2008	8/28/2008
75086	G7PUBIMP	D3414	D3414 - PP 967604/LAURA MATE	(590)		(590)			$ 133,477	-	133,477	5/1/2008	12/31/2050	7/1/2008	11/28/2008
75086	G7PUBIMP	E0294	E0294 - HILTON DR	(42)		(42)			$ 1,157	6,415	(5,258)	7/29/2008	12/31/2009	8/1/2008	4/15/2009
75086	G7PUBIMP	E4594	E4594 - ROGERS RD VILLA HILLS	(245)		(245)			$ 119,454	91,099	28,355	2/27/2009	2/27/2014	4/1/2009	9/24/2009
75086	G7PUBIMP	G8241	G8241 - SUNSET DRIVE - THREE MILE RD IMP	(473)		(473)			$ 153,385	175,201	(21,816)	8/16/2012	1/31/2016	2/1/2015	2/5/2016
75086	G7PUBIMP	MX0783884	MX0783884 - PLEASANT VALLEY ROAD/CAMP ERNST ROA	98,763		98,763			$ 1,955,109	1,689,689	265,420	4/26/2018	8/25/2018	5/1/2018	1/22/2019
75086	G7PUBIMP	MX0790794	MX0790794 - ARLINGTON RD. ROADWAY IMP	(43,660)		(43,660)			$ 353,160	227,712	125,448	1/23/2018	3/30/2018	3/1/2018	9/26/2018
75086	G7PUBIMP	MX0976110	MX0976110 - INSTALL STREET IMPROVEMENT PROJECT	86,222		86,222			$ 572,509	274,448	298,061	7/19/2018	10/28/2018	7/1/2018	12/19/2018
75086	G7PUBIMP	MX1376296	MX1376296 - LONGBRANCH RD.	256,216		256,216			$ 370,026	70,969	299,057	8/2/2019	3/5/2020	9/1/2019	9/15/2020
75086	G7PUBIMP	MX2362841	MX2362841 - AMSTERDAM RD.IMPS.,FORT WRIGHT,KY.(	(3,521)		(3,521)			$ 137,161	129,953	7,208	5/14/2018	8/26/2018	5/1/2018	10/24/2018
75086	G7PUBIMP	MX2541899	MX2541899 - KY-36/I-75 INTERCHANGE RECONSTRUCT	(1,295)		(1,295)			$ 1,122,765	906,757	216,008	3/2/2018	6/3/2018	4/1/2018	11/2/2018
75086	G7PUBIMP	MX2624631	MX2624631 - EWING BLVDI STREET IMPROVEMENT PROJ	50,131		50,131			$ 25,729	101,494	(75,765)	10/1/2019	2/27/2020	10/1/2019	4/9/2020
75086	G7PUBIMP	MX2698762	MX2698762 - DOH PENDELTON/CAMPBELL INSTALL STRE	288,358		288,358			$ 309,410	99,384	210,026	9/20/2019	4/3/2020	12/1/2019	7/9/2020
75086	G7PUBIMP	MX2911494	MX2911494 - UL 35 STREET IMPROVEMENT PROJECT	6,588		6,588			$ 28,840	51,296	(22,457)	8/2/2019	1/9/2020	9/1/2019	9/15/2020
75086	G7PUBIMP	MX3298765	MX3298765 - RIDGE RD. & WEST ORCHARD FT MITCHEL	57,216		57,216			$ 57,216	94,800	(37,584)	7/28/2020	10/16/2020	7/1/2020	1/11/2021
75086	G7PUBIMP	MX6477976	MX6477976 - CAMP ERNST STREET IMPROVEMENT PROJE	179,928		179,928			$ 179,928	99,251	80,677	4/29/2020	6/26/2020	5/1/2020	1/11/2021
75086	G7PUBIMP	MX6628393	MX6628393 - PLEASANT VALLEY 2020 RELOCATION	458,430		458,430			$ 458,430	399,033	59,397	5/18/2020	10/29/2020	6/1/2020	11/17/2020
75086	G7PUBIMP	MX6770232	MX6770232 - KYTC-06-0412.00 RICE PK & U.S.42 ST	(26,326)		(26,326)			$ 162,909	279,194	(116,285)	3/2/2018	5/25/2018	3/1/2018	10/25/2018
75086	G7PUBIMP	MX7035169	MX7035169 - BUTTERMILK PIKE STREET IMPROVEMENT	98,906		98,906			$ 98,906	74,108	24,798	7/8/2020	11/26/2020	7/1/2020	12/7/2020
75086	G7PUBIMP	MX7507727	MX7507727 - MXCONV-BROOKWOOD DR STI-EDGEWOOD, K	6,382		6,382			$ 238,643	238,847	(204)	4/6/2018	8/24/2018	4/1/2018	10/26/2018
75086	G7PUBIMP	MX7599942	MX7599942 - INSTALL STREET IMPROVEMENT PROJECT	117,038		117,038			$ 166,668	99,125	67,542	8/2/2019	2/27/2020	8/1/2019	2/29/2020
75086	G7PUBIMP	MX7720357	MX7720357 - BEECHWOOD RD STREET IMPROVEMENT PRO	5,289		5,289			$ 190,727	183,481	7,246	4/3/2019	7/14/2019	4/1/2019	10/3/2019
75086	G7PUBIMP	MX8175168	MX8175168 - BUTTERMILK PIKE STREET IMPROVEMENT	6,060		6,060			$ 6,857	62,696	(55,839)	11/19/2019	3/31/2021	11/1/2019	
75086	G7PUBIMP	MX8760866	MX8760866 - WKIP ROADWAY IMPROVEMENT JONES RD	215		215			$ 369,060	208,010	161,050	6/14/2018	10/12/2018	6/1/2018	2/3/2019
75086	G7PUBIMP	MX8840782	MX8840782 - INSTALL STREET IMPROVEMENT PROJECT-	686		686			$ 686	-	686	2/6/2020	12/7/2018	2/1/2020	
75086	G7PUBIMP	MX9244894	MX9244894 - MT.ZION RD KY536 STI	244,142		244,142			$ 244,142	1,026,778	(782,636)	11/8/2019	6/30/2023	1/1/2020	7/27/2021
75086	G7PUBIMP	O4165	O4165 - DUDLEY RD IMPROVEMENT	(336)		(336)			$ 106,899	145,627	(38,728)	7/23/2014	3/1/2015	8/1/2014	11/1/2014
75086	G7PUBIMP	P6167	P6167 - KYLES LN. @ DIXIE HWY FT. WRIGHT	(2,442)		(2,442)			$ 247,252	60,741	186,511	8/22/2014	6/28/2015	12/1/2014	8/5/2015
75086	G7PUBIMP	P6497	P6497 - HAYES STATION RD	(320)		(320)			$ 10,641	15,957	(5,316)	10/3/2014	4/10/2015	10/1/2014	12/5/2014
75086	G7PUBIMP	P6551	P6551 - DUDLEY RD - RELOCATION FOR STORM	(4,892)		(4,892)			$ 70,848	60,832	10,016	10/9/2014	4/30/2015	10/1/2014	2/19/2015
75086	G7PUBIMP	P7280	P7280 - GRAND AT FLORENCE ROADWAY IMPROVEME	(8,798)		(8,798)			$ 68,022	27,834	40,188	1/14/2015	9/25/2015	2/1/2015	6/20/2015
75086	G7PUBIMP	R6768	R6768 - STI 9359472 ROBBINS AVE	(1,029)		(1,029)			$ 30,409	20,414	9,994	2/11/2016	9/30/2016	3/1/2016	7/15/2016
75086	G7PUBIMP	S4545	S4545 - STI 10221124 ALTAVIA AVE	(122)		(122)			$ 43,122	15,146	27,976	5/10/2016	10/31/2016	5/1/2016	9/14/2016
75086	G7PUBIMP	S7874	S7874 - STI 4844778 THOMAS MORE PKWY	(611)		(611)			$ 69,934	11,697	58,237	6/13/2016	6/30/2017	6/1/2016	1/3/2017
75086	G7PUBIMP	S8867	S8867 - STI 10873483 MT ZION RD	(43,840)		(43,840)			$ 1,232,439	447,690	784,749	7/26/2016	1/30/2020	1/1/2017	12/21/2019
75086	G7PUINEW	INSREGREL	INSREGREL - INSTALL OR REMOVE REGULATOR/RELIEF	118,213		118,213			$ 1,230,642	800,000	430,642	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	SETMETER	SETMETER - SET OR REMOVE METER	1,306,157		1,306,157			$ 7,701,280	2,250,000	5,451,280	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGLG	AGECHGLG - KENTUCKY AGE CHANGE LARGE METER	58,361		58,361			$ 532,089	350,000	182,089	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGSM	AGECHGSM - KENTUCKY AGE CHANGE SMALL METER	315,842		315,842			$ 5,542,618	14,500,000	(8,957,382)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRLG	CHGMTRLG - CHANGE LARGE METER KENTUCKY	(22)		(22)			$ 164,959	725,000	(560,041)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRSM	CHGMTRSM - CHANGE SMALL METER KENTUCKY	228,924		228,924			$ 2,605,849	1,250,000	1,355,849	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGREGREL	CHGREGREL - CHANGE REGULATOR/RELIEF KENTUCKY	2,003		2,003			$ 155,433	800,000	(644,567)	3/3/2015	12/31/2050	4/1/2015	
75086	G7REG0026	MX7281967	MX7281967 - REG 0026 UPHIL AND HIGHWAY - REG SW	8,806		8,806			$ 8,806	48,954	(40,148)	7/7/2020	3/31/2021	8/1/2020	1/20/2021
75086	G7REG0048	MX7282035	MX7282035 - REG 0048 FIFTH AND PHILADELPHIA - R	12,795		12,795			$ 12,795	48,954	(36,159)	7/14/2020	3/31/2021	8/1/2020	10/28/2020
75086	G7REG0057	MX7281845	MX7281845 - REG 0057 SARATOGA AND ELEVENTH - OR	2,668		2,668			$ 2,668	44,954	(42,286)	7/7/2020	3/31/2021	7/1/2020	
75086	G7REPL	28051	28051 - SMALL REPL KY	43,877		43,877			$ 1,189,144	-	1,189,144	4/13/2000	12/31/2050	12/1/1999	
75086	G7REPL	G4517	G4517 - F/L 'UL07' MCCULLUM RD SLIDE	(1,833)		(1,833)			$ 95,659	76,220	19,439	8/17/2011	6/1/2012	9/1/2011	3/17/2012
75086	G7REPL	G8159	G8159 - REG 115K - INLET & OUTLET PIPING	(436)		(436)			$ 28,811	39,685	(10,874)	7/30/2012	6/30/2013	9/1/2012	3/5/2013
75086	G7REPL	MX0181170	MX0181170 - CENTRAL AVE NEWPORT- REPLACEMENT PR	(19,645)		(19,645)			$ 22,097	64,213	(42,116)	12/12/2018	11/21/2019	12/1/2018	11/27/2019
75086	G7REPL	MX1233047	MX1233047 - KY-9 FLOOD GATE-RPL	190,752		190,752			$ 195,696	92,509	103,187	10/23/2019	7/10/2020	10/1/2019	12/14/2020
75086	G7REPL	MX4065631	MX4065631 - CALIFORNIA CROSSROADS REPLACEMENT	7,014		7,014			$ 39,763	72,427	(32,664)	10/11/2019	3/19/2020	10/1/2019	4/15/2020
75086	G7REPL	MX4342633	MX4342633 - PLEASANT VALLEY STEEL REP (FOUNDERS	359,638		359,638			$ 386,487	166,756	219,731	10/18/2019	2/28/2020	10/1/2019	6/26/2020
75086	G7REPL	MX6840192	MX6840192 - BEAVER RD INSTALL REPLACEMENT PROJE	99		99			$ 99	48,085	(47,986)	8/13/2020	11/20/2020	8/1/2020	
75086	G7REPL	MX9056339	MX9056339 - ST. MATTHEWS CIRCLE REPLACEMENT	(12,894)		(12,894)			$ 81,156	107,808	(26,652)	9/25/2018	2/3/2019	10/1/2018	8/20/2019
75086	G7REPL	MX9545566	MX9545566 - RICHWOOD RD REPLACEMENT PROJ KY-338	265,088		265,088			$ 265,088	1,413,710	(1,148,622)	11/12/2019	6/14/2022	1/1/2020	3/1/2022
75086	G7REPL	P6335	P6335 - DUDLEY RD - RELOCATION FOR RSTORM	(5,228)		(5,228)			$ 92,993	74,701	18,292	9/19/2014	4/30/2015	10/1/2014	2/19/2015
75086	G7REPL	R3316	R3316 - GLENCOE - WEBSTER/RAILROAD ST	(385)		(385)			$ 8,697	13,545	(4,848)	9/28/2015	4/9/2016	10/1/2015	12/31/2015
75086	G7REPL	R3461	R3461 - STATION 577 INLET PIPING	(437)		(437)			$ 6,392	43,879	(37,487)	10/5/2015	6/15/2016	10/1/2015	3/17/2016
75086	G7REPL	R3462	R3462 - STATION 577 OUTLET PIPING	(469)		(469)			$ 2,771	17,739	(14,969)	10/5/2015	6/15/2016	10/1/2015	3/17/2016
75086	G7REPL	R4609	R4609 - RP 8866200 RIPPLE CREEK	(3,216)		(3,216)			$ 71,711	51,984	19,727	11/19/2015	6/18/2016	12/1/2015	5/20/2016
75086	G7REPL	S8507	S8507 - CANCEL STA 809 WATERWORKS RD OUTLET	15		15			$ -	11,918	(11,918)	6/30/2016	12/31/2018	10/1/2016	10/1/2018
75086	G7REPL	T1130	T1130 - RPL 11859007 BALLYSHANNON - RELOCAT	338		338			$ 593	37,388	(36,795)	12/20/2016	7/1/2017	12/1/2016	6/11/2017
75086	G7S3300	V7041	V7041 - LINE UL02 SEG 3300 PLEASANT VALLEY	(1,802,822)		(1,802,822)			$ (47,966)	2,643,704	(2,691,670)	11/6/2018	7/30/2020	1/1/2019	1/15/2020
75086	G7SECCON	V5175	V5175 - ERLANGER PROPANE SECURITY UPGRADE	29,783		29,783			$ 2,949,390	950,000	1,999,390	8/21/2018	5/14/2020	2/1/2019	3/31/2020
75086	G7SERVMC	28519	28519 - HOPEFUL RD 6302/DMG	516		516			$ 516	-	516	4/13/2000	12/31/2050	4/1/1996	7/17/1996
75086	G7SERVMC	28716	28716 - PARK PL 19/DMG	183		183			$ 182	-	182	4/13/2000	12/31/2050	5/1/1996	5/30/1996
75086	G7SERVMC	28718	28718 - ALLISON 212/DMG	103		103			$ 102	-	102	4/13/2000	12/31/2050	5/1/1996	5/30/1996
75086	G7SERVMC	A1592	A1592 - 2312 CASINO DR	113		113			$ 113	-	113	5/25/2000	12/31/2050	6/1/2000	12/18/2002

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75086	G7SERVMC	A2242	A2242 - 0000265/11 SHELBY/RENEW M-C	183		183			$ 182	-	182	7/21/2000	12/31/2050	7/1/2000	12/18/2002
75086	G7SERVMC	A2367	A2367 - 11722 MADISON PK/RENEW M-C	24		24			$ 24	-	24	8/1/2000	12/31/2050	8/1/2000	12/18/2002
75086	G7SERVMC	A2577	A2577 - 0000299/7114 PRICE PK	224		224			$ 221	-	221	8/20/2000	12/31/2050	8/1/2000	12/18/2002
75086	G7SERVMC	C7799	C7799 - CIMOS C-M 070 START 20061001	(3,431)		(3,431)			$ 221,012	-	221,012	8/25/2006	12/31/2012	10/1/2006	4/1/2007
75086	G7SERVMC	CMRP70	CMRP70 - REPLACE C-M PLASTIC 2 INCH AND UNDE	203,769		203,769			$ 12,435,228	-	12,435,228	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVMC	LCMRP70	LCMRP70 - GREATER THAN 2" C-M REPL PLASTIC	7,138		7,138			$ 23,376	2,500,000	(2,476,624)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRP70	LMCRP70 - GREATER THAN 2" M-C REPL PLASTIC	55,359		55,359			$ 255,421	2,500,000	(2,244,579)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	MCRP70	MCRP70 - REPLACE (NON-AMRP) M-C PLASTIC 2 IN	1,095,779		1,095,779			$ 16,842,983	-	16,842,983	7/1/2008	12/31/2050	7/1/2008	12/20/2009
75086	G7SERVMC	MCRS70	MCRS70 - REPLACE M-C STEEL 2 INCH AND UNDER	5,523		5,523			$ 530,530	-	530,530	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVNEW	CMNEWP70	CMNEWP70 - NEW C-M PLASTIC 2 INCH AND UNDER KY	419,806		419,806			$ 7,668,402	1	7,668,401	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	CMNEWS70	CMNEWS70 - 2" OR LESS STEEL NEW C-M	1,153		1,153			$ 282,504	5,000,000	(4,717,496)	1/13/2016	12/31/2050	5/1/2016	
75086	G7SERVNEW	LCMNEWP70	LCMNEWP70 - GREATER THAN 2" C-M PLASTIC	529		529			$ 234,133	2,500,000	(2,265,867)	1/13/2016	12/31/2050	2/1/2016	
75086	G7SERVNEW	LMCNEWP70	LMCNEWP70 - GREATER THAN 2" M-C PLASTIC	158,344		158,344			$ 447,352	2,500,000	(2,052,648)	1/13/2016	12/31/2050	3/1/2016	
75086	G7SERVNEW	LMCNEWS70	LMCNEWS70 - GREATER THAN 2" M-C STEEL	57,674		57,674			$ 102,206	2,500,000	(2,397,794)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVNEW	MCNEWP70	MCNEWP70 - NEW M-C PLASTIC 2 INCH AND UNDER KY	2,451,660		2,451,660			$ 15,176,562	1	15,176,561	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	MCNEWS70	MCNEWS70 - NEW M-C STEEL 2 INCH AND UNDER KY	31,172		31,172			$ 235,539	1	235,538	12/31/2010	12/31/2050	4/1/2011	
75086	G7STA876	MX6800938	MX6800938 - STA 876 WARSAW TOWN BORDER- STATION	44,447		44,447			$ 83,602	252,984	(169,382)	1/10/2018	9/30/2022	1/1/2018	9/29/2023
75086	G7TAM00B	AW2146	AW2146 - LINE AM00B RETROFIT REPL	641,732		641,732			$ 641,732	6,528,636	(5,886,904)	5/19/2020	10/15/2022	5/1/2020	9/17/2022
75086	G7TOOLS	28073	28073 - PURCHASE GAS TOOLS BLANKET	133,315		133,315			$ 720,614	-	720,614	4/13/2000	12/31/2015	12/1/1999	
75086	G7TUL06	AW1592	AW1592 - LINE UL06 - PIPELINE REPLACEMENTS	570,465		570,465			$ 570,465	10,253,358	(9,682,893)	1/5/2020	12/30/2021	2/1/2020	12/3/2021
75086	G7TUL06	AW2021	AW2021 - LINE UL06 - PIPELINE REPLACEMENTS L	88,255		88,255			$ 88,255	115,000	(26,745)	4/13/2020	12/31/2021	7/1/2020	12/3/2021
75086	G7UL02PH1	V8191	V8191 - UL60 PIPELINE PHASE 1 (PIPE)	36,195,166		36,195,166			$ 37,992,003	26,326,195	11,665,808	1/23/2019	3/30/2021	1/1/2019	2/25/2021
75086	G7UL02PH1	V8351	V8351 - UL60 PIPELINE PHASE 1 (STATION)	1,729,006		1,729,006			$ 1,729,350	6,287,827	(4,558,477)	2/11/2019	3/30/2021	7/1/2019	3/13/2021
75086	G7UL02PH1	V8352	V8352 - UL60 PIPELINE P1 - LAND RIGHTS PROJ	3,798,058		3,798,058			$ 4,852,995	1,941,000	2,911,995	2/11/2019	3/30/2021	3/1/2019	2/25/2021
75086	G7UL02PH2	V9444	V9444 - PHASE II UL60 BYPASS	1,526,340		1,526,340			$ 1,597,275	22,514,005	(20,916,730)	6/12/2019	3/30/2022	10/1/2019	11/18/2021
75086	G7UL02PH2	V9445	V9445 - PHASE II UL60 (LAND RIGHTS)	1,604,209		1,604,209			$ 1,713,352	733,000	980,352	6/12/2019	2/2/2022	7/1/2019	11/18/2021
75086	G7WFD	MX5518434	MX5518434 - WENDELL FORD DIST. PROJ;	48,673		48,673			$ 48,673	262,528	(213,855)	4/16/2020	10/2/2020	5/1/2020	2/11/2021
75086	G7WFD	MX6889178	MX6889178 - CANCEL WENDELL FORD	295		295			$ 295	274,232	(273,937)	5/22/2020	8/21/2020	5/1/2020	2/16/2021
75086	GITKYCAP	GSMRTLKSV	GSMRTLKSV - GAS SMART - LEAK SURVEY LINE PATROL	(3,862)		(3,862)			$ 232,168	136,600	95,568	8/26/2016	3/31/2018	9/1/2016	8/30/2019
75086	GITKYCAP	SMARTPH2	SMARTPH2 - GAS SMART DATA AVAILABILITY PHASE 2	(1,512)		(1,512)			$ -	-	-	12/11/2015	6/30/2018	12/1/2015	
75086	GMAINS	MX0225249	MX0225249 - LITTON LN. PRESSURE IMPROVEMENT PRO	4,041		4,041			$ 174,151	133,009	41,142	12/6/2018	3/10/2019	12/1/2018	4/10/2019
75086	KYCIBS05	B8011	B8011 - 2005 KY CIBS MODULE 321/DJS	(37,816)		(37,816)			$ 437,078	-	437,078	5/11/2004	12/31/2050	7/1/2004	2/17/2009
75086	KYCIBS07	C7795	C7795 - CIBS M-C 070 START20061001	(165,035)		(165,035)			$ 3,489,887	-	3,489,887	8/25/2006	12/31/2012	10/1/2006	4/1/2007
75086	KYCIBS07	C7796	C7796 - CIBS C-M 070 STARTING 20061001	(34,437)		(34,437)			$ 2,937,187	-	2,937,187	8/25/2006	12/31/2012	10/1/2006	4/1/2007
75086	PCTAITMWM	PCTAIT85B	PCTAIT85B - INT85B CTA MWMS CONSOLIDATION	22		22			$ 1,730,253	285,463	1,444,790	11/3/2015	9/30/2017	10/1/2015	7/31/2017
75086	SG000358F	SG358HW19	SG358HW19 - SG DEE MDM SCALE HWRE PHASE 4 - 358	(9)		(9)			$ 40,182	21,103	19,079	5/9/2018	8/18/2019	5/1/2018	9/24/2019
75086	SG000358F	SG358SVR	SG358SVR - DEE MDM SCALE	999		999			$ 1,791	1,048	743	9/24/2019	1/31/2020	11/1/2019	3/31/2020
75086	SG000358F	SG358SVR2	SG358SVR2 - DEE MDM SCALE	1,310		1,310			$ 1,310	1,378	(68)	4/16/2020	8/31/2020	4/1/2020	7/31/2020
75086	SG000489F	SG489SVR2	SG489SVR2 - DEE OPENWAY SCALE	199		199			$ 10,946	15,568	(4,622)	1/22/2019	3/31/2020	1/1/2019	9/30/2019
75086	SG000489F	SG489SVR3	SG489SVR3 - DEE OPENWAY SCALE	3,509		3,509			$ 3,516	1,190	2,326	9/25/2019	10/31/2020	9/1/2019	10/26/2020
75086	SG000489F	SG489SVR4	SG489SVR4 - DEE OPENWAY SCALE	4		4			$ 4	442	(438)	1/29/2020	10/31/2020	3/1/2020	
75086	SG000489F	SG489SVRS	SG489SVRS - SG DEE OPENWAY SCALE SERVERS	0		0			$ 29,590	31,330	(1,739)	4/24/2017	12/31/2018	5/1/2017	3/31/2019
75086	SG000489F	SG489SW2	SG489SW2 - DEE OPENWAY SCALE	4,525		4,525			$ 4,525	2,008	2,517	2/3/2020	10/31/2020	1/1/2020	10/26/2020
75086	SG000540F	SG540HW	SG540HW - DEE VEHICLE AREA NETWORK	7,311		7,311			$ 64,791	117,926	(53,135)	4/13/2018	12/17/2020	9/1/2018	5/15/2021
75086	SG000540F	SG540SW	SG540SW - DEE VEHICLE AREA NETWORK	0		0			$ 107	107,801	(107,694)	4/13/2017	12/17/2020	4/1/2017	7/16/2018
75086	SG000723F	SG723SW	SG723SW - DEE AMI OPERATIONS TOOL	12,707		12,707			$ 12,707	26,599	(13,892)	3/3/2020	7/30/2022	3/1/2020	7/31/2022
75086	SG000724F	SG724SW	SG724SW - DEE MDM TECHNICAL HEALTH	8,509		8,509			$ 8,509	15,916	(7,407)	8/19/2020	6/24/2021	8/1/2020	9/30/2021
75086	SG000781F	SG781SW	SG781SW - SG DEE PPM PIMS PHASE 2 BUILD OUT	(513)		(513)			$ 77,936	76,874	1,062	7/12/2018	3/31/2021	7/1/2018	3/31/2022
75086	SG000940F	SG940SVR	SG940SVR - DEE EDMS PLATFORM UPGRADE	11,757		11,757			$ 11,757	9,477	2,280	4/24/2020	12/18/2020	5/1/2020	2/7/2021
75086	SG001040F	SG1040SW	SG1040SW - DEE SGG LICENSE EXTENSION	5,410		5,410			$ 5,410	-	5,410	4/16/2020	5/31/2020	4/1/2020	7/21/2020
75086	SG001042F	SG1042SW	SG1042SW - DEE OPENWAY LICENSE EXTENSION	12,022		12,022			$ 12,022	11,784	238	7/28/2020	10/30/2020	9/1/2020	12/31/2020
75086	SGKAMIF	SG169MTRS	SG169MTRS - SG KY AMI GAS METERS - 169	1,416		1,416			$ 9,375,354	9,563,026	(187,672)	6/7/2017	2/28/2019	6/1/2017	
75087	CUSTCONN	315986A	315986A - CUSTOMER CONNECT - CORE	1,357,936		1,357,936			$ 2,928,651	2,325,960	602,691	8/10/2017	12/5/2022	8/1/2017	7/6/2022
75087	CUSTCONN	315986C	315986C - CUSTOMER CONNECT- RELEASE 2	4,982		4,982			$ 306,110	187,946	118,163	8/10/2017	5/28/2019	8/1/2017	6/18/2019
75087	CUSTCONN	315986D	315986D - CUSTOMER CONNECT- RELEASE 3	400		400			$ 193,414	280,417	(87,003)	8/10/2017	12/30/2019	8/1/2017	12/31/2019
75087	CUSTCONN	315986E	315986E - CUSTOMER CONNECT- UNIVERSAL BILL	84,172		84,172			$ 243,784	117,210	126,574	8/11/2017	9/1/2020	8/1/2017	9/1/2020
75087	CUSTCONN	315986HW5	315986HW5 - CUSTOMER CONNECT- HARDWARE PROJ 3	12,855		12,855			$ 76,179	42,700	33,479	9/3/2019	6/1/2020	9/1/2019	6/15/2020
75087	CUSTCONN	315986HW6	315986HW6 - CUSTOMER CONNECT- HARDWARE PROJ 4	58,411		58,411			$ 58,411	21,350	37,061	3/12/2020	3/15/2021	3/1/2020	6/1/2021
75087	FPIT	307482001	307482001 - CUSTOMER MOBILE APP - PHASE 2	128		128			$ 21,367	28,166	(6,799)	12/28/2018	3/31/2020	1/1/2019	3/20/2020
75087	FPIT	307482002	307482002 - CUSTOMER MOBILE APP - PHASE 3	3,036		3,036			$ 3,036	26,324	(23,288)	12/19/2019	3/15/2022	1/1/2020	3/31/2022
75087	FPIT	307482SW2	307482SW2 - CUSTOMER MOBILE APP - PHASE 3	13,533		13,533			$ 13,533	30,258	(16,725)	4/13/2020	3/15/2022	4/1/2020	3/31/2022
75087	FPIT	336593019	336593019 - NEW CALL CTR SIP TRUNKS	61		61			$ 15,793	10,444	5,349	3/14/2018	3/31/2020	3/1/2018	3/31/2020
75087	FPIT	344598001	344598001 - DUKE CUSTOMER IVR REPLACEMENT	9,285		9,285			$ 151,374	197,081	(45,707)	4/10/2018	1/28/2020	4/1/2018	1/30/2020
75087	FPIT	348527007	348527007 - MY DUKE REPLACEMENT	4,708		4,708			$ 68,807	51,758	17,049	10/2/2019	3/31/2020	10/1/2019	2/15/2020
75087	FPIT	354154002	354154002 - DURABLE TEAM - DXT	3,252		3,252			$ 3,252	20,684	(17,432)	3/5/2020	9/28/2020	3/1/2020	9/30/2020
75087	FPIT	354299001	354299001 - OUTAGE MAP REFRESH	1,553		1,553			$ 20,760	21,193	(433)	10/2/2019	4/30/2020	10/1/2019	4/30/2020
75087	FPIT	CC1900001	CC1900001 - CUSTOMER ANALYTICS ENGINE	15,571		15,571			$ 15,571	26,306	(10,735)	1/27/2020	3/31/2022	2/1/2020	3/31/2022
75087	FPIT	CC2000003	CC2000003 - SITECORE JSS FRONT END MODERNIZATIO	13,424		13,424			$ 13,424	28,721	(15,297)	6/25/2020	5/30/2022	8/1/2020	5/31/2022
75087	FPIT	CS1900001	CS1900001 - VOICE OF THE CUSTOMER ENGAGEMENT PL	17,478		17,478			$ 17,478	13,742	3,736	1/29/2020	3/31/2022	2/1/2020	3/31/2022

Duke Energy Kentucky Natural Gas
Year 2021

Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	EAMHPBU	349472008	349472008 - EAM 2021 MAXIMO DURABLE TEAM	41,000		41,000			41,000	84,630	(43,630)	1/22/2021	5/30/2022	2/1/2021	8/15/2022
75086	EAMHPBU	349472009	349472009 - NEW EAM 2021 MOBILE DURABLE TEAM	1,735		1,735			1,735	39,130	(37,395)	1/13/2021	5/30/2022	2/1/2021	8/15/2022
75086	FARCOSSW	ARCOS21	ARCOS21 - ARCOS RENEWAL	15		15			59,342	59,327	15	12/17/2020	9/30/2021	12/1/2020	4/25/2021
75086	FMDT2020	MDTGAS20	MDTGAS20 - INSTALL WIN 7 PANASONIC TOUGHBOOKS	31,119		31,119			495,963	403,995	91,968	10/10/2019	3/31/2021	12/1/2019	3/31/2021
75086	FPIT	338802006	338802006 - SMALLWORLD/MYWORLD DURABLE TEAM	(11)		(11)			-	48,911	(48,911)	9/6/2018	5/28/2020	10/1/2018	11/10/2020
75086	FPIT	338802HW3	338802HW3 - EAM PLATFORM OPTIMIZATION	(4)		(4)			-	59,872	(59,872)	4/25/2018	10/31/2019	7/1/2020	3/31/2020
75086	FPIT	349472005	349472005 - ESRI SUBSCRIPTION LICENSE AGREEMENT	91,332		91,332			91,332	1,153,589	(1,062,257)	12/15/2020	5/30/2021	1/1/2021	4/1/2021
75086	FPIT	349472010	349472010 - NEW SMALLWORLD STORAGE SERVERS	1,338		1,338			1,338	17,389	(16,051)	12/29/2020	3/31/2022	2/1/2021	3/31/2022
75086	FPIT	349472016	349472016 - AUTODESK SUBSCRIPTION AGREEMENT	11,786		11,786			11,786	11,803	(17)	10/29/2021	3/20/2022	11/1/2021	3/20/2022
75086	FPIT	349472S13	349472S13 - JUMP APPLICATION	2,433		2,433			2,433	2,199	233	2/8/2021	7/30/2022	6/1/2021	10/1/2022
75086	FPIT	349472S14	349472S14 - NEW ESRI INTEGRATIONS AND INFRA	4,759		4,759			4,759	532,359	(527,600)	2/9/2021	11/30/2023	3/1/2021	3/6/2024
75086	FPIT	349472SW6	349472SW6 - EAM-SC NEXT GEN MOBILE PLATFORM SW	8,266		8,266			8,266	12,210	(3,944)	12/15/2020	7/29/2022	1/1/2021	9/27/2022
75086	FPIT	CC2000001	CC2000001 - NGBU COMMUNICATIONS PLATFORM	33,475		33,475			58,427	1,242,489	(1,184,062)	3/30/2020	3/31/2022	4/1/2020	3/31/2022
75086	FPIT	GCTA30060	GCTA30060 - CONSOLIDATED SCADA APP ANALYSIS	(1,856)		(1,856)			275,769	149,205	126,564	4/11/2017	6/30/2020	4/1/2017	6/30/2020
75086	FPIT	GCTA3006K	GCTA3006K - INTGO_PI SCADA DATA IMPLEMENTATION	1,888		1,888			91,075	133,026	(41,951)	11/15/2019	3/17/2022	11/1/2019	3/1/2022
75086	FPIT	GCTA47001	GCTA47001 - INTGO_MATERIALS TRACEABILITY	(1,028)		(1,028)			100,529	120,205	(19,676)	12/6/2018	3/31/2022	1/1/2019	5/31/2020
75086	FPIT	GCTA4700A	GCTA4700A - INTGO_TRACEABILITY FORM EAM	58,759		58,759			58,759	29,280	29,479	12/4/2018	3/31/2021	1/1/2019	3/14/2021
75086	FPIT	GCTA4700B	GCTA4700B - INTGO_TRACEABILITY FORM FDC	1,742		1,742			107,662	215,691	(108,029)	12/6/2018	3/31/2021	12/1/2018	3/14/2021
75086	FPIT	IT1900065	IT1900065 - GDPM PHASE 2	5,686		5,686			74,755	87,832	(13,077)	2/7/2020	3/31/2021	2/1/2020	3/31/2021
75086	FPIT	IT1900067	IT1900067 - ARM TO MAXIMO INTEGRATION	(1,039)		(1,039)			14	-	14	10/12/2020	7/31/2021	10/1/2020	7/27/2021
75086	FPIT	IT1900069	IT1900069 - TRG - WAM MEASUREMENT PROJECT	(27,330)		(27,330)			215	65,041	(64,826)	2/21/2020	12/31/2021	3/1/2020	
75086	FPIT	IT1900073	IT1900073 - EAM 2020 MOBILE DURABLE TEAM	11,134		11,134			84,371	36,572	47,799	1/20/2020	5/30/2021	1/1/2020	6/8/2021
75086	FPIT	IT1900074	IT1900074 - EAM 2020 MAXIMO DURABLE TEAM	3,481		3,481			188,198	229,288	(41,090)	1/20/2020	5/30/2021	1/1/2020	6/8/2021
75086	FPIT	IT2000091	IT2000091 - GIM TOOL ENHANCEMENTS AND NOTIFICAT	23,800		23,800			23,800	37,595	(13,795)	12/14/2020	3/31/2022	3/1/2021	6/25/2022
75086	FPIT	IT2000092	IT2000092 - GTIS ENHANCEMENT AND ACOG	93,023		93,023			93,023	111,184	(18,161)	12/22/2020	3/31/2023	1/1/2021	12/26/2022
75086	FPIT	IT2000093	IT2000093 - NG SCADA TRAINING SIMULATOR	2,837		2,837			2,837	91,646	(88,809)	12/29/2020	1/29/2022	2/1/2021	3/20/2022
75086	FPIT	IT2000095	IT2000095 - TRACEABILITY PHASE 2	88,057		88,057			88,057	275,326	(187,269)	1/5/2021	3/31/2022	1/1/2021	3/31/2022
75086	FPIT	IT2000098	IT2000098 - GAS SALES PLATFORM PHASE 2	224,637		224,637			224,637	254,148	(29,511)	1/21/2021	3/31/2023	1/1/2021	3/31/2022
75086	FPIT	IT2000111	IT2000111 - KEY CONTROL SYSTEM	31,351		31,351			31,351	30,928	423	1/13/2021	3/31/2022	2/1/2021	5/31/2022
75086	FPIT	IT2100084	IT2100084 - DEVONWAY LICENSE RENEWAL	7,509		7,509			7,509	47,034	(39,525)	8/13/2021	8/31/2022	8/1/2021	8/31/2022
75086	FPIT	LTHGCHTRS	LTHGCHTRS - LIGHTHOUSE: GAS OPS CHARTER	59,811		59,811			59,811	86,372	(26,561)	3/17/2021	9/30/2022	4/1/2021	6/30/2022
75086	FPIT	LTHGDBS	LTHGDBS - LIGHTHOUSE: GAS OPS - DAMAGE BILLIN	1,531		1,531			1,531	70,748	(69,217)	11/19/2020	10/30/2022	1/1/2021	7/31/2022
75086	FPIT	TC2000057	TC2000057 - PNG TELECOM - LNG AND COMPRESSOR ST	54,216		54,216			54,216	216,847	(162,631)	12/22/2020	3/31/2022	1/1/2021	5/15/2022
75086	FPIT	V5136	V5136 - COMMUNICATION RADIO INSTALL	(585)		(585)			27,005	23,120	3,885	8/20/2018	12/31/2018	8/1/2018	7/31/2019
75086	FUNCTOHKY	107GASCK	107GASCK - GAS CAPITAL OVERHEAD	490,106		490,106			1,021,314	-	1,021,314	7/1/2008	12/31/2050	7/1/2008	
75086	G701660	AW4645	AW4645 - EMERGENT AM01 COVINGTON LEVEE PH 1	57,110		57,110			57,110	3,601,200	(3,544,090)	10/1/2021	1/30/2023	10/1/2021	2/28/2023
75086	G701662	AW4673	AW4673 - EMERGENT - CASING 34 - TAYLOR MILL	1,881		1,881			1,881	3,207,100	(3,205,219)	10/13/2021	2/28/2023	11/1/2021	1/7/2023
75086	G712237	MX4669122	MX4669122 - HEBRON LOOP PH 2 PRESSURE IMPROVEME	31,795		31,795			31,795	765	31,030	3/1/2021	3/4/2027	3/1/2021	
75086	G71373	AW0856	AW0856 - 1373 US 27 BRIDGE ATTACHMENT	3,554		3,554			71,075	91,770	(20,695)	7/30/2019	2/25/2020	11/1/2019	3/30/2020
75086	G7237BEAV	MX7783733	MX7783733 - BEAVER RD INSTALL REPLACEMENT PROJE	(29)		(29)			15,861	48,085	(32,224)	8/17/2020	10/30/2020	8/1/2020	1/10/2021
75086	G73701	V8405	V8405 - BRIDGE ATTACH 3701 NARROWS RD	332		332			13,050	11,496	1,554	2/18/2019	2/25/2020	9/1/2019	12/18/2019
75086	G73MILES	T1437	T1437 - STA 249: THREE MILE RD	(78)		(78)			25,443,284	15,406,228	10,037,056	1/5/2017	8/28/2020	1/1/2017	9/15/2020
75086	G74426	AW4587	AW4587 - CANCEL -GWUT DIGS ON AM07 (DUKE KY)	182		182			182	491,352	(491,170)	9/15/2021	3/31/2022	9/1/2021	
75086	G7575RBA	AW3396	AW3396 - 575 ROSSFORD BRIDGE ATTACHMENT	13,988		13,988			13,988	4,496	9,492	1/20/2021	3/31/2022	3/1/2021	7/13/2021
75086	G7AM00ACR	AW3397	AW3397 - LINE AM00A CORROSION REMEDIATION	132,680		132,680			132,680	180,372	(47,692)	1/20/2021	3/31/2022	12/1/2021	3/20/2022
75086	G7AM07IL2	AW4685	AW4685 - LINE AM07 PIPELINE REPLACEMENT PHAS	40,204		40,204			40,204	33,015,500	(32,975,296)	10/18/2021	2/28/2025	11/1/2021	2/6/2025
75086	G7AM07ILI	0233100	0233100 - LINE AM07 PIPELINE REPLACEMENT PHAS	771,564		771,564			772,997	37,717,000	(36,944,003)	12/9/2020	12/31/2023	12/1/2020	3/18/2024
75086	G7AM07ILI	AW3074	AW3074 - LINE AM07 PIPELINE REPLACE LAND	104,337		104,337			104,337	6,089,500	(5,985,163)	12/3/2020	12/31/2023	2/1/2021	3/18/2024
75086	G7AM07ILI	AW3138	AW3138 - LINE AM07 PIPELINE REPLACEMENT-STN	12,928		12,928			12,928	6,278,300	(6,265,372)	12/18/2020	4/30/2024	5/1/2021	9/28/2024
75086	G7ASDD	MX5515912	MX5515912 - AMAZON SOUTHWEST DELIVERY DIST. PRO	1,349		1,349			57,737	307,485	(249,748)	4/16/2020	10/11/2020	5/1/2020	4/4/2021
75086	G7ASRP	CMSP70	CMSP70 - ASRP CURB TO METER 3" OR LESS	1,131		1,131			8,880,564	20,388,002	(11,507,438)	3/4/2015	12/31/2019	7/1/2015	
75086	G7ASRP	MCSP70	MCSP70 - ASRP MAIN TO CURB 3" OR LESS	631,977		631,977			42,024,288	19,954,384	22,069,904	3/4/2015	12/31/2019	7/1/2015	
75086	G7CAS103	MX6366123	MX6366123 - 700 US RT 27 CASING #103 REMEDIATIO	72,848		72,848			72,848	19,397	53,451	3/2/2021	12/18/2020	3/1/2021	11/12/2021
75086	G7CAS53	V5417	V5417 - CASING 53 LINE AM07	(1,050)		(1,050)			87,764	409,578	(321,814)	8/29/2018	12/30/2018	10/1/2018	3/1/2019
75086	G7CAS718	V8637	V8637 - CASING #718 AM07C US RT 50	36,417		36,417			36,417	723,819	(687,402)	3/13/2019	12/30/2019	4/1/2019	12/6/2019
75086	G7ECOMPLX	V8967	V8967 - ERLANGER MODULAR COMPLEX	174,031		174,031			380,946	244,738	136,208	4/17/2019	10/30/2020	6/1/2019	1/30/2022
75086	G7ENCC	AW3484	AW3484 - ERLANGER CASINGS 2021	213,742		213,742			213,742	181,502	32,240	1/27/2021	3/31/2022	12/1/2021	4/13/2022
75086	G7ERGEMER	AW4046	AW4046 - EMERGENCY ERLANGER GAS CUT OUT	296,126		296,126			296,126	95,000	201,126	7/6/2021	10/30/2021	7/1/2021	11/6/2021
75086	G7ERLCP	AW1656	AW1656 - ERLANGER MAG ANODES	378,991		378,991			864,970	2,442,882	(1,577,912)	1/21/2020	12/31/2026	4/1/2020	
75086	G7HICKSP	MX5739585	MX5739585 - HICKS PIKE PRESSURE IMPROVEMENT PRO	747,187		747,187			747,187	254,017	493,170	4/20/2021	2/24/2022	5/1/2021	2/2/2022
75086	G7HMISTAT	AW0938	AW0938 - HMI WORK STATION ERLANGER	3,864		3,864			92,776	64,259	28,517	8/9/2019	3/2/2021	10/1/2019	8/15/2021
75086	G7IMPRPL	R0964	R0964 - REPLACE BANKLICK RD STATION INLET P	(395,895)		(395,895)			(395,895)	198,120	(594,015)	7/6/2015	9/10/2016	7/1/2015	8/27/2016
75086	G7INTDIG	AW2017	AW2017 - LINE UL06 INTEGRITY DIGS	(62,554)		(62,554)			1,326,004	2,024,700	(698,696)	4/9/2020	1/30/2021	4/1/2020	1/5/2021
75086	G7INTDIG	AW2018	AW2018 - LINE UL47 INTEGRITY DIGS	(25,880)		(25,880)			811,502	748,000	63,502	4/9/2020	1/30/2021	4/1/2020	10/9/2020
75086	G7LGMR	C9523	C9523 - PP864309/CWA	(2,678)		(2,678)			(2,678)	-	(2,678)	3/29/2007	12/31/2050	4/1/2007	10/8/2007
75086	G7LGMR	C9571	C9571 - CANCEL 2 STA 781-NUNN & UNV/CWA	(288)		(288)			(288)	-	(288)	4/10/2007	12/31/2050	4/1/2007	5/5/2008
75086	G7LGMR	E4656	E4656 - ABANDON SYSTEM STA 58	(1,240)		(1,240)			(1,240)	-	(1,240)	3/3/2009	4/30/2011	3/1/2010	11/24/2009
75086	G7LGMR	H0265	H0265 - REG 118K INSTALLATION	4,197		4,197			4,197	77,200	(73,002)	6/14/2013	6/30/2016	10/1/2014	1/25/2016

Duke Energy Kentucky Natural Gas
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Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	G7LGMR	H0485	H0485 - REG 21K IMPROVEMENTS-GRAND & FT THO	(2,730)		(2,730)			(2,730)	30,577	(33,307)	7/29/2013	6/30/2015	11/1/2013	2/11/2014
75086	G7LGMR	MX2218039	MX2218039 - INSTALL SCADA EQ-THREE MILE RD STA	52,620		52,620			601,163	411,228	189,934	9/21/2017	7/10/2020	10/1/2017	9/15/2020
75086	G7LGMR	MX6693835	MX6693835 - (CANCEL) REG 412 - 9TH & OVERTON	(59,231)		(59,231)			0	106,314	(106,314)	12/15/2017	3/31/2021	2/1/2018	
75086	G7LGMR	MX8652267	MX8652267 - OAKLAND VALVE HOUSE SCADA INSTALL	22,251		22,251			22,251	107,193	(84,942)	12/11/2018	9/30/2019	3/1/2019	10/24/2019
75086	G7LGMR	MX8672523	MX8672523 - (CANCEL)REG 119 BRISTOW RICHARDSON	(40,674)		(40,674)			-	262,006	(262,006)	3/21/2019	8/31/2020	5/1/2019	
75086	G7LGMR	T4002	T4002 - (CANCEL) STA 20933317 ERLANGER CP	(2,330)		(2,330)			(2,330)	31,943	(34,273)	3/17/2017	12/30/2018	8/1/2017	
75086	G7LGMR	T7778	T7778 - CANCEL-SCAD 21153712 KY	(1,006)		(1,006)			(1,006)	165,811	(166,817)	5/3/2017	6/29/2018	5/1/2017	
75086	G7LNUL57	AW0832	AW0832 - LINE UL57 MONOLITHIC INSULATORS	1,941		1,941			1,028,731	564,646	464,085	7/26/2019	12/25/2020	3/1/2020	12/3/2020
75086	G7LUL02	AW2880	AW2880 - LINE UL02 - MAOP REPLACEMENT	3,211,919		3,211,919			3,233,277	1,717,200	1,516,077	10/7/2020	3/31/2022	10/1/2020	1/5/2022
75086	G7LUL02	AW3546	AW3546 - LINE UL 02 MAOP REPL LAND	56,530		56,530			56,530	50,000	6,530	2/4/2021	3/31/2022	2/1/2021	1/5/2022
75086	G7MAINS	C9770	C9770 - CANCEL 2 STA 781-INLET/CWA	(108)		(108)			(108)	-	(108)	5/6/2007	12/31/2050	5/1/2007	5/5/2008
75086	G7MAINS	D1230	D1230 - CANCEL 2 844337/CHRIS AMPHER	(1,625)		(1,625)			(1,625)	-	(1,625)	7/23/2007	12/31/2050	9/1/2007	8/12/2008
75086	G7MAINS	E0351	E0351 - CANCEL 2 REG 51 INLET & OUTLET	(295)		(295)			(295)	62,278	(62,573)	8/6/2008	12/31/2009	6/1/2009	8/6/2008
75086	G7MAINS	E0468	E0468 - STA 795 OUTLET PIPING	(305)		(305)			(305)	12,659	(12,964)	8/12/2008	12/31/2050	9/1/2008	1/15/2009
75086	G7MAINS	E4954	E4954 - PP#1055138 2344 AMSTERDAM RD	(444)		(444)			(444)	1	(445)	3/19/2009	12/31/2010	6/1/2009	10/1/2009
75086	G7MAINS	E5278	E5278 - STA 793 INLET PIPING	(890)		(890)			(890)	28,188	(29,078)	3/30/2009	3/10/2014	4/1/2009	2/24/2010
75086	G7MAINS	E5285	E5285 - STA 793 - OUTLET PIPING	(706)		(706)			(706)	21,068	(21,774)	3/31/2009	3/11/2014	4/1/2009	2/24/2010
75086	G7MAINS	G1999	G1999 - STA 810 OUTLET PIPING F/L AM3	(501)		(501)			(501)	15,532	(16,033)	1/27/2011	6/1/2013	4/1/2011	2/4/2012
75086	G7MAINS	G3688	G3688 - STA 806 OUTLET PIPING	(2,368)		(2,368)			(2,368)	10,522	(12,889)	6/15/2011	6/30/2012	7/1/2011	1/28/2012
75086	G7MAINS	G3690	G3690 - STA 806 INLET PIPING	(1,129)		(1,129)			(1,129)	20,050	(21,179)	6/15/2011	3/31/2012	7/1/2011	1/28/2012
75086	G7MAINS	G5113	G5113 - REG 110K INLET & OUTLET PIPING	(2,697)		(2,697)			(2,697)	46,957	(49,655)	9/28/2011	2/10/2013	6/1/2012	11/17/2012
75086	G7MAINS	G8058	G8058 - CANCEL 2 JT EMAX 3298935 ARCADIA	339		339			339	49,594	(49,256)	7/13/2012	11/30/2014	7/1/2013	2/26/2014
75086	G7MAINS	H1364	H1364 - CANCEL 2 SUTTER DRIVE MN EXTENSION	(550)		(550)			(550)	1	(551)	12/2/2013	11/30/2014	8/1/2015	12/9/2015
75086	G7MAINS	MEAPJT70	MEAPJT70 - JOINT TRENCH PLASITC MAIN EXTENSION	1,126,599		1,126,599			4,877,162	10,000,000	(5,122,838)	1/13/2016	12/31/2050	2/1/2016	
75086	G7MAINS	MX0245370	MX0245370 - REDWOOD LIVING APARTMENTS - APPROAC	11,138		11,138			11,138	53,406	(42,268)	9/7/2021	5/29/2022	9/1/2021	4/20/2022
75086	G7MAINS	MX0270903	MX0270903 - FARM TAP PROJ. 3 MILE RD	(11,094)		(11,094)			403,127	365,845	37,283	3/21/2019	10/19/2019	4/1/2019	12/21/2019
75086	G7MAINS	MX0536654	MX0536654 - CANCEL-NEWPORT CLIFTON SU - HOME	35		35			35	765	(730)	4/12/2021	8/13/2024	6/1/2021	
75086	G7MAINS	MX0556249	MX0556249 - FARM TAP PROJ; CALIFORNIA CROSSROAD	(6,460)		(6,460)			270,898	123,394	147,504	1/14/2019	10/24/2019	5/1/2019	1/3/2020
75086	G7MAINS	MX0579746	MX0579746 - JT-G-RIVERS POINTE ESTATES PHASE 1	50,228		50,228			75,499	109,259	(33,760)	3/9/2020	9/24/2020	11/1/2020	6/13/2021
75086	G7MAINS	MX0590999	MX0590999 - FARM TAP; E LOW GAP RD ALEXANDRIA	14,074		14,074			386,865	359,351	27,515	7/31/2019	10/19/2022	8/1/2019	5/21/2020
75086	G7MAINS	MX0602140	MX0602140 - FARM TAP PROJ; ENZWEILER RD	192,858		192,858			200,085	83,366	116,719	9/1/2020	10/17/2021	9/1/2020	10/6/2021
75086	G7MAINS	MX0602571	MX0602571 - FARM TAP PROJ; JOHNS HILL RD	(280)		(280)			15,775	112,221	(96,445)	7/16/2019	12/12/2019	7/1/2019	6/2/2020
75086	G7MAINS	MX0610527	MX0610527 - JT-G-BALLYSHANNON SECTION 5 PHASE 9	135		135			135	42,243	(42,108)	11/30/2021	11/20/2022	12/1/2021	9/9/2022
75086	G7MAINS	MX0864994	MX0864994 - MADONNA MANOR PH 2 MEA, VILLA HILLS	14,630		14,630			14,630	72,524	(57,895)	9/24/2021	12/21/2021	10/1/2021	5/13/2022
75086	G7MAINS	MX0938445	MX0938445 - JT-G-AUTUMN RIDGE PHASE 1 PART B	8,732		8,732			8,732	45,429	(36,697)	11/16/2021	8/17/2022	12/1/2021	4/22/2022
75086	G7MAINS	MX0964990	MX0964990 - 425' PLASTIC GAS MAIN EXTENSION. SA	68,975		68,975			68,975	26,397	42,578	7/19/2021	12/24/2024	8/1/2021	2/2/2022
75086	G7MAINS	MX1062851	MX1062851 - HOGREFE RD MEA-171 FT 4 INCH PL HP	17,072		17,072			17,072	18,026	(954)	7/26/2021	12/17/2024	8/1/2021	12/21/2021
75086	G7MAINS	MX1130180	MX1130180 - FARM TAP PROJ; MARTHA LAYNE COLLINS	(1,091)		(1,091)			73,448	62,901	10,548	2/7/2019	4/3/2019	3/1/2019	3/17/2020
75086	G7MAINS	MX1289118	MX1289118 - CENTRE VIEW FARM TAP PROJECT - CRES	36,067		36,067			36,067	53,120	(17,053)	3/19/2021	7/4/2021	3/1/2021	9/16/2021
75086	G7MAINS	MX1304901	MX1304901 - FARM TAP PROJ; WAGONER RD CALIFORNI	(973)		(973)			34,132	46,479	(12,347)	6/26/2019	11/14/2019	7/1/2019	1/22/2020
75086	G7MAINS	MX1356700	MX1356700 - FARM TAP PROJ; WINTERS LN HIGHLAND	(4,276)		(4,276)			254,247	147,466	106,781	6/27/2019	12/26/2019	7/1/2019	3/11/2020
75086	G7MAINS	MX1688384	MX1688384 - NEW BUFFINGTON PH 2 EXTENSION; ELSE	21,998		21,998			21,998	25,501	(3,503)	9/8/2021	4/23/2024	9/1/2021	2/3/2022
75086	G7MAINS	MX1811415	MX1811415 - 137 PLAZA DR. FARM TAP,HIGHLAND HEI	22,852		22,852			22,852	34,481	(11,629)	9/24/2021	3/3/2022	10/1/2021	2/8/2022
75086	G7MAINS	MX1921442	MX1921442 - FARM TAP PROJECT REDSTONE RD - ALEX	194,717		194,717			194,717	74,424	120,293	3/24/2021	10/7/2024	4/1/2021	11/30/2021
75086	G7MAINS	MX1957438	MX1957438 - FARM TAP PROJ; GRANDVIEW RD	468,421		468,421			520,044	161,979	358,065	9/29/2020	12/16/2021	9/1/2020	1/10/2022
75086	G7MAINS	MX1957677	MX1957677 - FARM TAP PROJECT; UPPER LICK BRANCH	132,282		132,282			132,282	88,638	43,644	10/12/2021	6/16/2022	10/1/2021	5/8/2022
75086	G7MAINS	MX1958084	MX1958084 - FARM TAP PROJ; FLAGG SPRINGS PIKE	(6,089)		(6,089)			574,986	541,626	33,360	2/5/2020	5/22/2020	2/1/2020	10/30/2020
75086	G7MAINS	MX2043872	MX2043872 - FARM TAP PROJ; BARRS BRANCH RD	134,576		134,576			134,576	83,718	50,858	8/20/2021	6/23/2022	8/1/2021	5/29/2022
75086	G7MAINS	MX2142600	MX2142600 - FARM TAP PROJ; THORNTON RD	(626)		(626)			27,461	54,542	(27,081)	7/18/2019	12/19/2019	7/1/2019	1/26/2020
75086	G7MAINS	MX2143073	MX2143073 - FARM TAP PROJ; REIDLIN RD	(777)		(777)			36,380	43,438	(7,058)	5/21/2019	10/31/2019	6/1/2019	1/22/2020
75086	G7MAINS	MX2271880	MX2271880 - MEA ~800 FT; 494 JONES RD	179		179			242,929	163,070	79,859	7/30/2019	2/27/2020	8/1/2019	5/13/2020
75086	G7MAINS	MX2331188	MX2331188 - MEA, MASON ROAD FARM TAP-TAYLOW MIL	351,567		351,567			351,567	240,393	111,174	9/15/2021	8/25/2022	10/1/2021	8/2/2022
75086	G7MAINS	MX2424919	MX2424919 - MEA ~550 FT; 2000 GATEWAY BLVD	(726)		(726)			31,628	50,616	(18,988)	7/2/2019	12/12/2019	7/1/2019	1/18/2020
75086	G7MAINS	MX2848811	MX2848811 - INDEPENDENCE RD MEA -	(105)		(105)			5,447	35,185	(29,738)	9/30/2019	1/30/2020	10/1/2019	2/2/2020
75086	G7MAINS	MX3351619	MX3351619 - HIGHLAND AVE AND WOODLAND PL MAE -	3,361		3,361			3,361	19,811	(16,450)	12/10/2021	5/19/2022	12/1/2021	3/27/2022
75086	G7MAINS	MX4146445	MX4146445 - MEA ~ 25 FT; 411 COACHLIGHT DR	94		94			3,379	13,325	(9,946)	10/1/2019	2/13/2020	11/1/2019	1/20/2020
75086	G7MAINS	MX4210795	MX4210795 - JT-G-BALLYSHANNON SECTION 5 PHASE 6	(453)		(453)			37,073	52,790	(15,717)	12/19/2019	12/31/2020	1/1/2020	8/21/2020
75086	G7MAINS	MX4837396	MX4837396 - JT-G-PARK POINTE	53,081		53,081			53,379	81,024	(27,645)	2/24/2020	2/24/2021	3/1/2020	7/14/2021
75086	G7MAINS	MX4861864	MX4861864 - TERMINAL DR MEA-CVG CONRAC PROJECT	8,401		8,401			167,555	166,549	1,006	6/12/2020	12/17/2020	6/1/2020	1/12/2021
75086	G7MAINS	MX4875568	MX4875568 - FARM TAP PROJECT; E ALEXANDRIA / CA	108,574		108,574			1,052,421	1,255,100	(202,679)	3/3/2020	9/11/2020	3/1/2020	12/26/2020
75086	G7MAINS	MX5652554	MX5652554 - CANCEL-MASON-TAYLOR MILL-4IN PE 6IN	(4,978)		(4,978)			23	237,226	(237,203)	12/16/2020	9/24/2021	12/1/2020	
75086	G7MAINS	MX5653109	MX5653109 - FARM TAP PROJ; CROSBY PKWY/MAGELLAN	372,182		372,182			372,960	194,197	178,763	9/29/2020	7/13/2023	10/1/2020	11/15/2023
75086	G7MAINS	MX5709107	MX5709107 - CANCEL-FARM TAP PROJ; BRANCH RD	9		9			9	83,288	(83,278)	2/25/2021	12/16/2021	2/1/2021	
75086	G7MAINS	MX5913989	MX5913989 - JT-G-AUTUMN RIDGE PHASE 1 PART A	39,027		39,027			39,027	49,558	(10,531)	12/17/2020	5/31/2021	1/1/2021	6/22/2021
75086	G7MAINS	MX5924338	MX5924338 - JT-G-RIVERS POINTE ESTATES PHASE 1B	40,857		40,857			40,857	58,425	(17,568)	3/11/2021	9/28/2020	3/1/2021	8/30/2021
75086	G7MAINS	MX6180533	MX6180533 - 440 FT MEA; MEDICAL VILLAGE DR	1,734		1,734			105,970	74,687	31,283	7/29/2020	10/16/2020	8/1/2020	1/25/2021
75086	G7MAINS	MX6243694	MX6243694 - ~400 FT MEA; DOLWICK DR	1,346		1,346			60,831	104,176	(43,345)	6/18/2020	9/29/2020	7/1/2020	4/7/2021
75086	G7MAINS	MX6245365	MX6245365 - ~425 FT MEA; SARAH LN	155		155			10,735	26,840	(16,105)	8/31/2020	11/15/2020	9/1/2020	2/10/2021

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75086	G7MAINS	MX6684040	MX6684040 - ~1825 FTMEA; WRIGHT BLVD	93,531		93,531			143,430	117,730	25,699	10/2/2020	12/18/2020	10/1/2020	3/8/2021
75086	G7MAINS	MX6835553	MX6835553 - JT-G-SOUTHWICK PHASE B PART 1	52,091		52,091			52,149	46,989	5,160	11/23/2020	8/19/2021	12/1/2020	7/25/2021
75086	G7MAINS	MX6891268	MX6891268 - CANCEL AMAZON SOUTHWEST DELIVERY	(5,685)		(5,685)			270,054	319,190	(49,136)	5/22/2020	3/31/2021	5/1/2020	
75086	G7MAINS	MX7078370	MX7078370 - CANCEL INVESTMENT WAY MEA	(255)		(255)			-	39,282	(39,282)	8/14/2020	10/16/2020	8/1/2020	
75086	G7MAINS	MX7122512	MX7122512 - 100 FT MEA; 10009 INDIAN HILL DR	1,555		1,555			27,626	21,630	5,997	9/22/2020	11/27/2020	10/1/2020	3/12/2021
75086	G7MAINS	MX7231229	MX7231229 - STONEWATER APPROACH MAIN	573,471		573,471			578,083	201,666	376,417	12/15/2020	12/18/2021	12/1/2020	8/14/2021
75086	G7MAINS	MX7488442	MX7488442 - CANCEL-UARY VILLAGE PHASE 1 PART 3	(75)		(75)			41	44,181	(44,141)	9/23/2020	3/22/2023	10/1/2020	
75086	G7MAINS	MX7900133	MX7900133 - NORTH DILCREST - FLORENCE - 2" PE -	57,299		57,299			57,299	31,911	25,388	1/22/2021	7/22/2021	2/1/2021	7/22/2021
75086	G7MAINS	MX8030455	MX8030455 - CAMP ERNST AND SOLOMON MAE	9,407		9,407			42,355	42,779	(423)	10/19/2020	4/12/2021	11/1/2020	4/26/2021
75086	G7MAINS	MX8059955	MX8059955 - ~440 FT MEA; 2 IN PL HP	35,393		35,393			37,873	29,426	8,447	12/1/2020	5/11/2021	12/1/2020	5/6/2021
75086	G7MAINS	MX8197104	MX8197104 - JT-G-REDWOOD LIVING APARTMENTS	219		219			219	95,066	(94,846)	3/26/2021	12/30/2022	4/1/2021	12/19/2022
75086	G7MAINS	MX8230937	MX8230937 - JT-G-ARCADIA PHASE K & L	34,548		34,548			34,548	80,397	(45,850)	1/5/2021	12/28/2021	1/1/2021	7/26/2021
75086	G7MAINS	MX8451945	MX8451945 - INVESTMENT WAY MEA	504		504			27,319	16,225	11,095	10/16/2020	12/30/2020	11/1/2020	2/2/2021
75086	G7MAINS	MX8505395	MX8505395 - ~350 FT MEA; 351 KENTON LANDS	65,912		65,912			66,365	32,684	33,681	12/1/2020	2/28/2021	12/1/2020	6/28/2021
75086	G7MAINS	MX8574441	MX8574441 - GAS MAIN EXTENSION - 10177 BIG BONE	(3,914)		(3,914)			97,621	80,516	17,105	8/22/2018	10/19/2018	8/1/2018	6/2/2019
75086	G7MAINS	MX8593433	MX8593433 - JT-G-BATTLERIDGE PHASE G PART 2	19,742		19,742			19,742	57,245	(37,503)	12/17/2020	2/2/2022	1/1/2021	7/14/2021
75086	G7MAINS	MX8822845	MX8822845 - NEW BUFFINGTON RD - ELSMERE - 6" PE	100,011		100,011			100,011	84,635	15,376	1/25/2021	4/23/2021	2/1/2021	8/9/2021
75086	G7MAINS	MX9801147	MX9801147 - ELIJAH CREEK LOOP; NEYER DEVELOPMEN	3,232		3,232			3,232	88,033	(84,801)	11/30/2021	7/7/2022	12/1/2021	6/27/2022
75086	G7MAINS	MX9803235	MX9803235 - MARY GRUBS HWY - WALTON - 4" PE - M	33,617		33,617			33,617	20,070	13,547	5/10/2021	10/21/2024	6/1/2021	1/20/2022
75086	G7MAINS	P6888	P6888 - 201 STEELMAN MEA	(639)		(639)			(639)	11,921	(12,560)	11/20/2014	8/20/2015	2/1/2015	6/14/2015
75086	G7MAINS	S2732	S2732 - GO 9691430 STA 836 INLET PIPING	(17,842)		(17,842)			(17,842)	91,976	(109,819)	4/29/2016	12/11/2018	5/1/2016	12/28/2016
75086	G7MAINS	S2752	S2752 - GO 9691542 STA 836 OUTLET PIPING	188,728		188,728			188,728	48,219	140,509	4/29/2016	5/11/2018	5/1/2016	12/28/2016
75086	G7MASOINT	AW3449	AW3449 - DUKE MASON INTERCONNECT (KY)	891,362		891,362			891,362	2,000,000	(1,108,638)	1/26/2021	12/30/2021	1/1/2021	3/5/2022
75086	G7MREG118	MX2217622	MX2217622 - STATION 873 - 5TH & PHILADELPHIA	610		610			26,052	87,907	(61,855)	9/22/2017	11/30/2025	10/1/2017	
75086	G7MRUPG	AW1568	AW1568 - (CANCEL) STATION 338 MR UPGRADE	(68,189)		(68,189)			-	190,631	(190,631)	12/18/2019	3/30/2022	2/1/2020	
75086	G7MRUPG	AW1569	AW1569 - (CANCEL) STATION286 RILEY RD MR UPG	(45,326)		(45,326)			-	190,631	(190,631)	12/18/2019	3/30/2022	2/1/2020	
75086	G7MSCPRD	G1322	G1322 - REPLACE AIR DRYER ERLANGER	(741)		(741)			(741)	32,187	(32,928)	10/13/2010	6/30/2012	12/1/2010	5/11/2011
75086	G7PHMSA	V7283	V7283 - PHMSA CRM PLAN	144,757		144,757			1,988,909	416,794	1,572,115	11/14/2018	9/30/2020	12/1/2018	3/30/2021
75086	G7PRESIM	E7028	E7028 - COVINGTON AVE MAIN RPLC	(2,415)		(2,415)			(2,415)	43,788	(46,203)	6/11/2009	6/11/2014	6/1/2009	1/9/2010
75086	G7PRESIM	G6396	G6396 - TURKEYFOOT RD @ AUTUMN	(2,314)		(2,314)			(2,314)	206,055	(208,370)	1/4/2012	1/3/2013	4/1/2012	9/29/2012
75086	G7PRESIM	MX9177637	MX9177637 - INSTALL PRESSURE IMPROVEMENT PROJEC	(2,377)		(2,377)			(2,377)	-	(2,377)	9/24/2018	11/16/2018	12/1/2018	4/3/2019
75086	G7PUBIMP	30581	30581 - CANCEL- US 25 @ DRY RIDGE/GJH	(6,906)		(6,906)			(6,906)	-	(6,906)	4/13/2000	12/31/2003	7/1/1997	8/31/1997
75086	G7PUBIMP	A5943	A5943 - WATER WORKS RD BRIDGE/WJR	(6,511)		(6,511)			(6,511)	-	(6,511)	5/30/2001	12/31/2050	6/1/2001	5/4/2009
75086	G7PUBIMP	B1252	B1252 - CANCEL- BULLITSVILLE RD CONN/CWA	(6,946)		(6,946)			(6,946)	-	(6,946)	6/28/2002	12/31/2050	7/1/2002	
75086	G7PUBIMP	B2088	B2088 - 00-7015-1/CWA	(11,199)		(11,199)			(11,199)	-	(11,199)	9/20/2002	12/31/2050	8/1/2005	1/9/2009
75086	G7PUBIMP	B2469	B2469 - WILLIAMSTWN SERV ABAN/CWA	(2,431)		(2,431)			(2,431)	-	(2,431)	10/13/2002	12/31/2050	11/1/2002	11/11/2002
75086	G7PUBIMP	D2337	D2337 - PP495735/LAURA MATE	(7,911)		(7,911)			(7,911)	-	(7,911)	12/12/2007	12/31/2009	2/1/2009	10/23/2009
75086	G7PUBIMP	E6024	E6024 - SPILLMAN DR	(2,140)		(2,140)			(2,140)	128,455	(130,595)	4/29/2009	4/28/2014	5/1/2009	9/1/2009
75086	G7PUBIMP	G0795	G0795 - EDGECLIFF RD	(1,206)		(1,206)			(1,206)	40,331	(41,537)	8/26/2010	8/1/2011	9/1/2010	4/11/2011
75086	G7PUBIMP	G0796	G0796 - HAY & WILLOW STS	(815)		(815)			(815)	15,203	(16,018)	8/26/2010	3/31/2011	9/1/2010	12/13/2010
75086	G7PUBIMP	G0965	G0965 - JOHNS HILL RD	(2,039)		(2,039)			(2,039)	173,187	(175,226)	9/13/2010	4/1/2013	9/1/2011	9/13/2012
75086	G7PUBIMP	MX0073622	MX0073622 - CANCEL - NEWPORT CLIFTON STI	38		38			38	-	38	3/4/2021	7/20/2021	5/1/2021	
75086	G7PUBIMP	MX0129552	MX0129552 - CHAPMAN LN. - ROAD RECONSTRUCTION -	16,295		16,295			16,295	73,593	(57,297)	3/30/2021	2/17/2025	4/1/2021	6/29/2022
75086	G7PUBIMP	MX0503657	MX0503657 - JOYCE AVE STI-NEWPORT KY - 300' OF	129,066		129,066			129,066	50,389	78,677	6/22/2021	11/19/2024	6/1/2021	1/27/2022
75086	G7PUBIMP	MX0783884	MX0783884 - PLEASANT VALLEY ROAD/CAMP ERNST ROA	23,710		23,710			1,978,819	1,689,689	289,130	4/26/2018	8/25/2018	5/1/2018	1/22/2019
75086	G7PUBIMP	MX0790794	MX0790794 - ARLINGTON RD. ROADWAY IMP	(22,613)		(22,613)			330,547	227,712	102,835	1/23/2018	3/30/2018	3/1/2018	9/26/2018
75086	G7PUBIMP	MX1376296	MX1376296 - LONGBRANCH RD.	(9,895)		(9,895)			360,131	70,969	289,162	8/2/2019	3/5/2020	9/1/2019	9/15/2020
75086	G7PUBIMP	MX1682120	MX1682120 - CANCEL-*TEST HOLES* MADISON ST	2,949		2,949			2,949	-	2,949	8/18/2021	12/18/2024	9/1/2021	
75086	G7PUBIMP	MX2442598	MX2442598 - BROMLEY-CR. SPRINGS RD (KY 2373)	96,955		96,955			96,955	90,736	6,218	8/2/2021	2/6/2022	8/1/2021	1/31/2022
75086	G7PUBIMP	MX2624631	MX2624631 - EWING BLVDI STREET IMPROVEMENT PROJ	(290)		(290)			25,438	101,494	(76,056)	10/1/2019	2/27/2020	10/1/2019	4/9/2020
75086	G7PUBIMP	MX2698762	MX2698762 - DOH PENDELTON/CAMPBELL INSTALL STRE	1,761		1,761			311,171	99,384	211,787	9/20/2019	4/3/2020	12/1/2019	7/9/2020
75086	G7PUBIMP	MX2778391	MX2778391 - STI JAQUELINE DR ERLANGER 80' 4" ST	11,835		11,835			11,835	20,093	(8,257)	10/26/2021	5/22/2022	11/1/2021	3/6/2022
75086	G7PUBIMP	MX2781786	MX2781786 - CANCEL_KYTC 19-9001 I-275 GRAVES RD	91,399		91,399			91,399	70,083	21,316	12/9/2020	11/22/2023	6/1/2021	
75086	G7PUBIMP	MX2911494	MX2911494 - UL 35 STREET IMPROVEMENT PROJECT	(83)		(83)			28,757	51,296	(22,540)	8/2/2019	1/9/2020	9/1/2019	9/15/2020
75086	G7PUBIMP	MX3298765	MX3298765 - RIDGE RD. & WEST ORCHARD FT MITCHEL	(7,182)		(7,182)			50,034	94,800	(44,766)	7/28/2020	10/16/2020	7/1/2020	1/11/2021
75086	G7PUBIMP	MX3359474	MX3359474 - KYTC - RICHWOOD RD STI - BEAVERLICK	28,499		28,499			28,499	24,088	4,410	12/13/2021	12/31/2024	12/1/2021	6/22/2022
75086	G7PUBIMP	MX6477976	MX6477976 - CAMP ERNST STREET IMPROVEMENT PROJE	(17,776)		(17,776)			162,152	99,251	62,901	4/29/2020	6/26/2020	5/1/2020	1/11/2021
75086	G7PUBIMP	MX6628393	MX6628393 - PLEASANT VALLEY 2020 RELOCATION	(68,737)		(68,737)			389,693	399,033	(9,340)	5/18/2020	10/29/2020	6/1/2020	11/17/2020
75086	G7PUBIMP	MX7035169	MX7035169 - BUTTERMILK PIKE STREET IMPROVEMENT	(8,222)		(8,222)			90,684	74,108	16,576	7/8/2020	11/26/2020	7/1/2020	12/7/2020
75086	G7PUBIMP	MX7507727	MX7507727 - MXCONV-BROOKWOOD DR STI-EDGEWOOD, K	(21,357)		(21,357)			217,286	238,847	(21,561)	4/6/2018	8/24/2018	4/1/2018	10/26/2018
75086	G7PUBIMP	MX7599942	MX7599942 - INSTALL STREET IMPROVEMENT PROJECT	(1,611)		(1,611)			165,057	99,125	65,931	8/2/2019	2/27/2020	8/1/2019	2/29/2020
75086	G7PUBIMP	MX7625297	MX7625297 - STREET IMPROVEMENT PROJECT KY-338 J	30,941		30,941			30,941	45,951	(15,010)	4/4/2018	8/24/2018	4/1/2018	9/5/2018
75086	G7PUBIMP	MX7832792	MX7832792 - BROOKWOOD DR. SOUTH - EDGEWOOD - 4"	108,439		108,439			108,439	75,946	32,493	9/9/2020	5/21/2021	3/1/2021	9/7/2021
75086	G7PUBIMP	MX8175168	MX8175168 - CANCEL BUTTERMILK PIKE STR IMPROV	(6,859)		(6,859)			(1)	62,696	(62,697)	11/19/2019	3/31/2021	11/1/2019	
75086	G7PUBIMP	MX8662697	MX8662697 - CANCEL-PLEAST VALY PT 3 INSL STREET	13		13			13	-	13	11/4/2020	5/2/2021	6/1/2021	
75086	G7PUBIMP	MX8760866	MX8760866 - WKIP ROADWAY IMPROVEMENT JONES RD	(17,875)		(17,875)			351,185	208,010	143,175	6/14/2018	10/12/2018	6/1/2018	2/3/2019
75086	G7PUBIMP	MX8840782	MX8840782 - CANCEL INSTALL STREET IMPROVEMENT	(679)		(679)			7	-	7	2/6/2020	12/7/2018	2/1/2020	
75086	G7PUBIMP	MX9244894	MX9244894 - KYTC - MT.ZION RD KY536 STI	44,222		44,222			288,363	1,026,778	(738,415)	11/8/2019	6/30/2023	1/1/2020	7/27/2021

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75086	G7PUBIMP	MX9853572	MX9853572 - GRAVES AND NORTHBEND ROUNDABOUT PRO	236,245		236,245			236,245	109,422	126,823	2/16/2021	12/28/2023	2/1/2021	2/14/2022
75086	G7PUBIMP	MX9948553	MX9948553 - WILBERS LN - FORT THOMAS - 2" PE -	99,980		99,980			99,980	75,861	24,119	7/13/2021	12/16/2024	7/1/2021	2/21/2023
75086	G7PUBIMP	S8867	S8867 - STI 10873483 MT ZION RD	1,172,545		1,172,545			2,404,984	447,690	1,957,294	7/26/2016	1/30/2020	1/1/2017	12/21/2019
75086	G7PUINEW	INSREGREL	INSREGREL - INSTALL OR REMOVE REGULATOR/RELIEF	155,369		155,369			1,386,012	800,000	586,012	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	MX8375093	MX8375093 - M&R; 3087 TERMINAL DR; CVG AIRPORT	51,256		51,256			51,256	51,696	(440)	5/4/2021	8/24/2021	6/1/2021	6/27/2022
75086	G7PUINEW	SETMETER	SETMETER - SET OR REMOVE METER	2,145,872		2,145,872			9,847,152	2,250,000	7,597,152	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	T2904	T2904 - CANCEL-MTR 11540114 1 CARBON WAY	(2,056)		(2,056)			(2,056)	29,846	(31,902)	3/8/2017	12/31/2018	12/1/2017	
75086	G7PUINMR	AGECHGLG	AGECHGLG - KENTUCKY AGE CHANGE LARGE METER	71,872		71,872			603,960	350,000	253,960	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGSM	AGECHGSM - KENTUCKY AGE CHANGE SMALL METER	1,328,829		1,328,829			6,871,446	14,500,000	(7,628,554)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRLG	CHGMTRLG - CHANGE LARGE METER KENTUCKY	67		67			165,026	725,000	(559,974)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRSM	CHGMTRSM - CHANGE SMALL METER KENTUCKY	347,213		347,213			2,953,062	1,250,000	1,703,062	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGREGREL	CHGREGREL - CHANGE REGULATOR/RELIEF KENTUCKY	12,590		12,590			168,023	800,000	(631,977)	3/3/2015	12/31/2050	4/1/2015	
75086	G7REG0026	MX7281967	MX7281967 - REG 0026 UPHIL AND HIGHWAY - REG SW	(53)		(53)			8,753	48,954	(40,200)	7/7/2020	3/31/2021	8/1/2020	1/20/2021
75086	G7REG0031	MX2737090	MX2737090 - REG 0031 - NINTH AND YORK - ABANDON	121		121			121	-	121	11/2/2021	3/15/2022	12/1/2021	3/29/2022
75086	G7REG0048	MX7282035	MX7282035 - REG 0048 FIFTH AND PHILADELPHIA - R	9		9			12,803	48,954	(36,150)	7/14/2020	3/31/2021	8/1/2020	10/28/2020
75086	G7REG0057	MX7281845	MX7281845 - CANCEL -REG 0057 SARATOGA 11TH - OR	(28)		(28)			2,640	44,954	(42,313)	7/7/2020	3/31/2021	7/1/2020	
75086	G7REG0089	AW3224	AW3224 - REG 0427 EMPIRE DR	287,988		287,988			287,988	732,000	(444,012)	12/30/2020	10/30/2025	7/1/2021	
75086	G7REG0089	AW3246	AW3246 - REG 0427 EMPIRE DR LAND	48,525		48,525			48,525	82,500	(33,975)	1/2/2021	3/31/2026	4/1/2021	
75086	G7REG010	AW3280	AW3280 - REG 0010 STEVENSON AND LEXINGTON RE	27,569		27,569			27,569	58,000	(30,431)	1/6/2021	3/31/2022	6/1/2021	11/2/2021
75086	G7REG013	AW3273	AW3273 - REG 0013 SIXTEENTH AND HOLMAN REPAI	22,176		22,176			22,176	39,300	(17,124)	1/6/2021	3/31/2022	7/1/2021	11/24/2021
75086	G7REG017	AW3195	AW3195 - REG 0017 FOOTE AND FAIRFIELD REPAIR	23,266		23,266			23,266	429,700	(406,434)	12/29/2020	3/31/2023	9/1/2021	12/17/2021
75086	G7REG021	AW3278	AW3278 - REG 0021 GRAND AND S FT THOMAS REPA	13,852		13,852			13,852	56,400	(42,548)	1/6/2021	3/31/2022	7/1/2021	10/23/2021
75086	G7REG026	AW3184	AW3184 - REG 0437 UPHILL & HIGHWAY	8,596		8,596			8,596	507,300	(498,704)	12/28/2020	3/31/2023	12/1/2021	2/8/2023
75086	G7REG045	AW3228	AW3228 - REG 0432 TENTH & BRIGHTON	5,652		5,652			5,652	660,800	(655,148)	12/30/2020	3/31/2021	11/1/2021	7/11/2023
75086	G7REG045	AW3356	AW3356 - CANCEL- REG0432 TENTH-BRIGHTON LAND	17		17			17	82,500	(82,483)	1/13/2021	3/31/2023	9/1/2021	
75086	G7REG049	AW3290	AW3290 - REG 0049 PEARL AND TWENTIETH REPAIR	25,122		25,122			25,122	58,000	(32,878)	1/6/2021	3/31/2022	6/1/2021	10/24/2021
75086	G7REG051	AW3919	AW3919 - REG 0051 WALNUT AND ELECTRIC REPAIR	31,048		31,048			31,048	175,200	(144,152)	5/25/2021	3/31/2022	8/1/2021	11/23/2021
75086	G7REG053	MX9751457	MX9751457 - REG 0053 - OVERTON AND NINTH - REG	63,003		63,003			63,003	43,954	19,050	2/8/2021	3/31/2022	6/1/2021	10/28/2021
75086	G7REG055	AW3288	AW3288 - REG 0055 WRIGHT AND SPRING REPAIR	12,938		12,938			12,938	56,400	(43,462)	1/6/2021	3/31/2022	7/1/2021	10/23/2021
75086	G7REG057	AW3180	AW3180 - REG 0431 SARATOGA & ELEVENTH	8,665		8,665			8,665	796,400	(787,735)	12/28/2020	3/31/2023	11/1/2021	11/8/2023
75086	G7REG057	AW3354	AW3354 - CANCEL-REG431 SARATOGA-ELEVENTH ROW	11		11			11	82,500	(82,489)	1/13/2021	3/31/2023	6/1/2021	
75086	G7REG059	AW3177	AW3177 - REG 0059 HIGHLAND AND GRAND RS REPL	251,347		251,347			251,347	746,000	(494,653)	12/28/2020	9/30/2022	6/1/2021	2/9/2023
75086	G7REG059	AW3353	AW3353 - REG 0059 HIGHLAND AND GRAND LAND	6,870		6,870			6,870	82,500	(75,630)	1/13/2021	9/30/2022	4/1/2021	2/9/2023
75086	G7REG069	AW3287	AW3287 - REG 0069 JEFFERSON AND HAWTHORNE RE	22,091		22,091			22,091	56,400	(34,309)	1/6/2021	3/31/2022	7/1/2021	11/14/2021
75086	G7REG073	AW3286	AW3286 - REG 0073 GRAVES AND HULBERT REPAIR	43,814		43,814			43,814	58,000	(14,186)	1/6/2021	3/31/2022	6/1/2021	11/28/2021
75086	G7REG093	AW3284	AW3284 - REG 0093 ALEXANDRIA AND BLOSSUM REP	35,302		35,302			35,302	61,000	(25,698)	1/6/2021	3/31/2022	7/1/2021	11/20/2021
75086	G7REG095	AW3283	AW3283 - REG 0095 BAUM AND BURNET	36,593		36,593			36,593	402,900	(366,307)	1/6/2021	3/31/2022	8/1/2021	11/20/2021
75086	G7REG097	AW3282	AW3282 - REG 0097 HOME AND MAIN REPAIR	38,578		38,578			38,578	73,500	(34,922)	1/6/2021	3/31/2022	7/1/2021	1/13/2022
75086	G7REG684	MX9167642	MX9167642 - (CANCEL) REG0684-SHAW BLVD-REG UPG	46		46			46	51,954	(51,907)	1/8/2021	4/29/2021	2/1/2021	
75086	G7REG713	MX9168019	MX9168019 - REG 0713 - STATE RT 9 - REG UPGRADE	6,278		6,278			6,278	43,954	(37,675)	12/17/2020	4/29/2021	2/1/2021	5/12/2021
75086	G7REG74K	AW3285	AW3285 - REG 0074 MCALPIN N OF HOPE LN REPAI	40,504		40,504			40,504	54,100	(13,596)	1/6/2021	3/31/2022	7/1/2021	12/24/2021
75086	G7REPL	28051	28051 - SMALL REPL KY	140,084		140,084			1,329,228	-	1,329,228	4/13/2000	12/31/2050	12/1/1999	
75086	G7REPL	C6990	C6990 - CANCEL 2 R/W FOR STA 761/CWA	(10,613)		(10,613)			(10,613)	-	(10,613)	6/16/2006	12/31/2011	6/1/2006	9/18/2007
75086	G7REPL	E4280	E4280 - CANCEL 2 DRY CREEK LP03 R/W	(12)		(12)			(12)	9,510	(9,522)	2/11/2009	2/11/2014	5/1/2009	9/10/2009
75086	G7REPL	G2962	G2962 - CANCEL-MOORE ST	(201)		(201)			(201)	21,531	(21,732)	4/8/2011	10/15/2011	11/1/2011	11/3/2010
75086	G7REPL	MX0181170	MX0181170 - CENTRAL AVE NEWPORT- REPLACEMENT PR	(595)		(595)			21,501	64,213	(42,712)	12/12/2018	11/21/2019	12/1/2018	11/27/2019
75086	G7REPL	MX1233047	MX1233047 - KY-9 FLOOD GATE-RPL	(32,724)		(32,724)			162,972	92,509	70,463	10/23/2019	7/10/2020	10/1/2019	12/14/2020
75086	G7REPL	MX1379992	MX1379992 - WEST 13TH ST RPL PROJECT, NEWPORT,	13,824		13,824			13,824	44,019	(30,195)	9/13/2021	4/15/2024	9/1/2021	9/28/2022
75086	G7REPL	MX2163251	MX2163251 - CANCEL HIGHLAND AVE WOODLAND PL	7,128		7,128			7,128	24,723	(17,596)	9/30/2021	5/12/2022	10/1/2021	
75086	G7REPL	MX6840192	MX6840192 - CANCEL BEAVER RD INSTALL REPLACE	(99)		(99)			-	48,085	(48,085)	8/13/2020	11/20/2020	8/1/2020	
75086	G7REPL	MX8171793	MX8171793 - 2 INSTALL REPLACE	273		273			273	84,328	(84,055)	8/3/2018	9/28/2018	8/1/2018	1/16/2019
75086	G7REPL	MX9545566	MX9545566 - RICHWOOD RD REPLACEMENT PROJ KY-338	575,956		575,956			841,043	1,413,710	(572,667)	11/12/2019	6/14/2022	1/1/2020	3/1/2022
75086	G7REPL	MX9817206	MX9817206 - DUVENECK SQUARE RPL/MAE - COVINGTON	383,112		383,112			383,112	101,692	281,420	4/8/2021	10/1/2024	5/1/2021	12/14/2021
75086	G7REPL	T1130	T1130 - RPL 11859007 BALLYSHANNON - RELOCAT	(593)		(593)			-	37,388	(37,388)	12/20/2016	7/1/2017	12/1/2016	6/11/2017
75086	G7REPL	T2230	T2230 - RPL 20745900 HUDSON AVE	1,375		1,375			1,375	105,241	(103,866)	2/16/2017	3/31/2018	2/1/2017	9/28/2017
75086	G7REPL	T9340	T9340 - CANCEL RPL WATERWORKS RD. INLET	(2,648)		(2,648)			(2,648)	28,103	(30,750)	7/14/2017	9/1/2018	4/1/2018	
75086	G7REPL	T9341	T9341 - CANCEL RPL WATERWORKS RD. OUTLET	(2,936)		(2,936)			(2,936)	28,103	(31,039)	7/14/2017	9/1/2018	4/1/2018	
75086	G7RGPI	MX9217475	MX9217475 - GARVEY AVE. PRI, ELSMERE, 9400' 8"	748,257		748,257			748,257	507,691	240,566	8/16/2021	12/1/2022	9/1/2021	11/21/2022
75086	G7S3300	V7041	V7041 - LINE UL02 SEG 3300 PLEASANT VALLEY	60,725		60,725			12,759	2,643,704	(2,630,945)	11/6/2018	7/30/2020	1/1/2019	1/15/2020
75086	G7SECCON	V5175	V5175 - ERLANGER PROPANE SECURITY UPGRADE	(147,470)		(147,470)			2,801,921	950,000	1,851,921	8/21/2018	5/14/2020	2/1/2019	3/31/2020
75086	G7SERVMC	28763	28763 - CANCEL 2 LAKEVIEW DR/DMG	(366)		(366)			(366)	-	(366)	4/13/2000	12/31/2050	6/1/1996	6/11/1996
75086	G7SERVMC	30144	30144 - CANCEL-OAKMONT 821/DMG	(67)		(67)			(67)	-	(67)	4/13/2000	12/31/2050	11/1/1996	11/5/1996
75086	G7SERVMC	34524	34524 - 00-3054-4/KGA	(77)		(77)			(77)	-	(77)	4/13/2000	12/31/2005	10/1/2000	10/18/2000
75086	G7SERVMC	A2242	A2242 - 0000265/11 SHELBY/RENEW M-C	(814)		(814)			(632)	-	(632)	7/21/2000	12/31/2050	7/1/2000	12/18/2002
75086	G7SERVMC	A2577	A2577 - 0000299/7114 PRICE PK	(309)		(309)			(88)	-	(88)	8/20/2000	12/31/2050	8/1/2000	12/18/2002
75086	G7SERVMC	C9839	C9839 - CANCEL 2 PP896043/CWA	(99)		(99)			(99)	-	(99)	5/17/2007	12/31/2050	5/1/2007	9/22/2007
75086	G7SERVMC	CMRP70	CMRP70 - REPLACE C-M PLASTIC 2 INCH AND UNDE	212,023		212,023			12,647,252	-	12,647,252	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVMC	CMRS70	CMRS70 - 2" OR LESS STEEL C-M REPLACE	10,359		10,359			10,359	1,000,000	(989,641)	1/13/2016	12/31/2050	3/1/2016	

Duke Energy Kentucky Natural Gas
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Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	G7SERVMC	LCMRP70	LCMRP70 - GREATER THAN 2" C-M REPL PLASTIC	17,763		17,763			41,139	2,500,000	(2,458,861)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRP70	LMCRP70 - GREATER THAN 2" M-C REPL PLASTIC	56,771		56,771			312,192	2,500,000	(2,187,808)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRS70	LMCRS70 - GREATER THAN 2" M-C REPL STEEL	10,041		10,041			10,041	1,000,000	(989,959)	1/13/2016	12/31/2050	11/1/2016	
75086	G7SERVMC	MCRP70	MCRP70 - REPLACE (NON-AMRP) M-C PLASTIC 2 IN	2,521,083		2,521,083			19,364,066	-	19,364,066	7/1/2008	12/31/2050	7/1/2008	12/20/2009
75086	G7SERVMC	MCRS70	MCRS70 - REPLACE M-C STEEL 2 INCH AND UNDER	20,240		20,240			550,770	-	550,770	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVNEW	CMNEWP70	CMNEWP70 - NEW C-M PLASTIC 2 INCH AND UNDER KY	256,155		256,155			7,924,557	1	7,924,556	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	LMCNEWP70	LMCNEWP70 - GREATER THAN 2" M-C PLASTIC	33,159		33,159			480,511	2,500,000	(2,019,489)	1/13/2016	12/31/2050	3/1/2016	
75086	G7SERVNEW	LMCNEWS70	LMCNEWS70 - GREATER THAN 2" M-C STEEL	7,010		7,010			109,216	2,500,000	(2,390,784)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVNEW	MCNEWP70	MCNEWP70 - NEW M-C PLASTIC 2 INCH AND UNDER KY	2,652,517		2,652,517			17,829,079	1	17,829,078	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	MCNEWS70	MCNEWS70 - NEW M-C STEEL 2 INCH AND UNDER KY	14,364		14,364			249,903	1	249,902	12/31/2010	12/31/2050	4/1/2011	
75086	G7STA001	AW3315	AW3315 - STA 0001 ALEXANDRIA AM4 REPAIR	32,630		32,630			32,630	39,700	(7,070)	1/7/2021	3/31/2023	7/1/2021	12/29/2021
75086	G7STA011	AW3227	AW3227 - STA 0949 DAYTON VALVE HOUSE	33,513		33,513			33,513	1,062,400	(1,028,887)	12/30/2020	10/30/2025	11/1/2021	
75086	G7STA011	AW3250	AW3250 - STA 0949 DAYTON VALVE HOUSE LAND	19		19			19	82,500	(82,481)	1/2/2021	11/29/2025	6/1/2021	
75086	G7STA014	AW3251	AW3251 - CANCEL_STA 0014 EAST ALEXANDRIAPIKE	7		7			7	82,500	(82,493)	1/3/2021	3/31/2023	6/1/2021	
75086	G7STA034	AW3313	AW3313 - STA 0034 WILDERS PLANT REPAIR	41,320		41,320			41,320	76,500	(35,180)	1/7/2021	3/31/2022	7/1/2021	11/2/2021
75086	G7STA0375	AW3193	AW3193 - STA 0375 ELECTRIC AVE RS REPLACEMEN	1,380,350		1,380,350			1,380,350	829,000	551,350	12/28/2020	4/22/2022	5/1/2021	5/9/2022
75086	G7STA0375	AW3691	AW3691 - STA 00375 LAND ELECTRIC	233,918		233,918			233,918	82,500	151,418	2/27/2021	2/28/2022	4/1/2021	11/27/2021
75086	G7STA056	AW3310	AW3310 - STA 0056 BURLINGTON PIKE REPAIR	27,319		27,319			27,319	56,400	(29,081)	1/7/2021	3/31/2022	8/1/2021	11/23/2021
75086	G7STA064	AW3217	AW3217 - STA 0940 GLECOE TB	19,317		19,317			19,317	510,900	(491,583)	12/30/2020	3/31/2021	11/1/2021	9/27/2023
75086	G7STA064	AW3268	AW3268 - STA 0940 STA GLENCOE TB LAND	18		18			18	82,500	(82,482)	1/5/2021	3/31/2023	8/1/2021	9/27/2023
75086	G7STA072	AW3308	AW3308 - STA 0072 TENTH AND BRIGHTON REPAIR	21,787		21,787			21,787	58,000	(36,213)	1/7/2021	3/31/2022	6/1/2021	10/22/2021
75086	G7STA074	AW3307	AW3307 - STA 0074 LOUIS B NUNN REPAIR	32,323		32,323			32,323	59,300	(26,977)	1/7/2021	3/31/2022	6/1/2021	11/21/2021
75086	G7STA0836	AW3191	AW3191 - STA 0838 ROSSFORD AVE RS REPLACEMEN	1,367,466		1,367,466			1,367,466	539,500	827,966	12/28/2020	4/30/2022	5/1/2021	5/22/2022
75086	G7STA0836	AW3686	AW3686 - STA 0836 - LAND ROSSFORD AVE	54,181		54,181			54,181	82,500	(28,319)	2/26/2021	2/28/2022	4/1/2021	11/27/2021
75086	G7STA100	AW3306	AW3306 - STA 0100 CHESAPEAKE AND KYLE REPAIR	32,928		32,928			32,928	106,700	(73,772)	1/7/2021	3/31/2022	8/1/2021	1/13/2022
75086	G7STA117	AW3305	AW3305 - STA 0117 AMSTERDAM AND REDWOOD REPA	23,606		23,606			23,606	56,400	(32,794)	1/7/2021	3/31/2022	7/1/2021	10/27/2021
75086	G7STA276	AW3212	AW3212 - STA 0276 MARY INGLES HWY RS ABANDON	25,789		25,789			25,789	553,900	(528,111)	12/30/2020	3/31/2021	11/1/2021	11/18/2022
75086	G7STA276	AW3689	AW3689 - CANCEL-STA 0276 MARY IGLES HWY LAND	2,288		2,288			2,288	82,500	(80,212)	2/26/2021	3/31/2023	6/1/2021	
75086	G7STA280	AW3213	AW3213 - STA 0938 TAYLOR MILL & LONE OAK	10,337		10,337			10,337	562,000	(551,663)	12/30/2020	9/30/2023	11/1/2021	9/8/2023
75086	G7STA280	AW3272	AW3272 - STA0938 TAYLOR MILL & LONE OAK LAND	4,630		4,630			4,630	82,500	(77,870)	1/5/2021	3/31/2023	8/1/2021	9/8/2023
75086	G7STA286	AW3216	AW3216 - STA 0929 RILEY RD	67,592		67,592			67,592	635,200	(567,608)	12/30/2020	3/31/2021	9/1/2021	6/28/2023
75086	G7STA286	AW3271	AW3271 - STA 0929 RILEY RD LAND	18		18			18	82,500	(82,482)	1/5/2021	3/31/2023	6/1/2021	6/28/2023
75086	G7STA338	AW3192	AW3192 - STA 0941 GUBSER MILL	107,778		107,778			107,778	538,800	(431,022)	12/28/2020	12/30/2025	9/1/2021	
75086	G7STA338	AW3690	AW3690 - STA 0941 GUBSER MILL LAND	3,163		3,163			3,163	82,500	(79,337)	2/27/2021	10/25/2025	6/1/2021	
75086	G7STA444	AW3186	AW3186 - STA 0948 THIRD & CRESCENT	32,075		32,075			32,075	948,400	(916,325)	12/28/2020	11/27/2025	11/1/2021	
75086	G7STA444	AW3230	AW3230 - STA 0948 THIRD & CRESCENT LAND	2		2			2	82,500	(82,498)	12/31/2020	11/27/2025	8/1/2021	
75086	G7STA535	AW3299	AW3299 - STA 0535 DRY RIDGE EAST REPAIR	29,749		29,749			29,749	56,400	(26,651)	1/7/2021	8/31/2022	6/1/2021	12/2/2022
75086	G7STA750	AW3296	AW3296 - STA 0750 TURFWAY STATION REPAIR	17,649		17,649			17,649	112,700	(95,051)	1/7/2021	3/31/2022	7/1/2021	11/19/2021
75086	G7STA793	AW3188	AW3188 - STA 0942 CAMP ERNST RD	9,538		9,538			9,538	887,300	(877,762)	12/28/2020	9/30/2023	11/1/2021	1/18/2024
75086	G7STA793	AW3767	AW3767 - STA 0942 CAMP ERNST RD LAND	1,959		1,959			1,959	82,500	(80,541)	3/16/2021	3/31/2023	6/1/2021	1/18/2024
75086	G7STA822	AW3189	AW3189 - STA 0822 COX RD RS REPAIR	54,514		54,514			54,514	541,600	(487,086)	12/28/2020	12/31/2022	11/1/2021	11/18/2022
75086	G7STA822	AW3685	AW3685 - CANCEL 0822 - COX RD. RS REP - LAND	2,235		2,235			2,235	82,500	(80,265)	2/26/2021	12/31/2022	6/1/2021	
75086	G7STA876	MX6800938	MX6800938 - STA 876 WARSAW TOWN BORDER- STATION	62,634		62,634			146,236	252,984	(106,748)	1/10/2018	9/30/2022	1/1/2018	9/29/2023
75086	G7TAM00B	AW2146	AW2146 - LINE AM00B RETROFIT REPL	1,101,920		1,101,920			1,743,653	6,528,636	(4,784,983)	5/19/2020	10/15/2022	5/1/2020	9/17/2022
75086	G7TAM00B	AW3634	AW3634 - LINE AM00B ILI RETROFIT-LAND	36,480		36,480			36,480	127,500	(91,020)	2/17/2021	10/15/2022	10/1/2021	9/17/2022
75086	G7TOOLS	28073	28073 - PURCHASE GAS TOOLS BLANKET	120,817		120,817			841,430	-	841,430	4/13/2000	12/31/2015	12/1/1999	
75086	G7TOOLS	8SFYTOOLS	8SFYTOOLS - KENTUCKY HIGH RISK TOOLS	11,703		11,703			11,703	100,000	(88,297)	10/13/2020	12/30/2021	2/1/2021	3/31/2022
75086	G7TOOLS	AW4691	AW4691 - CGI UPGRADE KENTUCKY	53,130		53,130			53,130	120,000	(66,870)	10/22/2021	6/30/2022	12/1/2021	
75086	G7TUL06	AW1592	AW1592 - LINE UL06 - PIPELINE REPLACEMENTS	9,110,491		9,110,491			9,680,956	10,253,358	(572,402)	1/5/2020	12/30/2021	2/1/2020	12/3/2021
75086	G7TUL06	AW2021	AW2021 - LINE UL06 - PIPELINE REPLACEMENTS L	13,094		13,094			101,350	115,000	(13,650)	4/13/2020	12/31/2021	7/1/2020	12/3/2021
75086	G7UL02PH1	V8191	V8191 - UL60 PIPELINE PHASE 1 (PIPE)	624,617		624,617			38,616,620	26,326,195	12,290,425	1/23/2019	3/30/2021	1/1/2019	2/25/2021
75086	G7UL02PH1	V8351	V8351 - UL60 PIPELINE PHASE 1 (STATION)	64,939		64,939			1,794,289	6,287,827	(4,493,538)	2/11/2019	3/30/2021	7/1/2019	3/13/2021
75086	G7UL02PH1	V8352	V8352 - UL60 PIPELINE P1 - LAND RIGHTS PROJ	43,898		43,898			4,896,893	1,941,000	2,955,893	2/11/2019	3/30/2021	3/1/2019	2/25/2021
75086	G7UL02PH2	AW3877	AW3877 - UL60 PIPELINE PHASE II - STATION	83,744		83,744			83,744	1,004,152	(920,408)	4/29/2021	3/30/2022	5/1/2021	11/18/2021
75086	G7UL02PH2	V9444	V9444 - UL60 PIPELINE PHASE II - PIPE	23,821,700		23,821,700			25,418,975	22,514,005	2,904,970	6/12/2019	3/30/2022	10/1/2019	11/18/2021
75086	G7UL02PH2	V9445	V9445 - UL60 PIPELINE PHASE II- LAND RIGHTS	793,257		793,257			2,506,609	733,000	1,773,609	6/12/2019	2/2/2022	7/1/2019	11/18/2021
75086	G7WFD	MX5518434	MX5518434 - WENDELL FORD DIST. PROJ;	1,109		1,109			49,782	262,528	(212,746)	4/16/2020	10/2/2020	5/1/2020	2/11/2021
75086	G7WFD	MX6889178	MX6889178 - CANCEL WENDELL FORD	(295)		(295)			-	274,232	(274,232)	5/22/2020	8/21/2020	5/1/2020	2/16/2021
75086	G7WOODINT	AW3137	AW3137 - DUKE WOODSDALE INTERCONNECT (KY)	208,822		208,822			208,822	2,000,000	(1,791,178)	12/18/2020	12/31/2021	1/1/2021	1/31/2022
75086	GITKYCAP	F7146	F7146 - ITRON FCS KENTUCKY GAS	(422)		(422)			(422)	3,165	(3,587)	4/12/2010	5/15/2013	1/1/2012	2/7/2012
75086	GITKYCAP	R4959	R4959 - CANCEL 2 RICK ANALYSIS GAS TRANSMIS	(273)		(273)			(273)	2,431	(2,704)	12/7/2015	1/1/2017	4/1/2016	12/29/2016
75086	PEACHTRE	C5396	C5396 - CANCEL 2 PEACH TREE-R/W/PPW	(10,163)		(10,163)			(10,163)	-	(10,163)	1/22/2006	12/31/2011	8/1/2006	12/25/2007
75086	SG000489F	SG489SVR3	SG489SVR3 - DEE OPENWAY SCALE	4		4			3,520	1,190	2,330	9/25/2019	10/31/2020	9/1/2019	10/26/2020
75086	SG000489F	SG489SVR4	SG489SVR4 - DEE OPENWAY SCALE	(4)		(4)			-	442	(442)	1/29/2020	10/31/2020	3/1/2020	
75086	SG000540F	SG540HW	SG540HW - DEE VEHICLE AREA NETWORK	7,425		7,425			72,215	117,926	(45,711)	4/13/2018	12/17/2020	9/1/2018	5/15/2021
75086	SG000540F	SG540SW	SG540SW - DEE VEHICLE AREA NETWORK	(107)		(107)			-	107,801	(107,801)	4/13/2017	12/17/2020	4/1/2017	7/16/2018
75086	SG000723F	SG723SW	SG723SW - DEE AMI OPERATIONS TOOL	16,110		16,110			28,818	26,599	2,219	3/3/2020	7/30/2022	3/1/2020	7/31/2022
75086	SG000724F	SG724SW	SG724SW - DEE MDM TECHNICAL HEALTH	3,417		3,417			11,926	15,916	(3,990)	8/19/2020	6/24/2021	8/1/2020	9/30/2021

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Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	SG000781F	SG781SW	SG781SW - SG DEE PPM PIMS PHASE 2 BUILD OUT	(0)		(0)			77,936	76,874	1,062	7/12/2018	3/31/2021	7/1/2018	3/31/2022
75086	SG000940F	SG940SVR	SG940SVR - DEE EDMS PLATFORM UPGRADE	(62)		(62)			11,695	9,477	2,218	4/24/2020	12/18/2020	5/1/2020	2/7/2021
75086	SG001042F	SG1042SW	SG1042SW - DEE OPENWAY LICENSE EXTENSION	(107)		(107)			11,914	11,784	130	7/28/2020	10/30/2020	9/1/2020	12/31/2020
75086	SG001117F	SG001117	SG001117 - DEE LMR CONSOLES	92,729		92,729			92,729	124,921	(32,192)	8/25/2021	3/31/2023	10/1/2021	11/30/2022
75086	SGKAMIF	SG169MTRS	SG169MTRS - SG KY AMI GAS METERS - 169	395		395			9,375,749	9,563,026	(187,277)	6/7/2017	2/28/2019	6/1/2017	
75087	CUSTCONN	315986A	315986A - CUSTOMER CONNECT - CORE	655,235		655,235			3,583,886	2,325,960	1,257,926	8/10/2017	12/5/2022	8/1/2017	7/6/2022
75087	CUSTCONN	315986E	315986E - CUSTOMER CONNECT- UNIVERSAL BILL	48		48			243,832	117,210	126,622	8/11/2017	9/1/2020	8/1/2017	9/1/2020
75087	CUSTCONN	315986F	315986F - CUSTOMER CONNECT- R6-8 SCOPE	272,168		272,168			272,168	53,917	218,251	3/30/2021	6/30/2022	4/1/2021	7/6/2022
75087	CUSTCONN	315986HW6	315986HW6 - CUSTOMER CONNECT- HARDWARE PROJ 4	11,926		11,926			70,337	21,350	48,987	3/12/2020	3/15/2021	3/1/2020	6/1/2021
75087	CUSTCONN	315986HW7	315986HW7 - CUSTOMER CONNECT - HARDWARE PROJ 5	28,428		28,428			28,428	62,454	(34,026)	4/21/2021	12/31/2021	4/1/2021	12/31/2021
75087	CUSTCONN	315986HW8	315986HW8 - CUSTOMER CONNECT- HARDWARE PROJ 6	19,941		19,941			19,941	67,100	(47,159)	9/27/2021	6/30/2022	10/1/2021	9/15/2022
75087	FPIT	307482002	307482002 - CUSTOMER MOBILE APP - PHASE 3	70		70			3,106	26,324	(23,218)	12/19/2019	3/15/2022	1/1/2020	3/31/2022
75087	FPIT	307482SW2	307482SW2 - CUSTOMER MOBILE APP - PHASE 3	16,709		16,709			30,242	30,258	(16)	4/13/2020	3/15/2022	4/1/2020	3/31/2022
75087	FPIT	344598001	344598001 - DUKE CUSTOMER IVR REPLACEMENT	1,016		1,016			152,390	197,081	(44,691)	4/10/2018	1/28/2020	4/1/2018	1/30/2020
75087	FPIT	344637001	344637001 - MW TEST DATA ENHANCEMENT	(0)		(0)			(0)	1,828	(1,828)	3/14/2018	12/28/2018	3/1/2018	12/28/2018
75087	FPIT	400055002	400055002 - CHATBOT CHANNELS	17,979		17,979			17,979	6,219	11,760	12/8/2020	3/31/2022	1/1/2021	3/31/2022
75087	FPIT	400055005	400055005 - BUILDER PORTAL 2021	6,697		6,697			6,697	17,824	(11,127)	12/10/2020	9/30/2023	1/1/2021	9/30/2023
75087	FPIT	400055008	400055008 - PNG - CRT	902		902			902	11,377	(10,476)	4/30/2021	2/28/2022	5/1/2021	3/31/2022
75087	FPIT	400055009	400055009 - CALL CENTER ANALYTICS SW	57,180		57,180			57,180	5,888	51,292	5/26/2021	9/30/2022	6/1/2021	9/30/2022
75087	FPIT	400055010	400055010 - DIGITAL ASSISTANT PLATFORM PH 1	1,446		1,446			1,446	6,670	(5,224)	7/26/2021	3/15/2022	10/1/2021	3/31/2022
75087	FPIT	CC1900001	CC1900001 - CUSTOMER ANALYTICS ENGINE	19,857		19,857			35,428	26,306	9,122	1/27/2020	3/31/2022	2/1/2020	3/31/2022
75087	FPIT	CC2000003	CC2000003 - SITECORE JSS FRONT END MODERNIZATIO	16,986		16,986			30,410	28,721	1,689	6/25/2020	5/30/2022	8/1/2020	5/31/2022
75087	FPIT	CS1900001	CS1900001 - VOICE OF THE CUSTOMER ENGAGEMENT PL	14,018		14,018			31,496	13,742	17,754	1/29/2020	3/31/2022	2/1/2020	3/31/2022
75087	FPIT	CS2100003	CS2100003 - ASPECT LICENSE PURCHASE	5,848		5,848			5,848	5,845	3	4/26/2021	8/29/2021	6/1/2021	9/30/2021
75087	FPIT	CS2100004	CS2100004 - AVAYA LICENSE PURCHASE	22,259		22,259			22,259	22,443	(184)	5/12/2021	9/28/2021	5/1/2021	9/30/2021
75087	FPIT	CS2100005	CS2100005 - INFRASTRUCTURE FOR 24/7 INTOUCH	1,963		1,963			1,963	1,954	9	5/27/2021	1/31/2022	6/1/2021	2/28/2022
75087	FPIT	CS2100006	CS2100006 - UPLAND RIGHT ANSWER LICENSE PURCHAS	3,913		3,913			3,913	6,007	(2,094)	6/16/2021	1/31/2022	7/1/2021	1/31/2022
75087	FPIT	CS2100007	CS2100007 - VERINT LICENSE PURCHASE	10,156		10,156			10,156	17,714	(7,558)	7/20/2021	12/29/2021	9/1/2021	12/31/2021
75087	FPIT	CS2100008	CS2100008 - NUANCE IVR ENHANCEMENTS	2,737		2,737			2,737	4,174	(1,437)	7/16/2021	8/31/2022	8/1/2021	8/31/2022
75087	FPIT	CS2100009	CS2100009 - AVAYA LICENSE PURCHASE #2	10,839		10,839			10,839	18,874	(8,035)	7/27/2021	11/29/2021	9/1/2021	12/31/2021
75087	FPIT	LTHCESCS	LTHCESCS - WO OPTIMIZATION WORK INPUT/CALL-SW	4,789		4,789			4,789	13,750	(8,961)	2/25/2021	3/31/2022	2/1/2021	3/31/2021
75088	CY1900015	349395006	349395006 - ITOT OT SIEM PHASE 2 HW WORKSTREAM	(68,642)		(68,642)			51,508	5,497	46,011	4/13/2020	10/28/2022	5/1/2020	
75088	CY1900015	349395SW6	349395SW6 - ITOT OT SIEM SW WORKSTREAM	74,358		74,358			74,358	6,089	68,269	12/9/2021	10/28/2022	12/1/2021	
75088	CY1900015	CY190HW15	CY190HW15 - IT-OT ANA WORKSTREAM HW	15,558		15,558			15,650	113,909	(98,259)	12/11/2019	10/28/2022	1/1/2020	
75088	CY1900015	CY190SW15	CY190SW15 - IT-OT ANA WORKSTREAM SW	201		201			201	10,808	(10,607)	12/11/2019	10/28/2022	3/1/2021	
75088	MRTP2021	400052004	400052004 - DEK - TB5800 TEST SETS	3,915		3,915			3,915	26,866	(22,951)	9/17/2021	2/17/2022	12/1/2021	
				69,176,587	67,376,749	1,799,838	3%								

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Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	EAMHPBU	349472008	349472008 - EAM 2021 MAXIMO DURABLE TEAM	23,726		23,726			$ 64,726	84,630	(19,904)	1/22/2021	5/30/2022	2/1/2021	8/15/2022
75086	EAMHPBU	349472009	349472009 - NEW EAM 2021 MOBILE DURABLE TEAM	108		108			$ 1,842	39,130	(37,288)	1/13/2021	5/30/2022	2/1/2021	8/15/2022
75086	EAMHPBU	349472018	349472018 - EAM 2022 MAXIMO DURABLE TEAM	10,772		10,772			$ 10,772	6,760	4,012	1/4/2022	5/30/2023	1/1/2022	7/17/2023
75086	FMDT2020	MDTGAS20	MDTGAS20 - INSTALL WIN 7 PANASONIC TOUGHBOOKS	38,450		38,450			$ 534,413	403,995	130,418	10/10/2019	3/31/2021	12/1/2019	3/31/2021
75086	FPIT	349472016	349472016 - AUTODESK SUBSCRIPTION AGREEMENT	(4)		(4)			$ 11,782	11,803	(21)	10/29/2021	3/20/2022	11/1/2021	3/20/2022
75086	FPIT	349472020	349472020 - SLATE - EAM WORK MGMT SCHEDULING TO	12,519		12,519			$ 12,519	22,340	(9,821)	3/18/2022	6/30/2024	3/1/2022	6/30/2024
75086	FPIT	349472021	349472021 - FMA ENHANCEMENTS	2,994		2,994			$ 2,994	4,713	(1,719)	5/18/2022	3/31/2026	6/1/2022	
75086	FPIT	349472023	349472023 - SMALLWORLD ENHANCEMENTS	908		908			$ 908	15,341	(14,433)	9/29/2022	3/30/2025	11/1/2022	3/31/2024
75086	FPIT	349472024	349472024 - NEW PRIMAVERA OAM SERVERS	37		37			$ 37	173	(136)	9/29/2022	8/8/2023	10/1/2022	8/8/2023
75086	FPIT	349472S13	349472S13 - JUMP APPLICATION	1,015		1,015			$ 3,448	2,199	1,248	2/8/2021	7/30/2022	6/1/2021	10/1/2022
75086	FPIT	349472S14	349472S14 - NEW ESRI INTEGRATIONS AND INFRA	45,131		45,131			$ 49,890	532,359	(482,469)	2/9/2021	11/30/2023	3/1/2021	3/6/2024
75086	FPIT	349472SW6	349472SW6 - EAM-SC NEXT GEN MOBILE PLATFORM SW	3,601		3,601			$ 11,867	12,210	(343)	12/15/2020	7/29/2022	1/1/2021	9/27/2022
75086	FPIT	400055013	400055013 - NGBU COMMUNICATIONS PLATFORM ENHANC	36,260		36,260			$ 36,260	62,056	(25,796)	12/28/2021	9/29/2023	1/1/2022	7/31/2023
75086	FPIT	CC2000001	CC2000001 - NGBU COMMUNICATIONS PLATFORM	1,143		1,143			$ 59,570	1,242,489	(1,182,919)	3/30/2020	3/31/2022	4/1/2020	3/31/2022
75086	FPIT	IT1900067	IT1900067 - ARM TO MAXIMO INTEGRATION	(14)		(14)			$ 0	-	0	10/12/2020	7/31/2021	10/1/2020	7/27/2021
75086	FPIT	IT1900069	IT1900069 - TRG - WAM MEASUREMENT PROJECT	(215)		(215)			$ 0	65,041	(65,041)	2/21/2020	12/31/2021	3/1/2020	
75086	FPIT	IT2000091	IT2000091 - GIM TOOL ENHANCEMENTS AND NOTIFICAT	7,524		7,524			$ 31,324	37,595	(6,271)	12/14/2020	3/31/2022	3/1/2021	6/25/2022
75086	FPIT	IT2000092	IT2000092 - GTIS ENHANCEMENT AND ACOG	105,258		105,258			$ 198,280	111,184	87,096	12/22/2020	3/31/2023	1/1/2021	12/26/2022
75086	FPIT	IT2000093	IT2000093 - NG SCADA TRAINING SIMULATOR	51,005		51,005			$ 53,843	91,646	(37,803)	12/29/2020	1/29/2022	2/1/2021	3/20/2022
75086	FPIT	IT2000095	IT2000095 - TRACEABILITY PHASE 2	4,263		4,263			$ 92,319	275,326	(183,007)	1/5/2021	3/31/2022	1/1/2021	3/31/2022
75086	FPIT	IT2000098	IT2000098 - GAS SALES PLATFORM PHASE 2	16,784		16,784			$ 241,421	254,148	(12,727)	1/21/2021	3/31/2023	1/1/2021	3/31/2022
75086	FPIT	IT2000111	IT2000111 - KEY CONTROL SYSTEM	4,161		4,161			$ 35,512	30,928	4,584	1/13/2021	3/31/2022	2/1/2021	5/31/2022
75086	FPIT	IT2100084	IT2100084 - DEVONWAY LICENSE RENEWAL	5,216		5,216			$ 12,726	47,034	(34,308)	8/13/2021	8/31/2022	8/1/2021	8/31/2022
75086	FPIT	IT2100095	IT2100095 - MOBILE MAPPING CONSOLIDATION	288		288			$ 288	49,072	(48,784)	2/16/2022	2/28/2023	2/1/2022	
75086	FPIT	IT2100113	IT2100113 - GAS SALES PLATFORM PHASE 3	62,579		62,579			$ 62,579	77,035	(14,456)	1/7/2022	9/17/2023	1/1/2022	10/12/2023
75086	FPIT	IT2100114	IT2100114 - TRACEABILITY PHASE 2 EXTENSION	94,131		94,131			$ 94,131	132,599	(38,468)	1/20/2022	3/31/2023	1/1/2022	3/31/2023
75086	FPIT	IT2100132	IT2100132 - NGBU REPAIR PLAN EXPANSION	90,822		90,822			$ 90,822	75,912	14,910	1/27/2022	11/30/2023	2/1/2022	11/21/2023
75086	FPIT	IT2200081	IT2200081 - ENERGY EFFICIENCY REBATE PROCESSING	15,326		15,326			$ 15,326	11,692	3,634	6/10/2022	2/28/2023	6/1/2022	1/31/2023
75086	FPIT	LTHGBLDPL	LTHGBLDPL - LIGHTHOUSE GAS BUILDER PORTAL	59,754		59,754			$ 59,754	146,642	(86,888)	4/25/2022	10/31/2023	5/1/2022	7/26/2023
75086	FPIT	LTHGCHTRS	LTHGCHTRS - LIGHTHOUSE: GAS OPS CHARTER	30,005		30,005			$ 89,815	86,372	3,443	3/17/2021	9/30/2022	4/1/2021	6/30/2022
75086	FPIT	MOBILEMP	MOBILEMP - MOBILE MAPPING CONSOLIDATION	25,570		25,570			$ 25,570	-	25,570	8/16/2021	12/31/2022	8/1/2021	12/31/2022
75086	FPIT	TC2000057	TC2000057 - PNG TELECOM - LNG AND COMPRESSOR ST	26,282		26,282			$ 80,499	216,847	(136,348)	12/22/2020	3/31/2022	1/1/2021	5/15/2022
75086	FUNCTOHKY	107GASCK	107GASCK - GAS CAPITAL OVERHEAD	647,274		647,274			$ 1,668,589	-	1,668,589	7/1/2008	12/31/2050	7/1/2008	
75086	G701660	AW4645	AW4645 - EMERGENT AM01 COVINGTON LEVEE PH 1	5,267,886		5,267,886			$ 5,324,996	3,601,200	1,723,796	10/1/2021	1/30/2023	10/1/2021	2/28/2023
75086	G701662	AW4673	AW4673 - EMERGENT - CASING 34 - TAYLOR MILL	2,717,558		2,717,558			$ 2,719,440	3,207,100	(487,661)	10/13/2021	2/28/2023	11/1/2021	1/7/2023
75086	G701662	AW4878	AW4878 - ROW - CASING 34 - TAYLOR MILL	1,152		1,152			$ 1,152	71,800	(70,648)	12/22/2021	2/28/2023	6/1/2022	1/7/2023
75086	G712237	MX4669122	MX4669122 - HEBRON LOOP PH 2 PRESSURE IMPROVEME	20,516		20,516			$ 52,311	765	51,546	3/1/2021	3/4/2027	3/1/2021	
75086	G74092	MX3645041	MX3645041 - CHARTER - BRISTOW RD. PRESSURE IMP	32,296		32,296			$ 32,296	2,366	29,930	10/13/2022	7/24/2025	12/1/2022	10/28/2024
75086	G74238	43848219	43848219 - LAND - CHARTER - PATTY LN	3,226		3,226			$ 3,226	40,000	(36,774)	5/6/2022	3/31/2026	7/1/2022	
75086	G74381	AW5096	AW5096 - DRY RIDGE - EXPOSED MAIN	46,895		46,895			$ 46,895	33,500	13,395	2/17/2022	8/31/2022	3/1/2022	6/17/2022
75086	G74426	AW4587	AW4587 - CANCEL -GWUT DIGS ON AM07 (DUKE KY)	(182)		(182)			$ -	491,352	(491,352)	9/15/2021	3/31/2022	9/1/2021	
75086	G74964	MX5762350	MX5762350 - CHARTER - ST RT 536 - INDEPENDANCE	777,968		777,968			$ 777,968	842,183	(64,214)	2/23/2022	1/31/2024	3/1/2022	2/1/2023
75086	G75449	AW5471	AW5471 - LN AM07 SCCDA DIGS	722,650		722,650			$ 722,650	1,642,099	(919,448)	5/26/2022	12/31/2022	6/1/2022	11/27/2022
75086	G75498	MX5370534	MX5370534 - CHARTER-LP03 INSTALL PRESSURE IMPRO	189,688		189,688			$ 189,688	765	188,923	7/8/2022	3/30/2023	10/1/2022	3/6/2023
75086	G75629	AW5648	AW5648 - LN AM07 ECDA DIGS	1,639,865		1,639,865			$ 1,639,865	1,466,970	172,895	7/1/2022	12/31/2022	7/1/2022	1/20/2023
75086	G75683	MX4850228	MX4850228 - TOEBBEN DR - FLORENCE - 12" PL & 8"	415,571		415,571			$ 415,571	49,862	365,709	7/14/2022	12/29/2022	7/1/2022	12/26/2022
75086	G75920	AW5953	AW5953 - LN AM07 STATION ECDA DIGS	841,192		841,192			$ 841,192	734,404	106,788	7/29/2022	12/31/2022	8/1/2022	1/20/2023
75086	G75924	AW5965	AW5965 - LN AM00B ECDA DIGS	801,999		801,999			$ 801,999	1,098,620	(296,621)	8/3/2022	12/31/2022	8/1/2022	1/31/2023
75086	G75979	MX4329859	MX4329859 - CHARTER-KYTC 06-445.00 MINEOLA PK-E	2,377		2,377			$ 2,377	697,744	(695,366)	9/12/2022	3/28/2024	10/1/2022	12/6/2023
75086	G76300	AW6368	AW6368 - EMERGENT - AM07 EXPOSED MAIN (KY)	90,032		90,032			$ 90,032	1,348,700	(1,258,668)	11/16/2022	12/30/2023	11/1/2022	1/9/2024
75086	G76446	MX1322454	MX1322454 - CHARTER-KYTC-162.40-BRISTOW RD-STI-	42,422		42,422			$ 42,422	786,870	(744,448)	10/7/2022	10/29/2025	10/1/2022	3/7/2025
75086	G7AM00ACR	AW3397	AW3397 - LINE AM00A CORROSION REMEDIATION	60,837		60,837			$ 193,517	180,372	13,145	1/20/2021	3/31/2022	12/1/2021	3/20/2022
75086	G7AM00BVL	V5471	V5471 - AM00B & UL06 VALVE AUTOMATION	257,827		257,827			$ 257,827	1,830,100	(1,572,273)	11/22/2021	12/30/2023	4/1/2022	12/6/2023
75086	G7AM07IL2	AW4685	AW4685 - LINE AM07 PIPELINE REPLACEMENT PHAS	569,485		569,485			$ 609,689	33,015,500	(32,405,811)	10/18/2021	2/28/2025	11/1/2021	2/6/2025
75086	G7AM07IL2	AW5957	AW5957 - CANCEL_LINE AM07 PHASE 2 - STATION	66		66			$ 66	9,656,000	(9,655,934)	8/1/2022	2/28/2025	10/1/2022	
75086	G7AM07ILI	0233100	0233100 - LINE AM07 PIPELINE REPLACEMENT PHAS	1,119,078		1,119,078			$ 1,892,075	37,717,000	(35,824,925)	12/9/2020	12/31/2023	12/1/2020	3/18/2024
75086	G7AM07ILI	AW3074	AW3074 - LINE AM07 PIPELINE REPLACE LAND	1,019,261		1,019,261			$ 1,123,597	6,089,500	(4,965,903)	12/3/2020	12/31/2023	2/1/2021	3/18/2024
75086	G7AM07ILI	AW3138	AW3138 - LINE AM07 PIPELINE REPLACEMENT-STN	2,049,567		2,049,567			$ 2,062,495	6,278,300	(4,215,805)	12/18/2020	4/30/2024	5/1/2021	9/28/2024
75086	G7ASDD	MX5515912	MX5515912 - AMAZON SOUTHWEST DELIVERY DIST. PRO	270,054		270,054			$ 327,791	307,485	20,306	4/16/2020	10/11/2020	5/1/2020	4/4/2021
75086	G7ASRP	CMSP70	CMSP70 - ASRP CURB TO METER 3" OR LESS	19,295		19,295			$ 8,899,859	20,388,002	(11,488,143)	3/4/2015	12/31/2019	7/1/2015	
75086	G7ASRP	MCSP70	MCSP70 - ASRP MAIN TO CURB 3" OR LESS	993,992		993,992			$ 43,018,280	19,954,384	23,063,896	3/4/2015	12/31/2019	7/1/2015	
75086	G7CORREM	AW5064	AW5064 - KENTUCKY - CORROSION REMEDIATION	124,670		124,670			$ 124,670	272,000	(147,330)	2/10/2022	9/30/2025	8/1/2022	
75086	G7ECOMPLX	V8967	V8967 - ERLANGER MODULAR COMPLEX	(2,367)		(2,367)			$ 378,579	244,738	133,841	4/17/2019	10/30/2020	6/1/2019	1/30/2022
75086	G7EDGE	39171904	39171904 - CANCEL-ROW- EDGEWOOD PRESSURE IMP	29,427		29,427			$ 29,427	40,000	(10,573)	6/7/2022	1/31/2023	8/1/2022	
75086	G7EDGE	MX9171904	MX9171904 - EDGEWOOD PRESSURE IMP	413,627		413,627			$ 413,627	108,826	304,801	9/22/2022	7/29/2023	9/1/2022	7/24/2023
75086	G7EM6131	AW6193	AW6193 - KLEERBAND REMED AND COAT KY	4,793		4,793			$ 4,793	120,000	(115,207)	10/3/2022	6/30/2023	12/1/2022	5/13/2023
75086	G7EMAM07	AW5092	AW5092 - EMERGENT - LINE AM07 - EXPOSED MAIN	339,762		339,762			$ 339,762	1,319,200	(979,438)	2/15/2022	6/30/2023	4/1/2022	9/30/2023
75086	G7ENCC	AW3484	AW3484 - ERLANGER CASINGS 2021	79		79			$ 213,821	181,502	32,320	1/27/2021	3/31/2022	12/1/2021	4/13/2022
75086	G7ERGEMER	AW4046	AW4046 - EMERGENCY ERLANGER GAS CUT OUT	(4,338)		(4,338)			$ 291,788	95,000	196,788	7/6/2021	10/30/2021	7/1/2021	11/6/2021
75086	G7ERLCP	AW1656	AW1656 - ERLANGER MAG ANODES	729,327		729,327			$ 1,594,296	2,442,882	(848,585)	1/21/2020	12/31/2026	4/1/2020	
75086	G7ESPEP	MX9171927	MX9171927 - ELSMERE PRESSURE IMP	1,381,514		1,381,514			$ 1,381,514	327,968	1,053,546	4/25/2022	7/29/2023	5/1/2022	7/5/2023
75086	G7HARRPK	AW4778	AW4778 - ROW - HARRIS PIKE UL45 EXT	35,509		35,509			$ 35,509	926,800	(891,291)	11/16/2021	11/30/2026	7/1/2022	
75086	G7HARRPK	AW4796	AW4796 - HARRIS PIKE UL45 EXT - PRESSURE IMP	366,895		366,895			$ 366,895	7,884,400	(7,517,505)	11/19/2021	11/30/2026	2/1/2022	
75086	G7HICKSP	MX5739585	MX5739585 - HICKS PIKE PRESSURE IMPROVEMENT PRO	3,800		3,800			$ 750,988	254,017	496,970	4/20/2021	2/24/2022	5/1/2021	2/2/2022
75086	G7HMISTAT	AW0938	AW0938 - HMI WORK STATION ERLANGER	4,705		4,705			$ 97,481	64,259	33,222	8/9/2019	3/2/2021	10/1/2019	8/15/2021
75086	G7LGMR	MX6828172	MX6828172 - TO BE CANCEL-REG420BELAIR&SPICEWOOD	(28,971)		(28,971)			$ 83	139,842	(139,759)	4/4/2018	3/31/2021	1/1/2019	
75086	G7LGMR	T4002	T4002 - (CANCEL) STA 20933317 ERLANGER CP	(78)		(78)			$ (2,408)	31,943	(34,351)	3/17/2017	12/30/2018	8/1/2017	
75086	G7LGMR	T7778	T7778 - CANCEL-SCAD 21153712 KY	(53)		(53)			$ (1,059)	165,811	(166,870)	5/3/2017	6/29/2018	5/1/2017	
75086	G7LUL02	AW2880	AW2880 - LINE UL02 - MAOP REPLACEMENT	8,794		8,794			$ 3,242,071	1,717,200	1,524,871	10/7/2020	3/31/2022	10/1/2020	1/5/2022

75086	G7LUL02	AW3546	AW3546 - LINE UL 02 MAOP REPL LAND	1,647	1,647	$	58,177	50,000	8,177	2/4/2021	3/31/2022	2/1/2021	1/5/2022
75086	G7MAINS	42331188	42331188 - MEA, MASON ROAD FARM TAP-TAYLOW MIL	135	135	$	135	40,000	(39,865)	3/4/2022	8/27/2022	3/1/2022	8/4/2022
75086	G7MAINS	42698978	42698978 - ROW E MT ZION RD; INDEPNDNCE	2,458	2,458	$	2,458	15,000	(12,542)	2/28/2022	1/31/2023	6/1/2022	2/16/2023
75086	G7MAINS	AW6146	AW6146 - CANCEL_ROW LAKELAND PARK DR; LIM	3,410	3,410	$	3,410	25,000	(21,590)	9/20/2022	12/31/2023	10/1/2022	
75086	G7MAINS	AW6147	AW6147 - CANCEL-ROW MEA -STANBERY RIDGE	410	410	$	410	25,000	(24,590)	9/20/2022	9/9/2023	10/1/2022	
75086	G7MAINS	MEAPJT70	MEAPJT70 - JOINT TRENCH PLASITC MAIN EXTENSION	1,014,176	1,014,176	$	5,891,338	10,000,000	(4,108,662)	1/13/2016	12/31/2050	2/1/2016	
75086	G7MAINS	MX0245370	MX0245370 - REDWOOD LIVING APARTMENTS - APPROAC	120,390	120,390	$	131,528	53,406	78,122	9/7/2021	5/29/2022	9/1/2021	4/20/2022
75086	G7MAINS	MX0536654	MX0536654 - CANCEL-NEWPORT CLIFTON SU - HOME	(35)	(35)	$	-	765	(765)	4/12/2021	8/13/2024	6/1/2021	
75086	G7MAINS	MX0610527	MX0610527 - JT-G-BALLYSHANNON SECTION 5 PHASE 9	43,865	43,865	$	44,000	42,243	1,757	11/30/2021	11/20/2022	12/1/2021	9/9/2022
75086	G7MAINS	MX0864994	MX0864994 - MADONNA MANOR PH 2 MEA, VILLA HILLS	98,664	98,664	$	113,293	72,524	40,769	9/24/2021	12/21/2021	10/1/2021	5/13/2022
75086	G7MAINS	MX0938445	MX0938445 - JT-G-AUTUMN RIDGE PHASE 1 PART B	21,139	21,139	$	29,871	45,429	(15,558)	11/16/2021	8/17/2022	12/1/2021	4/22/2022
75086	G7MAINS	MX0964990	MX0964990 - 425' PLASTIC GAS MAIN EXTENSION. SA	873	873	$	69,847	26,397	43,450	7/19/2021	12/24/2024	8/1/2021	2/2/2022
75086	G7MAINS	MX1062851	MX1062851 - HOGREFE RD MEA-171 FT 4 INCH PL HP	1,237	1,237	$	18,310	18,026	284	7/26/2021	12/17/2024	8/1/2021	12/21/2021
75086	G7MAINS	MX1688384	MX1688384 - NEW BUFFINGTON PH 2 EXTENSION; ELSE	1,003	1,003	$	23,001	25,501	(2,500)	9/8/2021	4/23/2024	9/1/2021	2/3/2022
75086	G7MAINS	MX1811415	MX1811415 - 137 PLAZA DR. FARM TAP,HIGHLAND HEI	3,227	3,227	$	26,079	34,481	(8,402)	9/24/2021	3/3/2022	10/1/2021	2/8/2022
75086	G7MAINS	MX1921442	MX1921442 - FARM TAP PROJECT REDSTONE RD - ALEX	195	195	$	194,912	74,424	120,488	3/24/2021	10/7/2024	4/1/2021	11/30/2021
75086	G7MAINS	MX1957438	MX1957438 - FARM TAP PROJ; GRANDVIEW RD	(25,174)	(25,174)	$	494,870	161,979	332,891	9/29/2020	12/16/2021	9/1/2020	1/10/2022
75086	G7MAINS	MX1957677	MX1957677 - FARM TAP PROJECT; UPPER LICK BRANCH	22,648	22,648	$	154,929	88,638	66,292	10/12/2021	6/16/2022	10/1/2021	5/8/2022
75086	G7MAINS	MX2043872	MX2043872 - FARM TAP PROJ; BARRS BRANCH RD	23,869	23,869	$	158,445	83,718	74,727	8/20/2021	6/23/2022	8/1/2021	5/29/2022
75086	G7MAINS	MX2061333	MX2061333 - STONEWATER PHASE B1 APPROACH MAIN	159,157	159,157	$	159,157	128,083	31,074	2/10/2022	8/4/2022	2/1/2022	7/21/2022
75086	G7MAINS	MX2061362	MX2061362 - JT-G-THE RESERVE AT BELLEVUE	80,637	80,637	$	80,637	46,815	33,822	12/16/2021	3/1/2023	1/1/2022	12/14/2022
75086	G7MAINS	MX2331188	MX2331188 - MEA, MASON ROAD FARM TAP-TAYLOW MIL	256,955	256,955	$	608,522	240,393	368,128	9/15/2021	8/25/2022	10/1/2021	8/2/2022
75086	G7MAINS	MX2698978	MX2698978 - E MT ZION RD; INDEPENDENCE; 6" PL;	532,305	532,305	$	532,305	161,397	370,907	7/21/2022	2/26/2023	7/1/2022	2/21/2023
75086	G7MAINS	MX2700925	MX2700925 - BRECKENRIDGE; ALEXANDRIA; 4" PL; MA	126,578	126,578	$	126,578	76,343	50,235	5/18/2022	11/17/2022	5/1/2022	11/8/2022
75086	G7MAINS	MX3351619	MX3351619 - HIGHLAND AVE AND WOODLAND PL MAE -	29,906	29,906	$	33,268	19,811	13,456	12/10/2021	5/19/2022	12/1/2021	3/27/2022
75086	G7MAINS	MX3676138	MX3676138 - JT-G-MEMORIAL POINTE PART 1	158	158	$	158	30,149	(29,990)	9/14/2022	8/4/2024	10/1/2022	9/26/2023
75086	G7MAINS	MX3738158	MX3738158 - JT-G-SAWGRASS PHASE D PART 2	158	158	$	158	36,692	(36,534)	10/4/2022	4/22/2024	10/1/2022	10/23/2023
75086	G7MAINS	MX3880107	MX3880107 - SERVICE RD; WALTON; 6" PL; MEA	81,615	81,615	$	81,615	54,841	26,773	4/20/2022	9/15/2022	5/1/2022	9/5/2022
75086	G7MAINS	MX3955327	MX3955327 - LOCK RD-BUTLER-1200 FT 4 INCH PL MA	152,492	152,492	$	152,492	66,243	86,249	7/15/2022	12/29/2022	7/1/2022	12/20/2022
75086	G7MAINS	MX4296108	MX4296108 - RICE PK; UNION; 4" PL; MEA	107,237	107,237	$	107,237	79,193	28,044	6/7/2022	11/17/2022	6/1/2022	11/16/2022
75086	G7MAINS	MX4309183	MX4309183 - JT-G-BALLYSHANNON SECTION 5 PHASE 1	23,985	23,985	$	23,985	58,460	(34,475)	4/7/2022	6/5/2023	4/1/2022	2/9/2023
75086	G7MAINS	MX4309894	MX4309894 - HICKS PK; UNION; 4" PL; MEA	31,077	31,077	$	31,077	21,184	9,893	4/20/2022	9/15/2022	5/1/2022	9/11/2022
75086	G7MAINS	MX4720432	MX4720432 - 498 MASON RD FARM TAP EXTENSION	22,241	22,241	$	22,241	17,882	4,359	8/25/2022	3/9/2023	8/1/2022	2/16/2023
75086	G7MAINS	MX4752800	MX4752800 - MILITARY PKWY-FORT THOMAS-60 FT 2 I	15,798	15,798	$	15,798	389	15,409	6/15/2022	11/24/2022	6/1/2022	10/27/2022
75086	G7MAINS	MX5095081	MX5095081 - EAST FROGTOWN RD; RICHWOOD; 6" PL;	92,835	92,835	$	92,835	71,068	21,767	8/18/2022	3/30/2023	8/1/2022	2/20/2023
75086	G7MAINS	MX5190163	MX5190163 - FROGTOWN CONNECTOR; RICHWOOD ; 4" P	54,978	54,978	$	54,978	2,851	52,127	8/3/2022	1/12/2023	8/1/2022	1/1/2023
75086	G7MAINS	MX5652554	MX5652554 - CANCEL-MASON-TAYLOR MILL-4IN PE 6IN	(23)	(23)	$	0	237,226	(237,226)	12/16/2020	9/24/2021	12/1/2020	
75086	G7MAINS	MX5653109	MX5653109 - FARM TAP PROJ; CROSBY PKWY/MAGELLAN	176,792	176,792	$	549,752	194,197	355,554	9/29/2020	7/13/2023	10/1/2020	11/15/2023
75086	G7MAINS	MX5709107	MX5709107 - CANCEL-FARM TAP PROJ; BRANCH RD	(9)	(9)	$	-	83,288	(83,288)	2/25/2021	12/16/2021	2/1/2021	
75086	G7MAINS	MX5751969	MX5751969 - MEA - STANBERY RIDGE-FORT THOMAS-47	103,580	103,580	$	103,580	24,699	78,880	10/4/2022	3/23/2023	10/1/2022	3/21/2023
75086	G7MAINS	MX6108813	MX6108813 - PARKVIEW ESTATES APP - UNION - 8" &	168,822	168,822	$	168,822	134,092	34,729	10/26/2022	3/23/2023	11/1/2022	4/10/2023
75086	G7MAINS	MX6362268	MX6362268 - SERVICE RD; WALTON; 6" PL; MEA	13,570	13,570	$	13,570	61,478	(47,908)	11/10/2022	4/13/2023	11/1/2022	4/20/2023
75086	G7MAINS	MX6445818	MX6445818 - CARBON WAY; RICHWOOD; 6" PL; MEA	28,344	28,344	$	28,344	100,162	(71,818)	11/14/2022	6/8/2023	11/1/2022	5/30/2023
75086	G7MAINS	MX6891268	MX6891268 - CANCEL AMAZON SOUTHWEST DELIVERY	(270,054)	(270,054)	$	-	319,190	(319,190)	5/22/2020	3/31/2021	5/1/2020	
75086	G7MAINS	MX7488442	MX7488442 - CANCEL-UARY VILLAGE PHASE 1 PART 3	(41)	(41)	$	-	44,181	(44,181)	9/23/2020	3/22/2023	10/1/2020	
75086	G7MAINS	MX8197104	MX8197104 - JT-G-REDWOOD LIVING APARTMENTS	25,637	25,637	$	25,856	95,066	(69,210)	3/26/2021	12/30/2022	4/1/2021	12/19/2022
75086	G7MAINS	MX9801147	MX9801147 - ELIJAH CREEK LOOP; NEYER DEVELOPMEN	155,087	155,087	$	158,319	88,033	70,286	11/30/2021	7/7/2022	12/1/2021	6/27/2022
75086	G7MAINS	MX9803235	MX9803235 - MARY GRUBS HWY - WALTON - 4" PE - M	5,567	5,567	$	39,183	20,070	19,113	5/10/2021	10/21/2024	6/1/2021	1/20/2022
75086	G7MREG118	MX2217622	MX2217622 - STATION 873 - 5TH & PHILADELPHIA	152,915	152,915	$	178,967	87,907	91,060	9/22/2017	11/30/2025	10/1/2017	
75086	G7PUBIMP	MX0073622	MX0073622 - CANCEL - NEWPORT CLIFTON STI	(38)	(38)	$	-	-	-	3/4/2021	7/20/2021	5/1/2021	
75086	G7PUBIMP	MX0129552	MX0129552 - CHAPMAN LN. - ROAD RECONSTRUCTION -	121,065	121,065	$	137,361	73,593	63,768	3/30/2021	2/17/2025	4/1/2021	6/29/2022
75086	G7PUBIMP	MX0503657	MX0503657 - JOYCE AVE STI-NEWPORT KY - 300' OF	12,595	12,595	$	141,661	50,389	91,272	6/22/2021	11/19/2024	6/1/2021	1/27/2022
75086	G7PUBIMP	MX1682120	MX1682120 - CANCEL-*TEST HOLES* MADISON ST	(2,949)	(2,949)	$	-	-	-	8/18/2021	12/18/2024	9/1/2021	
75086	G7PUBIMP	MX2442598	MX2442598 - BROMLEY-CR. SPRINGS RD (KY 2373)	152,623	152,623	$	249,577	90,736	158,841	8/2/2021	2/6/2022	8/1/2021	1/31/2022
75086	G7PUBIMP	MX2778391	MX2778391 - STI JAQUELINE DR ERLANGER 80' 4" ST	(202)	(202)	$	11,633	20,093	(8,459)	10/26/2021	5/22/2022	11/1/2021	3/6/2022
75086	G7PUBIMP	MX2781786	MX2781786 - CANCEL_KYTC 19-9001 I-275 GRAVES RD	13,395	13,395	$	104,794	70,083	34,712	12/9/2020	11/22/2023	6/1/2021	
75086	G7PUBIMP	MX2911494	MX2911494 - UL 35 STREET IMPROVEMENT PROJECT	(2,000)	(2,000)	$	26,757	51,296	(24,540)	8/2/2019	1/9/2020	9/1/2019	9/15/2020
75086	G7PUBIMP	MX3359474	MX3359474 - KYTC - RICHWOOD RD STI - BEAVERLICK	291,540	291,540	$	320,039	24,088	295,951	12/13/2021	12/31/2024	12/1/2021	6/22/2022
75086	G7PUBIMP	MX4199889	MX4199889 - US-25 WALTON - 4" PL - STI	135,623	135,623	$	135,623	38,705	96,917	7/25/2022	3/30/2023	8/1/2022	2/16/2023
75086	G7PUBIMP	MX4966474	MX4966474 - 7639 TURFWAY - FLORENCE - 8" PL - S	85,020	85,020	$	85,020	3,294	81,726	6/27/2022	3/30/2023	7/1/2022	3/1/2023
75086	G7PUBIMP	MX5108455	MX5108455 - KENTABOO DR - FLORENCE - 4" PL - ST	62,979	62,979	$	62,979	4,544	58,434	6/21/2022	11/10/2022	6/1/2022	10/28/2022
75086	G7PUBIMP	MX6266002	MX6266002 - US27/MARSHALL LN. TO JOHNS HILL RD.	18,713	18,713	$	18,713	31,832	(13,120)	2/4/2022	1/12/2023	8/1/2022	12/25/2022
75086	G7PUBIMP	MX6798234	MX6798234 - KYTC 06-8916 HOUSTON RD-ERLANGER-ST	15,602	15,602	$	15,602	142,183	(126,581)	10/21/2022	1/11/2024	11/1/2022	3/19/2024
75086	G7PUBIMP	MX7832792	MX7832792 - BROOKWOOD DR. SOUTH - EDGEWOOD - 4"	23,795	23,795	$	132,234	75,946	56,288	9/9/2020	5/21/2021	3/1/2021	9/7/2021
75086	G7PUBIMP	MX8662697	MX8662697 - CANCEL-PLEAST VALY PT 3 INSL STREET	(13)	(13)	$	-	-	-	11/4/2020	5/2/2021	6/1/2021	
75086	G7PUBIMP	MX9244894	MX9244894 - KYTC - MT.ZION RD KY536 STI	722,810	722,810	$	1,011,173	1,026,778	(15,605)	11/8/2019	6/30/2023	1/1/2020	7/27/2021
75086	G7PUBIMP	MX9853572	MX9853572 - GRAVES AND NORTHBEND ROUNDABOUT PRO	33,464	33,464	$	269,709	109,422	160,287	2/16/2021	12/28/2023	2/1/2021	2/14/2022
75086	G7PUBIMP	MX9856643	MX9856643 - CANCEL-KYTC - KY-536 DONALDSON RD	39,332	39,332	$	39,332	-	39,332	9/6/2022	12/31/2024	11/1/2022	
75086	G7PUBIMP	MX9948553	MX9948553 - WILBERS LN - FORT THOMAS - 2" PE -	26,004	26,004	$	125,984	75,861	50,123	7/13/2021	12/16/2024	7/1/2021	2/21/2023
75086	G7PUINEW	INSREGREL	INSREGREL - INSTALL OR REMOVE REGULATOR/RELIEF	86,464	86,464	$	1,472,476	800,000	672,476	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	MX8375093	MX8375093 - M&R; 3087 TERMINAL DR; CVG AIRPORT	7,349	7,349	$	58,606	51,696	6,909	5/4/2021	8/24/2021	6/1/2021	6/27/2022
75086	G7PUINEW	SETMETER	SETMETER - SET OR REMOVE METER	2,586,675	2,586,675	$	12,433,827	2,250,000	10,183,827	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	T2904	T2904 - CANCEL-MTR 11540114 1 CARBON WAY	(69)	(69)	$	(2,125)	29,846	(31,971)	3/8/2017	12/31/2018	12/1/2017	
75086	G7PUINMR	AGECHGLG	AGECHGLG - KENTUCKY AGE CHANGE LARGE METER	155,546	155,546	$	759,506	350,000	409,506	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGSM	AGECHGSM - KENTUCKY AGE CHANGE SMALL METER	725,529	725,529	$	7,596,976	14,500,000	(6,903,024)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRLG	CHGMTRLG - CHANGE LARGE METER KENTUCKY	3	3	$	165,029	725,000	(559,971)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRSM	CHGMTRSM - CHANGE SMALL METER KENTUCKY	143,797	143,797	$	3,096,858	1,250,000	1,846,858	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGREGREL	CHGREGREL - CHANGE REGULATOR/RELIEF KENTUCKY	1	1	$	168,025	800,000	(631,975)	3/3/2015	12/31/2050	4/1/2015	
75086	G7REG0026	MX7281967	MX7281967 - REG 0026 UPHIL AND HIGHWAY - REG SW	(6,342)	(6,342)	$	2,411	48,954	(46,542)	7/7/2020	3/31/2021	8/1/2020	1/20/2021
75086	G7REG0031	MX2737090	MX2737090 - REG 0031 - NINTH AND YORK - ABANDON	(121)	(121)	$	-	-	-	11/2/2021	3/15/2022	12/1/2021	3/29/2022
75086	G7REG0089	AW3224	AW3224 - REG 0427 EMPIRE DR	534,451	534,451	$	822,439	732,000	90,439	12/30/2020	10/30/2025	7/1/2021	
75086	G7REG0089	AW3246	AW3246 - REG 0427 EMPIRE DR LAND	14,785	14,785	$	63,310	82,500	(19,190)	1/2/2021	3/31/2026	4/1/2021	
75086	G7REG010	AW3280	AW3280 - REG 0010 STEVENSON AND LEXINGTON RE	(16)	(16)	$	27,552	58,000	(30,448)	1/6/2021	3/31/2022	6/1/2021	11/2/2021

75086	G7REG017	AW3195	AW3195 - REG 0017 FOOTE AND FAIRFIELD REPAIR	5,128	5,128	$	28,394	429,700	(401,306)	12/29/2020	3/31/2023	9/1/2021	12/17/2021
75086	G7REG021	AW3278	AW3278 - REG 0021 GRAND AND S FT THOMAS REPA	559	559	$	14,410	56,400	(41,990)	1/6/2021	3/31/2022	7/1/2021	10/23/2021
75086	G7REG026	AW3184	AW3184 - REG 0437 UPHILL & HIGHWAY	1,413,968	1,413,968	$	1,422,563	507,300	915,263	12/28/2020	3/31/2023	12/1/2021	2/8/2023
75086	G7REG026	AW3355	AW3355 - REG 0437 UPHILL & HIGHWAY - LAND	8,265	8,265	$	8,265	82,500	(74,235)	1/13/2021	3/31/2023	3/1/2022	2/8/2023
75086	G7REG0359	AW4715	AW4715 - REG 0359 - TAYLOR MILL RD N - RS UP	64,751	64,751	$	64,751	37,100	27,651	10/28/2021	3/30/2023	1/1/2022	2/18/2023
75086	G7REG045	AW3228	AW3228 - REG 0432 TENTH & BRIGHTON	323,760	323,760	$	329,412	660,800	(331,388)	12/30/2020	3/31/2021	11/1/2021	7/11/2023
75086	G7REG045	AW3356	AW3356 - CANCEL- REG0432 TENTH-BRIGHTON LAND	8,487	8,487	$	8,503	82,500	(73,997)	1/13/2021	3/31/2023	9/1/2021	
75086	G7REG049	AW3290	AW3290 - REG 0049 PEARL AND TWENTIETH REPAIR	(738)	(738)	$	24,385	58,000	(33,615)	1/6/2021	3/31/2022	6/1/2021	10/24/2021
75086	G7REG051	AW3919	AW3919 - REG 0051 WALNUT AND ELECTRIC REPAIR	(215)	(215)	$	30,833	175,200	(144,367)	5/25/2021	3/31/2022	8/1/2021	11/23/2021
75086	G7REG055	AW3288	AW3288 - REG 0055 WRIGHT AND SPRING REPAIR	(1,280)	(1,280)	$	11,658	56,400	(44,742)	1/6/2021	3/31/2022	7/1/2021	10/23/2021
75086	G7REG057	AW3180	AW3180 - REG 0431 SARATOGA & ELEVENTH	461,542	461,542	$	470,207	796,400	(326,193)	12/28/2020	3/31/2023	11/1/2021	11/8/2023
75086	G7REG057	AW3354	AW3354 - CANCEL-REG431 SARATOGA-ELEVENTH ROW	8,092	8,092	$	8,103	82,500	(74,397)	1/13/2021	3/31/2023	6/1/2021	
75086	G7REG059	AW3177	AW3177 - REG 0059 HIGHLAND AND GRAND RS REPL	2,520,150	2,520,150	$	2,771,497	746,000	2,025,497	12/28/2020	9/30/2022	6/1/2021	2/9/2023
75086	G7REG059	AW3353	AW3353 - REG 0059 HIGHLAND AND GRAND LAND	81,027	81,027	$	87,897	82,500	5,397	1/13/2021	9/30/2022	4/1/2021	2/9/2023
75086	G7REG074	AW4985	AW4985 - REG 0074 - MCALPIN N OF HOPE - RELI	808,517	808,517	$	808,517	135,940	672,577	3/1/2022	8/31/2022	5/1/2022	10/7/2022
75086	G7REG074	MXA751466	MXA751466 - CANCEL - REG 0074 - MCALPIN N - R	13,054	13,054	$	13,054	9,702	3,352	6/21/2022	9/20/2022	6/1/2022	
75086	G7REG093	AW3284	AW3284 - REG 0093 ALEXANDRIA AND BLOSSUM REP	(410)	(410)	$	34,892	61,000	(26,108)	1/6/2021	3/31/2022	7/1/2021	11/20/2021
75086	G7REG095	AW3283	AW3283 - REG 0095 BAUM AND BURNET	(323)	(323)	$	36,270	402,900	(366,630)	1/6/2021	3/31/2022	8/1/2021	11/20/2021
75086	G7REG684	MX9167642	MX9167642 - (CANCEL) REG0684-SHAW BLVD-REG UPG	(46)	(46)	$	-	51,954	(51,954)	1/8/2021	4/29/2021	2/1/2021	
75086	G7REG74K	AW3285	AW3285 - REG 0074 MCALPIN N OF HOPE LN REPAI	(1,718)	(1,718)	$	38,786	54,100	(15,314)	1/6/2021	3/31/2022	7/1/2021	12/24/2021
75086	G7REPL	28051	28051 - SMALL REPL KY	274,502	274,502	$	1,603,730	-	1,603,730	4/13/2000	12/31/2050	12/1/1999	
75086	G7REPL	AW6197	AW6197 - CANCEL- ROW SCHOOL RD - WALTON	1,959	1,959	$	1,959	25,000	(23,041)	10/6/2022	6/17/2023	11/1/2022	
75086	G7REPL	MX1379992	MX1379992 - WEST 13TH ST RPL PROJECT, NEWPORT,	325,079	325,079	$	338,903	44,019	294,884	9/13/2021	4/15/2024	9/1/2021	9/28/2022
75086	G7REPL	MX2163251	MX2163251 - CANCEL HIGHLAND AVE WOODLAND PL	(7,133)	(7,133)	$	(5)	24,723	(24,729)	9/30/2021	5/12/2022	10/1/2021	
75086	G7REPL	MX3269023	MX3269023 - KYTC - HANDS PIKE - EDGEWOOD - 4" P	281,941	281,941	$	281,941	12,424	269,517	6/27/2022	12/31/2024	7/1/2022	11/18/2022
75086	G7REPL	MX4962663	MX4962663 - ALEXANDRIA PK - ALEXANDRIA- 8" SIZE	155,145	155,145	$	155,145	93,664	61,480	8/10/2022	5/11/2023	8/1/2022	5/3/2023
75086	G7REPL	MX6343996	MX6343996 - 182 MT ZION - FLORENCE - 8" PL - RP	1,025	1,025	$	1,025	6,095	(5,070)	10/4/2022	10/25/2022	10/1/2022	10/27/2022
75086	G7REPL	MX9545566	MX9545566 - RICHWOOD RD REPLACEMENT PROJ KY-338	871,484	871,484	$	1,712,527	1,413,710	298,817	11/12/2019	6/14/2022	1/1/2020	3/1/2022
75086	G7REPL	MX9817206	MX9817206 - DUVENECK SQUARE RPL/MAE - COVINGTON	33,185	33,185	$	416,297	101,692	314,605	4/8/2021	10/1/2024	5/1/2021	12/14/2021
75086	G7RGPI	MX9217475	MX9217475 - GARVEY AVE. PRI, ELSMERE, 9400' 8"	726,984	726,984	$	1,475,242	507,691	967,551	8/16/2021	12/1/2022	9/1/2021	11/21/2022
75086	G7RRPI	MX9219249	MX9219249 - RICHARDSON RD PRESSURE IMP 7300' OF	32,277	32,277	$	32,277	765	31,511	10/21/2022	3/12/2026	11/1/2022	
75086	G7SERVMC	CMRP70	CMRP70 - REPLACE C-M PLASTIC 2 INCH AND UNDE	332,943	332,943	$	12,980,195	-	12,980,195	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVMC	CMRS70	CMRS70 - 2" OR LESS STEEL C-M REPLACE	2	2	$	10,361	1,000,000	(989,639)	1/13/2016	12/31/2050	3/1/2016	
75086	G7SERVMC	LCMRP70	LCMRP70 - GREATER THAN 2" C-M REPL PLASTIC	34,402	34,402	$	75,542	2,500,000	(2,424,458)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRP70	LMCRP70 - GREATER THAN 2" M-C REPL PLASTIC	226,091	226,091	$	538,283	2,500,000	(1,961,717)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRS70	LMCRS70 - GREATER THAN 2" M-C REPL STEEL	6,254	6,254	$	16,295	1,000,000	(983,705)	1/13/2016	12/31/2050	11/1/2016	
75086	G7SERVMC	MCRP70	MCRP70 - REPLACE (NON-AMRP) M-C PLASTIC 2 IN	2,668,488	2,668,488	$	22,032,554	-	22,032,554	7/1/2008	12/31/2050	7/1/2008	12/20/2009
75086	G7SERVMC	MCRS70	MCRS70 - REPLACE M-C STEEL 2 INCH AND UNDER	41,000	41,000	$	591,770	-	591,770	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVNEW	CMNEWP70	CMNEWP70 - NEW C-M PLASTIC 2 INCH AND UNDER KY	252,453	252,453	$	8,177,009	1	8,177,008	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	LCMNEWP70	LCMNEWP70 - GREATER THAN 2" C-M PLASTIC	9,680	9,680	$	243,813	2,500,000	(2,256,187)	1/13/2016	12/31/2050	2/1/2016	
75086	G7SERVNEW	LMCNEWP70	LMCNEWP70 - GREATER THAN 2" M-C PLASTIC	67,131	67,131	$	547,642	2,500,000	(1,952,358)	1/13/2016	12/31/2050	3/1/2016	
75086	G7SERVNEW	LMCNEWS70	LMCNEWS70 - GREATER THAN 2" M-C STEEL	921	921	$	110,138	2,500,000	(2,389,862)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVNEW	MCNEWP70	MCNEWP70 - NEW M-C PLASTIC 2 INCH AND UNDER KY	2,736,165	2,736,165	$	20,565,243	1	20,565,242	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	MCNEWS70	MCNEWS70 - NEW M-C STEEL 2 INCH AND UNDER KY	18,027	18,027	$	267,930	1	267,929	12/31/2010	12/31/2050	4/1/2011	
75086	G7SERVNEW	MX7824128	MX7824128 - NEW COM; 7500 TURFWAY RD; TURFWAY P	20,611	20,611	$	20,611	70,174	(49,563)	12/16/2020	6/30/2022	1/1/2022	5/29/2022
75086	G7STA011	AW3227	AW3227 - STA 0949 DAYTON VALVE HOUSE	1,046,727	1,046,727	$	1,080,240	1,062,400	17,840	12/30/2020	10/30/2025	11/1/2021	
75086	G7STA011	AW3250	AW3250 - STA 0949 DAYTON VALVE HOUSE LAND	26,089	26,089	$	26,108	82,500	(56,392)	1/2/2021	11/29/2025	6/1/2021	
75086	G7STA014	AW3251	AW3251 - CANCEL_STA 0014 EAST ALEXANDRIAPIKE	70	70	$	77	82,500	(82,423)	1/3/2021	3/31/2023	6/1/2021	
75086	G7STA034	AW3313	AW3313 - STA 0034 WILDERS PLANT REPAIR	(1,164)	(1,164)	$	40,156	76,500	(36,344)	1/7/2021	3/31/2022	7/1/2021	11/2/2021
75086	G7STA0375	AW3193	AW3193 - STA 0375 ELECTRIC AVE RS REPLACEMEN	882,935	882,935	$	2,263,286	829,000	1,434,286	12/28/2020	4/22/2022	5/1/2021	5/9/2022
75086	G7STA0375	AW3691	AW3691 - STA 00375 LAND ELECTRIC	(1,845)	(1,845)	$	232,073	82,500	149,573	2/27/2021	2/28/2022	4/1/2021	11/27/2021
75086	G7STA056	AW3310	AW3310 - STA 0056 BURLINGTON PIKE REPAIR	(1,280)	(1,280)	$	26,039	56,400	(30,361)	1/7/2021	3/31/2022	8/1/2021	11/23/2021
75086	G7STA064	AW3217	AW3217 - STA 0940 GLECOE TB	375,632	375,632	$	394,949	510,900	(115,951)	12/30/2020	3/31/2021	11/1/2021	9/27/2023
75086	G7STA064	AW3268	AW3268 - STA 0940 STA GLENCOE TB LAND	7,149	7,149	$	7,167	82,500	(75,333)	1/5/2021	3/31/2023	8/1/2021	9/27/2023
75086	G7STA072	AW3308	AW3308 - STA 0072 TENTH AND BRIGHTON REPAIR	(887)	(887)	$	20,901	58,000	(37,099)	1/7/2021	3/31/2022	6/1/2021	10/22/2021
75086	G7STA074	AW3307	AW3307 - STA 0074 LOUIS B NUNN REPAIR	(1,296)	(1,296)	$	31,027	59,300	(28,273)	1/7/2021	3/31/2022	6/1/2021	11/21/2021
75086	G7STA0836	AW3191	AW3191 - STA 0838 ROSSFORD AVE RS REPLACEMEN	1,298,421	1,298,421	$	2,665,887	539,500	2,126,387	12/28/2020	4/30/2022	5/1/2021	5/22/2022
75086	G7STA0836	AW3686	AW3686 - STA 0836 - LAND ROSSFORD AVE	203	203	$	54,384	82,500	(28,116)	2/26/2021	2/28/2022	4/1/2021	11/27/2021
75086	G7STA100	AW3306	AW3306 - STA 0100 CHESAPEAKE AND KYLE REPAIR	(1,280)	(1,280)	$	31,648	106,700	(75,052)	1/7/2021	3/31/2022	8/1/2021	1/13/2022
75086	G7STA117	AW3305	AW3305 - STA 0117 AMSTERDAM AND REDWOOD REPA	(1,280)	(1,280)	$	22,326	56,400	(34,074)	1/7/2021	3/31/2022	7/1/2021	10/27/2021
75086	G7STA276	AW3212	AW3212 - STA 0276 MARY INGLES HWY RS ABANDON	62,340	62,340	$	88,128	553,900	(465,772)	12/30/2020	3/31/2021	11/1/2021	11/18/2022
75086	G7STA276	AW3689	AW3689 - CANCEL-STA 0276 MARY IGLES HWY LAND	1,144	1,144	$	3,432	82,500	(79,068)	2/26/2021	3/31/2023	6/1/2021	
75086	G7STA280	AW3213	AW3213 - STA 0938 TAYLOR MILL & LONE OAK	642,139	642,139	$	652,477	562,000	90,477	12/30/2020	9/30/2023	11/1/2021	9/8/2023
75086	G7STA280	AW3272	AW3272 - STA0938 TAYLOR MILL & LONE OAK LAND	135,157	135,157	$	139,787	82,500	57,287	1/5/2021	3/31/2023	8/1/2021	9/8/2023
75086	G7STA286	AW3216	AW3216 - STA 0929 RILEY RD	2,024,439	2,024,439	$	2,092,031	635,200	1,456,831	12/30/2020	3/31/2021	9/1/2021	6/28/2023
75086	G7STA286	AW3271	AW3271 - STA 0929 RILEY RD LAND	81,700	81,700	$	81,718	82,500	(782)	1/5/2021	3/31/2023	6/1/2021	6/28/2023
75086	G7STA338	AW3192	AW3192 - STA 0941 GUBSER MILL	309,821	309,821	$	417,598	538,800	(121,202)	12/28/2020	12/30/2025	9/1/2021	
75086	G7STA338	AW3690	AW3690 - STA 0941 GUBSER MILL LAND	34,438	34,438	$	37,601	82,500	(44,899)	2/27/2021	10/25/2025	6/1/2021	
75086	G7STA444	AW3186	AW3186 - STA 0948 THIRD & CRESCENT	536,803	536,803	$	568,878	948,400	(379,522)	12/28/2020	11/27/2025	11/1/2021	
75086	G7STA444	AW3230	AW3230 - STA 0948 THIRD & CRESCENT LAND	18,247	18,247	$	18,249	82,500	(64,251)	12/31/2020	11/27/2025	8/1/2021	
75086	G7STA535	AW3299	AW3299 - STA 0535 DRY RIDGE EAST REPAIR	34,779	34,779	$	64,528	56,400	8,128	1/7/2021	8/31/2022	6/1/2021	12/2/2022
75086	G7STA750	AW3296	AW3296 - STA 0750 TURFWAY STATION REPAIR	2,111	2,111	$	19,760	112,700	(92,940)	1/7/2021	3/31/2022	7/1/2021	11/19/2021
75086	G7STA793	AW3188	AW3188 - STA 0942 CAMP ERNST RD	690,171	690,171	$	699,709	887,300	(187,591)	12/28/2020	9/30/2023	11/1/2021	1/18/2024
75086	G7STA793	AW3767	AW3767 - STA 0942 CAMP ERNST RD LAND	64,980	64,980	$	66,939	82,500	(15,561)	3/16/2021	3/31/2023	6/1/2021	1/18/2024
75086	G7STA822	AW3189	AW3189 - STA 0822 COX RD RS REPAIR	198,467	198,467	$	252,981	541,600	(288,619)	12/28/2020	12/31/2022	11/1/2021	11/18/2022
75086	G7STA822	AW3685	AW3685 - CANCEL 0822 - COX RD. RS REP - LAND	2,281	2,281	$	4,516	82,500	(77,984)	2/26/2021	12/31/2022	6/1/2021	
75086	G7STA876	MX6800938	MX6800938 - STA 876 WARSAW TOWN BORDER- STATION	190,594	190,594	$	336,830	252,984	83,846	1/10/2018	9/30/2022	1/1/2018	9/29/2023
75086	G7TAM00B	AW2146	AW2146 - LINE AM00B RETROFIT REPL	13,074,132	13,074,132	$	14,817,784	6,528,636	8,289,148	5/19/2020	10/15/2022	5/1/2020	9/17/2022
75086	G7TAM00B	AW3634	AW3634 - LINE AM00B ILI RETROFIT-LAND	365,737	365,737	$	402,217	127,500	274,717	2/17/2021	10/15/2022	10/1/2021	9/17/2022
75086	G7TOOLS	28073	28073 - PURCHASE GAS TOOLS BLANKET	239,348	239,348	$	1,080,778	-	1,080,778	4/13/2000	12/31/2015	12/1/1999	
75086	G7TOOLS	AW4691	AW4691 - CGI UPGRADE KENTUCKY	282,564	282,564	$	335,694	120,000	215,694	10/22/2021	6/30/2022	12/1/2021	
75086	G7TUL06	AW1592	AW1592 - LINE UL06 - PIPELINE REPLACEMENTS	98,376	98,376	$	9,779,331	10,253,358	(474,027)	1/5/2020	12/30/2021	2/1/2020	12/3/2021
75086	G7TUL06	AW2021	AW2021 - LINE UL06 - PIPELINE REPLACEMENTS L	20,321	20,321	$	121,670	115,000	6,670	4/13/2020	12/31/2021	7/1/2020	12/3/2021

75086	G7UL02PH1	V8191	V8191 - UL60 PIPELINE PHASE 1 (PIPE)	19,281		19,281		$	38,635,901	26,326,195	12,309,706	1/23/2019	3/30/2021	1/1/2019	2/25/2021
75086	G7UL02PH2	AW3877	AW3877 - UL60 PIPELINE PHASE II - STATION	4,626,922		4,626,922		$	4,710,666	1,004,152	3,706,514	4/29/2021	3/30/2022	5/1/2021	11/18/2021
75086	G7UL02PH2	V9444	V9444 - UL60 PIPELINE PHASE II - PIPE	(4,473,543)		(4,473,543)		$	20,945,431	22,514,005	(1,568,574)	6/12/2019	3/30/2022	10/1/2019	11/18/2021
75086	G7UL02PH2	V9445	V9445 - UL60 PIPELINE PHASE II- LAND RIGHTS	46,060		46,060		$	2,552,669	733,000	1,819,669	6/12/2019	2/2/2022	7/1/2019	11/18/2021
75086	G7UL57	AW4824	AW4824 - STA0917 UL61 CHAMBERS RD TO DIXIE	473,228		473,228		$	473,228	873,000	(399,772)	12/9/2021	1/31/2024	2/1/2022	12/26/2023
75086	G7UL57	AW4840	AW4840 - UL61 CHAMBERS RD TO DIXIE HWY- LAND	101,414		101,414		$	101,414	82,500	18,914	12/14/2021	1/31/2023	2/1/2022	12/26/2023
75086	G7WOODINT	AW3137	AW3137 - DUKE WOODSDALE INTERCONNECT (KY)	(11,723)		(11,723)		$	197,098	2,000,000	(1,802,902)	12/18/2020	12/31/2021	1/1/2021	1/31/2022
75086	MRTP2021	400052004	400052004 - DEK - TB5800 TEST SETS	30,018		30,018		$	33,933	26,866	7,067	9/26/2022	2/17/2022	10/1/2022	4/30/2022
75086	SG000723F	SG723SW	SG723SW - DEE AMI OPERATIONS TOOL	3,706		3,706		$	32,524	26,599	5,925	3/3/2020	7/30/2022	3/1/2020	7/31/2022
75086	SG000781F	SG781SW	SG781SW - SG DEE PPM PIMS PHASE 2 BUILD OUT	268		268		$	78,203	76,874	1,330	7/12/2018	3/31/2021	7/1/2018	3/31/2022
75086	SG001117F	SG001117	SG001117 - DEE LMR CONSOLES	6,364		6,364		$	99,093	124,921	(25,828)	8/25/2021	3/31/2023	10/1/2021	11/30/2022
75087	CUSTCONN	315986A	315986A - CUSTOMER CONNECT - CORE	1,035,807		1,035,807		$	4,619,692	2,325,960	2,293,732	8/10/2017	12/5/2022	8/1/2017	7/6/2022
75087	CUSTCONN	315986F	315986F - CUSTOMER CONNECT- R6-8 SCOPE	189,686		189,686		$	461,855	53,917	407,938	3/30/2021	6/30/2022	4/1/2021	7/6/2022
75087	CUSTCONN	315986HW7	315986HW7 - CUSTOMER CONNECT - HARDWARE PROJ 5	8		8		$	28,436	62,454	(34,018)	4/21/2021	12/31/2021	4/1/2021	12/31/2021
75087	CUSTCONN	315986HW8	315986HW8 - CUSTOMER CONNECT- HARDWARE PROJ 6	17,401		17,401		$	37,341	67,100	(29,759)	9/27/2021	6/30/2022	10/1/2021	9/15/2022
75087	CUSTCONN	400109	400109 - CUST ENHANCEMENT AND OPTIMIZATION	130,568		130,568		$	130,568	480,680	(350,112)	6/20/2022	1/19/2024	7/1/2022	1/26/2024
75087	FPIT	307482002	307482002 - CUSTOMER MOBILE APP - PHASE 3	(0)		(0)		$	3,106	26,324	(23,218)	12/19/2019	3/15/2022	1/1/2020	3/31/2022
75087	FPIT	307482003	307482003 - CUSTOMER MOBILE APP - PHASE 4	163,856		163,856		$	163,856	24,891	138,965	12/30/2021	3/31/2023	1/1/2022	3/31/2023
75087	FPIT	307482SW2	307482SW2 - CUSTOMER MOBILE APP - PHASE 3	198		198		$	30,440	30,258	182	4/13/2020	3/15/2022	4/1/2020	3/31/2022
75087	FPIT	400055002	400055002 - CHATBOT CHANNELS	5		5		$	17,984	6,219	11,765	12/8/2020	3/31/2022	1/1/2021	3/31/2022
75087	FPIT	400055004	400055004 - INSPECTION PORTAL 2021	9,471		9,471		$	9,471	10,727	(1,256)	12/16/2020	7/3/2023	1/1/2022	7/31/2023
75087	FPIT	400055005	400055005 - BUILDER PORTAL 2021	5,609		5,609		$	12,306	17,824	(5,518)	12/10/2020	9/30/2023	1/1/2021	9/30/2023
75087	FPIT	400055008	400055008 - PNG - CRT	(902)		(902)		$	-	11,377	(11,377)	4/30/2021	2/28/2022	5/1/2021	3/31/2022
75087	FPIT	400055009	400055009 - CALL CENTER ANALYTICS SW	28,416		28,416		$	85,597	5,888	79,709	5/26/2021	9/30/2022	6/1/2021	9/30/2022
75087	FPIT	400055010	400055010 - DIGITAL ASSISTANT PLATFORM PH 1	246		246		$	1,691	6,670	(4,979)	7/26/2021	3/15/2022	10/1/2021	3/31/2022
75087	FPIT	400055015	400055015 - ATLANTIS (CUSTOMER ANALYTICS ENGINE	12,837		12,837		$	12,837	22,832	(9,995)	12/29/2021	12/30/2023	1/1/2022	1/1/2024
75087	FPIT	400055016	400055016 - TITAN (VOICE OF THE CUSTOMER ENGAGE	12,859		12,859		$	12,859	11,104	1,755	12/20/2021	10/31/2023	1/1/2022	10/31/2023
75087	FPIT	400055017	400055017 - DIGITAL ASSISTANT PLATFORM 2022 ENH	22,120		22,120		$	22,120	15,150	6,970	12/20/2021	6/30/2023	1/1/2022	7/4/2023
75087	FPIT	400055020	400055020 - SHORT URL MANAGEMENT APP	15,942		15,942		$	15,942	7,433	8,509	3/8/2022	1/15/2023	3/1/2022	11/15/2022
75087	FPIT	400055022	400055022 - BUSINESS OUTBOUND NOTIFICATION PLAT	19		19		$	19	5,949	(5,930)	5/19/2022	3/31/2023	10/1/2022	3/31/2023
75087	FPIT	CC1900001	CC1900001 - CUSTOMER ANALYTICS ENGINE	677		677		$	36,106	26,306	9,800	1/27/2020	3/31/2022	2/1/2020	3/31/2022
75087	FPIT	CC2000003	CC2000003 - SITECORE JSS FRONT END MODERNIZATIO	3,912		3,912		$	34,323	28,721	5,602	6/25/2020	5/30/2022	8/1/2020	5/31/2022
75087	FPIT	CO2200002	CO2200002 - UTILITY ASSISTANCE MODERN ARCHITECT	851		851		$	851	3,296	(2,445)	6/30/2022	12/29/2022	7/1/2022	3/15/2023
75087	FPIT	CS1900001	CS1900001 - VOICE OF THE CUSTOMER ENGAGEMENT PL	35		35		$	31,531	13,742	17,789	1/29/2020	3/31/2022	2/1/2020	3/31/2022
75087	FPIT	CS2100008	CS2100008 - NUANCE IVR ENHANCEMENTS	731		731		$	3,468	4,174	(706)	7/16/2021	8/31/2022	8/1/2021	8/31/2022
75087	FPIT	CS2100010	CS2100010 - CONTACT CENTER WORK FROM HOME	1,140		1,140		$	1,140	4,849	(3,709)	1/26/2022	11/28/2022	2/1/2022	1/6/2023
75087	FPIT	CS2200002	CS2200002 - IVR ENHANCEMENTS 2022	3,755		3,755		$	3,755	20,162	(16,407)	5/5/2022	5/1/2023	5/1/2022	4/30/2023
75087	FPIT	CS2200005	CS2200005 - UPLAND RIGHT ANSWER LICENSE PURCHAS	12,190		12,190		$	12,190	7,962	4,228	8/3/2022	1/29/2023	12/1/2022	5/31/2023
75087	FPIT	CS2200006	CS2200006 - VERINT UPGRADE	54,953		54,953		$	54,953	80,257	(25,304)	11/4/2022	3/31/2024	11/1/2022	3/31/2024
75087	FPIT	CS2200007	CS2200007 - FND LICENSES ADDITIONAL ENDPOINTS	7,828		7,828		$	7,828	7,591	237	11/1/2022	3/30/2023	12/1/2022	3/22/2023
75087	FPIT	CS2200008	CS2200008 - AVAYA PLATFORM UPGRADE - SERVER	14,517		14,517		$	14,517	44,473	(29,956)	11/14/2022	3/31/2024	11/1/2022	3/31/2024
75087	FPIT	CS220SW04	CS220SW04 - OPENWAY ENDPOINT SOFTWARE LICENSES	2,016		2,016		$	2,016	2,056	(40)	9/7/2022	3/31/2023	10/1/2022	1/10/2023
75087	FPIT	LTHCESCS	LTHCESCS - WO OPTIMIZATION WORK INPUT/CALL-SW	121		121		$	4,911	13,750	(8,839)	2/25/2021	3/31/2022	2/1/2021	3/31/2021
75088	CY1900015	349395006	349395006 - ITOT OT SIEM PHASE 2 HW WORKSTREAM	2,755		2,755		$	54,263	5,497	48,766	4/13/2020	10/28/2022	5/1/2020	
75088	CY1900015	349395SW6	349395SW6 - ITOT OT SIEM SW WORKSTREAM	829		829		$	75,187	6,089	69,098	12/9/2021	10/28/2022	12/1/2021	
75088	CY1900015	CY190HW15	CY190HW15 - IT-OT ANA WORKSTREAM HW	(15,650)		(15,650)		$	-	113,909	(113,909)	12/11/2019	10/28/2022	1/1/2020	
75088	CY1900015	CY190SW15	CY190SW15 - IT-OT ANA WORKSTREAM SW	(201)		(201)		$	-	10,808	(10,808)	12/11/2019	10/28/2022	3/1/2021	
75088	FPITKG	TC210HW57	TC210HW57 - CIOPS NERC CIP CYBERARK HW	286		286		$	286	304	(18)	12/10/2021	9/30/2024	1/1/2022	
75088	FPITKG	TC210SW57	TC210SW57 - CIOPS NERC CIP CYBERARK IMPLEMENTAT	1,768		1,768		$	1,768	3,357	(1,589)	12/10/2021	3/31/2024	2/1/2022	12/1/2023
75088	MRTP2021	400052004	400052004 - DEK - TB5800 TEST SETS	(3,915)		(3,915)		$	-	26,866	(26,866)	9/17/2021	2/17/2022	12/1/2021	
				74,578,386	69,331,819.65	5,246,566	7%								

Duke Energy Kentucky Natural Gas
Year 2023

Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	4000156F	04000156	04000156 - DEE EAM NEXTGEN GIS	166,842		166,842			$ 166,842	599,758	(432,916)	12/17/2022	12/31/2026	1/1/2023	
75086	EAMHPBU	349472018	349472018 - EAM 2022 MAXIMO DURABLE TEAM	19,868		19,868			$ 30,640	6,760	23,880	1/4/2022	5/30/2023	1/1/2022	7/17/2023
75086	EAMHPBU	349472022	349472022 - NEW BOUD SERVERS	490		490			$ 490	83	407	5/20/2022	3/31/2023	4/1/2023	10/30/2022
75086	FMDT2020	MDTGAS20	MDTGAS20 - INSTALL WIN 7 PANASONIC TOUGHBOOKS	47,122		47,122			$ 581,536	403,995	177,541	10/10/2019	3/31/2021	12/1/2019	3/31/2021
75086	FPIT	349395006	349395006 - ITOT OT SIEM PHASE 2 HW WORKSTREAM	46,331		46,331			$ 100,594	5,497	95,097	3/27/2023	10/28/2022	3/1/2023	10/18/2022
75086	FPIT	349395SW6	349395SW6 - ITOT OT SIEM SW WORKSTREAM	74,299		74,299			$ 149,487	6,089	143,398	3/27/2023	10/28/2022	3/1/2023	10/18/2022
75086	FPIT	349472020	349472020 - SLATE - EAM WORK MGMT SCHEDULING TO	33,056		33,056			$ 45,575	22,340	23,235	3/18/2022	6/30/2024	3/1/2022	6/30/2024
75086	FPIT	349472021	349472021 - FMA ENHANCEMENTS	6,385		6,385			$ 9,380	4,713	4,667	5/18/2022	3/31/2026	6/1/2022	
75086	FPIT	349472023	349472023 - SMALLWORLD ENHANCEMENTS	21,424		21,424			$ 22,331	15,341	6,990	9/29/2022	3/30/2025	11/1/2022	3/31/2024
75086	FPIT	349472024	349472024 - NEW PRIMAVERA OAM SERVERS	1		1			$ 38	173	(135)	9/29/2022	8/8/2023	10/1/2022	8/8/2023
75086	FPIT	349472026	349472026 - HITACHI SERVICE SUITE 9-5 YEAR SUBS	45,231		45,231			$ 45,231	45,683	(452)	1/26/2023	5/2/2023	2/1/2023	5/1/2023
75086	FPIT	349472027	349472027 - NEW EAM SERVERS	1		1			$ 1	621	(620)	2/3/2023	3/30/2024	9/1/2023	3/31/2024
75086	FPIT	349472028	349472028 - NEW FMA ENHANCEMENTS	11,763		11,763			$ 11,763	9,670	2,093	4/14/2023	3/31/2026	4/1/2023	
75086	FPIT	349472029	349472029 - MAXIMO INTEGRATIONS AND OTHER ENHAN	20,415		20,415			$ 20,415	19,914	501	4/6/2023	3/31/2026	4/1/2023	
75086	FPIT	349472030	349472030 - ESRI UPGRADE TO 10.9	22,911		22,911			$ 22,911	6,738	16,173	4/21/2023	3/30/2024	4/1/2023	3/31/2024
75086	FPIT	349472031	349472031 - MATERIAL ISSUE LIGHTING APPLICATION	916		916			$ 916	4,516	(3,600)	10/20/2023	6/30/2024	10/1/2023	6/30/2024
75086	FPIT	349472H14	349472H14 - NEW ESRI INTEGRATIONS AND INFRASTRU	9		9			$ 9	9,725	(9,716)	2/9/2021	11/30/2023	6/1/2023	3/6/2024
75086	FPIT	349472S14	349472S14 - NEW ESRI INTEGRATIONS AND INFRA	10,006		10,006			$ 59,895	532,359	(472,464)	2/9/2021	11/30/2023	3/1/2021	3/6/2024
75086	FPIT	400055013	400055013 - NGBU COMMUNICATIONS PLATFORM ENHANC	24,375		24,375			$ 60,635	62,056	(1,421)	12/28/2021	9/29/2023	1/1/2022	7/31/2023
75086	FPIT	400124010	400124010 - CISCO PARTNERSHIP AGREEMENT (SPA)	21,111		21,111			$ 21,111	21,158	(47)	11/1/2023	3/30/2024	11/1/2023	3/19/2024
75086	FPIT	400149HW2	400149HW2 - ESCA - ITOT CYBER CARBON BLACK HW	676		676			$ 676	2,282	(1,606)	8/9/2023	3/31/2026	8/1/2023	
75086	FPIT	IT2000092	IT2000092 - GTIS ENHANCEMENT AND ACOG	395		395			$ 198,675	111,184	87,491	12/22/2020	3/31/2023	1/1/2021	12/26/2022
75086	FPIT	IT2100095	IT2100095 - MOBILE MAPPING CONSOLIDATION	(288)		(288)			$ -	49,072	(49,072)	2/16/2022	2/28/2023	2/1/2022	
75086	FPIT	IT2100113	IT2100113 - GAS SALES PLATFORM PHASE 3	26,823		26,823			$ 89,402	77,035	12,367	1/7/2022	9/17/2023	1/1/2022	10/12/2023
75086	FPIT	IT2100114	IT2100114 - TRACEABILITY PHASE 2 EXTENSION	1,269		1,269			$ 95,400	132,599	(37,199)	1/20/2022	3/31/2023	1/1/2022	3/31/2023
75086	FPIT	IT2100132	IT2100132 - NGBU REPAIR PLAN EXPANSION	98,573		98,573			$ 189,395	75,912	113,483	1/27/2022	11/30/2023	2/1/2022	11/21/2023
75086	FPIT	IT2200155	IT2200155 - GAS SUPPLY - AUTOMATING CONFIRMATIO	25,169		25,169			$ 25,169	67,905	(42,736)	12/28/2022	6/30/2024	1/1/2023	10/31/2023
75086	FPIT	IT2200157	IT2200157 - FUTURE STATE 811 5 STATE LOCATE	69,714		69,714			$ 69,714	71,696	(1,982)	12/5/2022	4/30/2024	12/1/2022	4/30/2024
75086	FPIT	IT2200160	IT2200160 - NGBU-AI FRAMEWORK	64,084		64,084			$ 64,084	185,732	(121,647)	12/13/2022	3/30/2027	1/1/2023	
75086	FPIT	IT2200165	IT2200165 - NGBU TRACEABILITY PLATFORM	45,605		45,605			$ 45,605	125,985	(80,380)	12/1/2022	3/31/2026	1/1/2023	
75086	FPIT	IT2200175	IT2200175 - LOTO PROCEDURES DEVONWAY SOLUTIONS	11,371		11,371			$ 11,371	23,704	(12,333)	12/21/2022	8/31/2024	1/1/2023	8/31/2024
75086	FPIT	IT2300049	IT2300049 - GTIS EDI SOLUTION	26,945		26,945			$ 26,945	48,240	(21,295)	8/17/2023	7/30/2024	8/1/2023	7/20/2024
75086	FPIT	LTHGBLDPL	LTHGBLDPL - LIGHTHOUSE GAS BUILDER PORTAL	45,863		45,863			$ 105,618	146,642	(41,024)	4/25/2022	10/31/2023	5/1/2022	7/26/2023
75086	FPIT	LTHGCHTRS	LTHGCHTRS - LIGHTHOUSE: GAS OPS CHARTER	(660)		(660)			$ 89,155	86,372	2,783	3/17/2021	9/30/2022	4/1/2021	6/30/2022
75086	FPIT	LTHGIRFS	LTHGIRFS - LIGHTHOUSE: GAS IRIS	429,016		429,016			$ 429,016	218,641	210,375	5/20/2020	3/1/2025	6/1/2020	4/16/2025
75086	FPIT	LTHGIROS	LTHGIROS - LIGHTHOUSE: GAS IRIS	242,279		242,279			$ 242,279	99,723	142,556	5/20/2020	3/1/2024	5/1/2020	3/31/2024
75086	FPIT	LTHGVISTO	LTHGVISTO - LIGHTHOUSE INITIATIVE - GAS VISTO	59,805		59,805			$ 59,805	88,003	(28,198)	5/25/2023	9/30/2024	6/1/2023	9/30/2024
75086	FPIT	MOBILEMP	MOBILEMP - MOBILE MAPPING CONSOLIDATION	284		284			$ 25,855	-	25,855	8/16/2021	12/31/2022	8/1/2021	12/31/2022
75086	FPIT	PH2ASPAHW	PH2ASPAHW - ESCA-OT ASSET,PATCH & VULNERABILITY	272		272			$ 272	3,196	(2,924)	9/1/2023	3/31/2026	10/1/2023	
75086	FPIT	PH2ASPASW	PH2ASPASW - ESCA-OT ASSET,PATCH & VULNERABILITY	25,342		25,342			$ 25,342	323,116	(297,774)	9/1/2023	3/31/2026	9/1/2023	
75086	FPIT	TC210SW57	TC210SW57 - CIOPS NERC CIP CYBERARK IMPLEMENTAT	3,074		3,074			$ 4,843	3,357	1,486	3/27/2023	3/31/2024	3/1/2023	3/1/2024
75086	FUNCTOHKY	107GASCK	107GASCK - GAS CAPITAL OVERHEAD	1,006,224		1,006,224			$ 2,674,813	-	2,674,813	7/1/2008	12/31/2050	7/1/2008	
75086	G701660	AW4645	AW4645 - EMERGENT AM01 COVINGTON LEVEE PH 1	85,129		85,129			$ 5,410,125	3,601,200	1,808,925	10/1/2021	1/30/2023	10/1/2021	2/28/2023
75086	G701662	AW4673	AW4673 - EMERGENT - CASING 34 - TAYLOR MILL	277,239		277,239			$ 2,996,678	3,207,100	(210,422)	10/13/2021	2/28/2023	11/1/2021	1/7/2023
75086	G712237	MX4669122	MX4669122 - HEBRON LOOP PH 2 PRESSURE IMPROVEME	56,337		56,337			$ 108,648	765	107,882	3/1/2021	3/4/2027	3/1/2021	
75086	G74092	MX3645041	MX3645041 - CHARTER - BRISTOW RD. PRESSURE IMP	128,484		128,484			$ 160,780	2,366	158,414	10/13/2022	7/24/2025	12/1/2022	10/28/2024
75086	G74238	43848219	43848219 - LAND - CHARTER - PATTY LN	76		76			$ 3,302	40,000	(36,698)	5/6/2022	3/31/2026	7/1/2022	
75086	G74964	MX5762350	MX5762350 - CHARTER - ST RT 536 - INDEPENDANCE	(312,817)		(312,817)			$ 465,151	842,183	(377,032)	2/23/2022	1/31/2024	3/1/2022	2/1/2023
75086	G75449	AW5471	AW5471 - LN AM07 SCCDA DIGS	13,897		13,897			$ 736,548	1,642,099	(905,551)	5/26/2022	12/31/2022	6/1/2022	11/27/2022
75086	G75498	MX0458440	MX0458440 - CHARTER-AMSTERDAM RD- VILLA HILLS-	57,489		57,489			$ 57,489	18,171	39,318	9/15/2023	1/29/2024	9/1/2023	1/3/2024
75086	G75498	MX5370534	MX5370534 - CHARTER-LP03 INSTALL PRESSURE IMPRO	30,095		30,095			$ 219,783	765	219,018	7/8/2022	3/30/2023	10/1/2022	3/6/2023
75086	G75498	MX6650945	MX6650945 - CHARTER-AMSTERDAM RD- VILLA HILLS-P	74,019		74,019			$ 74,019	251,700	(177,681)	12/20/2022	2/27/2025	2/1/2023	1/7/2025
75086	G75629	AW5648	AW5648 - LN AM07 ECDA DIGS	382,263		382,263			$ 2,022,128	1,466,970	555,158	7/1/2022	12/31/2022	7/1/2022	1/20/2023
75086	G75683	MX4850228	MX4850228 - TOEBBEN DR - FLORENCE - 12" PL & 8"	4,634		4,634			$ 420,205	49,862	370,343	7/14/2022	12/29/2022	7/1/2022	12/26/2022
75086	G75710	MX6588521	MX6588521 - CHARTER-BONNIE LN- SOUTHGATE- REPLA	207,150		207,150			$ 207,150	127,456	79,693	2/1/2023	7/30/2023	2/1/2023	7/24/2023
75086	G75723	MX6588233	MX6588233 - CANCEL-RICHARD KNOCK HWY-WALTON-MA	25,430		25,430			$ 25,430	-	25,430	3/21/2023	8/30/2025	5/1/2023	
75086	G75734	AW6846	AW6846 - KENTUCKY - CORROSION REMEDIATION	58,000		58,000			$ 58,000	180,000	(122,000)	3/24/2023	9/30/2025	7/1/2023	
75086	G75920	AW5953	AW5953 - LN AM07 STATION ECDA DIGS	112		112			$ 841,304	734,404	106,900	7/29/2022	12/31/2022	8/1/2022	1/20/2023
75086	G75924	AW5965	AW5965 - LN AM00B ECDA DIGS	88,081		88,081			$ 890,080	1,098,620	(208,540)	8/3/2022	12/31/2022	8/1/2022	1/31/2023
75086	G75979	MX4329859	MX4329859 - CHARTER-KYTC 06-445.00 MINEOLA PK-E	1,149,222		1,149,222			$ 1,151,599	697,744	453,856	9/12/2022	3/28/2024	10/1/2022	12/6/2023
75086	G75995	AW6478	AW6478 - LINE AM07 - CASING 50 - HYDROTEST	292,830		292,830			$ 292,830	2,386,600	(2,093,770)	12/30/2022	10/1/2024	2/1/2023	9/10/2024
75086	G76300	AW6368	AW6368 - EMERGENT - AM07 EXPOSED MAIN (KY)	1,259,049		1,259,049			$ 1,349,081	1,348,700	381	11/16/2022	12/30/2023	11/1/2022	1/9/2024
75086	G76444	MX6909455	MX6909455 - KYTC 06-444 DONALDSON-ERLANGER-STI	1,837,365		1,837,365			$ 1,837,365	1,219,782	617,583	4/5/2023	9/1/2024	4/1/2023	5/29/2024
75086	G76446	MX1322454	MX1322454 - CHARTER-KYTC-162.40-BRISTOW RD-STI-	70,949		70,949			$ 113,372	786,870	(673,498)	10/7/2022	10/29/2025	10/1/2022	3/7/2025
75086	G76451	MX8051147	MX8051147 - CHARTER-SPARTA PIKE-EXPOSED MAIN RE	179,808		179,808			$ 179,808	9,490	170,318	5/2/2023	3/31/2025	9/1/2023	2/9/2024
75086	G76569	AW6597	AW6597 - EMERGENT - 6-9025 KY MAIN RELOCATE	559,459		559,459			$ 559,459	3,971,500	(3,412,041)	2/2/2023	7/15/2024	2/1/2023	8/2/2024
75086	G77046	MX9473869	MX9473869 - CHARTER-EMERGENT - MADISON PIKE - E	212,786		212,786			$ 212,786	267,037	(54,251)	7/27/2023	1/13/2024	7/1/2023	12/21/2023
75086	G77138	500000144	500000144 - THREE MILE - VRG CONTROL VALVE REPL	9,957		9,957			$ 9,957	22,770	(12,813)	6/29/2023	1/31/2024	8/1/2023	4/27/2024
75086	G7AM00BVL	V5471	V5471 - AM00B & UL06 VALVE AUTOMATION	214,474		214,474			$ 472,301	1,830,100	(1,357,799)	11/22/2021	12/30/2023	4/1/2022	12/6/2023
75086	G7AM07IL2	AW4685	AW4685 - LINE AM07 PIPELINE REPLACEMENT PHAS	6,805,064		6,805,064			$ 7,414,753	33,015,500	(25,600,747)	10/18/2021	2/28/2025	11/1/2021	2/6/2025
75086	G7AM07IL2	AW5957	AW5957 - CANCEL_LINE AM07 PHASE 2 - STATION	2,432,242		2,432,242			$ 2,432,309	9,656,000	(7,223,691)	8/1/2022	2/28/2025	10/1/2022	
75086	G7AM07IL2	AW7013	AW7013 - ROW - PIPELINE REPLACEMENT - PH2	187,158		187,158			$ 187,158	4,284,600	(4,097,443)	5/18/2023	4/18/2025	9/1/2023	2/6/2025
75086	G7AM07IL3	AW6387	AW6387 - LINE AM07 - PIPE REPLACEMENT - PH 3	856,065		856,065			$ 856,065	40,828,200	(39,972,135)	11/23/2022	12/31/2025	1/1/2023	
75086	G7AM07IL3	AW6388	AW6388 - LINE AM07 PHASE 3 - LAND	93,301		93,301			$ 93,301	4,060,000	(3,966,699)	11/28/2022	12/31/2025	9/1/2023	
75086	G7AM07ILI	0233100	0233100 - LINE AM07 PIPELINE REPLACEMENT PHAS	24,311,136		24,311,136			$ 26,203,210	37,717,000	(11,513,790)	12/9/2020	12/31/2023	12/1/2020	3/18/2024
75086	G7AM07ILI	AW3074	AW3074 - LINE AM07 PIPELINE REPLACE LAND	4,526,459		4,526,459			$ 5,650,057	6,089,500	(439,443)	12/3/2020	12/31/2023	2/1/2021	3/18/2024
75086	G7AM07ILI	AW3138	AW3138 - LINE AM07 PIPELINE REPLACEMENT-STN	7,604,544		7,604,544			$ 9,667,039	6,278,300	3,388,739	12/18/2020	4/30/2024	5/1/2021	9/28/2024
75086	G7ASRP	CMSP70	CMSP70 - ASRP CURB TO METER 3" OR LESS	48,986		48,986			$ 8,948,845	20,388,002	(11,439,157)	3/4/2015	12/31/2019	7/1/2015	
75086	G7ASRP	MCSP70	MCSP70 - ASRP MAIN TO CURB 3" OR LESS	946,449		946,449			$ 43,964,729	19,954,384	24,010,345	3/4/2015	12/31/2019	7/1/2015	
75086	G7CORREM	AW5064	AW5064 - KENTUCKY - CORROSION REMEDIATION	88,867		88,867			$ 213,537	272,000	(58,463)	2/10/2022	9/30/2025	8/1/2022	
75086	G7EDGE	39171904	39171904 - CANCEL-ROW- EDGEWOOD PRESSURE IMP	7,096		7,096			$ 36,524	40,000	(3,476)	6/7/2022	1/31/2023	8/1/2022	
75086	G7EDGE	MX9171904	MX9171904 - EDGEWOOD PRESSURE IMP	154,557		154,557			$ 568,184	108,826	459,358	9/22/2022	7/29/2023	9/1/2022	7/24/2023

75086	G7EM6131	AW6193	AW6193 - KLEERBAND REMED AND COAT KY	164,226	164,226	$	169,019	120,000	49,019	10/3/2022	6/30/2023	12/1/2022	5/13/2023
75086	G7EMAM07	AW5092	AW5092 - EMERGENT - LINE AM07 - EXPOSED MAIN	2,308,307	2,308,307	$	2,648,068	1,319,200	1,328,868	2/15/2022	6/30/2023	4/1/2022	9/30/2023
75086	G7ESPEP	MX9171927	MX9171927 - ELSMERE PRESSURE IMP	1,098,723	1,098,723	$	2,480,237	327,968	2,152,269	4/25/2022	7/29/2023	5/1/2022	7/5/2023
75086	G7HARRPK	AW4778	AW4778 - ROW - HARRIS PIKE UL45 EXT	102,849	102,849	$	138,358	926,800	(788,442)	11/16/2021	11/30/2026	7/1/2022	
75086	G7HARRPK	AW4796	AW4796 - HARRIS PIKE UL45 EXT - PRESSURE IMP	305,252	305,252	$	672,147	7,884,400	(7,212,253)	11/19/2021	11/30/2026	2/1/2022	
75086	G7HOPECH	MX1415972	MX1415972 - HOPEFUL CHURCH RD. PRI, FLORENCE 13	21,721	21,721	$	21,721	2,073,615	(2,051,894)	12/21/2022	6/26/2025	2/1/2023	6/17/2025
75086	G7LGMR	MX6828172	MX6828172 - TO BE CANCEL-REG420BELAIR&SPICEWOOD	(83)	(83)	$	(0)	139,842	(139,842)	4/4/2018	3/31/2021	1/1/2019	
75086	G7MAINS	42698978	42698978 - ROW E MT ZION RD; INDEPNDNCE	521	521	$	2,979	15,000	(12,021)	2/28/2022	1/31/2023	6/1/2022	2/16/2023
75086	G7MAINS	AW6146	AW6146 - CANCEL_ROW LAKELAND PARK DR; LIM	842	842	$	4,252	25,000	(20,748)	9/20/2022	12/31/2023	10/1/2022	
75086	G7MAINS	AW6147	AW6147 - CANCEL-ROW MEA -STANBERY RIDGE	8	8	$	418	25,000	(24,582)	9/20/2022	9/9/2023	10/1/2022	
75086	G7MAINS	AW6415	AW6415 - CANCEL-TBC ROW MEA-DECLARATION DR	6,386	6,386	$	6,386	25,000	(18,614)	12/5/2022	7/14/2023	1/1/2023	
75086	G7MAINS	AW6482	AW6482 - CANCEL_LIS RD; CONSTANCE; 6" PL	4,176	4,176	$	4,176	25,000	(20,824)	1/6/2023	8/25/2023	2/1/2023	
75086	G7MAINS	AW6483	AW6483 - CANCEL_CRESTVW HL; VILLA MADONNA DR	4,227	4,227	$	4,227	25,000	(20,773)	1/6/2023	4/28/2023	2/1/2023	
75086	G7MAINS	AW6484	AW6484 - CANCEL_OLD LEXINGTON PIKE_RICHWOOD	675	675	$	675	25,000	(24,325)	1/6/2023	10/13/2023	2/1/2023	
75086	G7MAINS	AW6694	AW6694 - CANCEL_ROW MEA - MANHATTAN BLVD-	2,770	2,770	$	2,770	25,000	(22,230)	2/20/2023	6/9/2023	3/1/2023	
75086	G7MAINS	MEAPJT70	MEAPJT70 - JOINT TRENCH PLASITC MAIN EXTENSION	1,343,600	1,343,600	$	7,234,938	10,000,000	(2,765,062)	1/13/2016	12/31/2050	2/1/2016	
75086	G7MAINS	MX0742327	MX0742327 - MEA - BEECHWOOD RD; FT MITCHEL; 4"	11,767	11,767	$	11,767	58,680	(46,913)	11/29/2023	4/18/2024	12/1/2023	4/17/2024
75086	G7MAINS	MX0840009	MX0840009 - JT-G- BALLYSHANNON SECTION 5 PHASE	81	81	$	81	50,461	(50,380)	11/7/2023	8/19/2024	12/1/2023	7/31/2024
75086	G7MAINS	MX2698978	MX2698978 - E MT ZION RD; INDEPENDENCE; 6" PL;	(4,603)	(4,603)	$	527,702	161,397	366,304	7/21/2022	2/26/2023	7/1/2022	2/21/2023
75086	G7MAINS	MX2700925	MX2700925 - BRECKENRIDGE; ALEXANDRIA; 4" PL; MA	(9,728)	(9,728)	$	116,849	76,343	40,507	5/18/2022	11/17/2022	5/1/2022	11/8/2022
75086	G7MAINS	MX3676138	MX3676138 - JT-G-MEMORIAL POINTE PART 1	81,811	81,811	$	81,969	30,149	51,820	9/14/2022	8/4/2024	10/1/2022	9/26/2023
75086	G7MAINS	MX3738158	MX3738158 - JT-G-SAWGRASS PHASE D PART 2	78,368	78,368	$	78,527	36,692	41,835	10/4/2022	4/22/2024	10/1/2022	10/23/2023
75086	G7MAINS	MX3955327	MX3955327 - LOCK RD-BUTLER-1200 FT 4 INCH PL MA	19,981	19,981	$	172,474	66,243	106,231	7/15/2022	12/29/2022	7/1/2022	12/20/2022
75086	G7MAINS	MX4309183	MX4309183 - JT-G-BALLYSHANNON SECTION 5 PHASE 1	941	941	$	24,927	58,460	(33,533)	4/7/2022	6/5/2023	4/1/2022	2/9/2023
75086	G7MAINS	MX4720432	MX4720432 - 498 MASON RD FARM TAP EXTENSION	(106)	(106)	$	22,135	17,882	4,253	8/25/2022	3/9/2023	8/1/2022	2/16/2023
75086	G7MAINS	MX4735611	MX4735611 - W 3RD ST & W 4TH ST-NEWPORT-2194 FT	161,512	161,512	$	161,512	268,126	(106,614)	10/25/2023	5/9/2024	10/1/2023	5/21/2024
75086	G7MAINS	MX5095081	MX5095081 - EAST FROGTOWN RD; RICHWOOD; 6" PL;	75,916	75,916	$	168,751	71,068	97,682	8/18/2022	3/30/2023	8/1/2022	2/20/2023
75086	G7MAINS	MX5502940	MX5502940 - JT-G-BALLYSHANNON SECTION 5 PHASE 2	171,079	171,079	$	171,079	141,473	29,606	4/3/2023	9/19/2023	4/1/2023	1/13/2024
75086	G7MAINS	MX5543296	MX5543296 - OLD LEXINGTON PIKE; RICHWOOD ; 8" P	2,086,484	2,086,484	$	2,086,484	465,508	1,620,976	12/15/2022	1/4/2024	2/1/2023	1/1/2024
75086	G7MAINS	MX5653109	MX5653109 - FARM TAP PROJ; CROSBY PKWY/MAGELLAN	397,253	397,253	$	947,004	194,197	752,807	9/29/2020	7/13/2023	10/1/2020	11/15/2023
75086	G7MAINS	MX5709799	MX5709799 - LAKELAND PARK DR; LIMABURG ; 6" PL;	202,280	202,280	$	202,280	28,079	174,201	12/20/2022	5/18/2023	1/1/2023	5/18/2023
75086	G7MAINS	MX5751969	MX5751969 - MEA - STANBERY RIDGE-FORT THOMAS-47	9,394	9,394	$	112,974	24,699	88,275	10/4/2022	3/23/2023	10/1/2022	3/21/2023
75086	G7MAINS	MX5777720	MX5777720 - CANCEL - MEMORIAL- SOUTHGATE -8"	(0)	(0)	$	(0)	156,448	(156,448)	11/15/2022	10/16/2023	1/1/2023	
75086	G7MAINS	MX6108586	MX6108586 - JT-G-ENCLAVE SUBDIVISION	58,148	58,148	$	58,148	87,609	(29,461)	1/19/2023	11/16/2023	2/1/2023	3/12/2024
75086	G7MAINS	MX6108813	MX6108813 - PARKVIEW ESTATES APP - UNION - 8" &	97,062	97,062	$	265,884	134,092	131,792	10/26/2022	3/23/2023	11/1/2022	4/10/2023
75086	G7MAINS	MX6119454	MX6119454 - JT-G-TUSCANY SECTION 39 & 40	24,254	24,254	$	24,254	20,175	4,079	12/14/2022	11/19/2023	5/1/2023	10/31/2023
75086	G7MAINS	MX6212508	MX6212508 - ELLIS RD; CONSTANCE; 6" PL; MEA	91,904	91,904	$	91,904	73,565	18,338	6/14/2023	11/9/2023	6/1/2023	10/30/2023
75086	G7MAINS	MX6362268	MX6362268 - SERVICE RD; WALTON; 6" PL; MEA	100,529	100,529	$	114,099	61,478	52,621	11/10/2022	4/13/2023	11/1/2022	4/20/2023
75086	G7MAINS	MX6445818	MX6445818 - CARBON WAY; RICHWOOD; 6" PL; MEA	257,255	257,255	$	285,599	100,162	185,437	11/14/2022	6/8/2023	11/1/2022	5/30/2023
75086	G7MAINS	MX6591941	MX6591941 - ST RT 42; UNION; 4" PL; MEA; UNION	175,961	175,961	$	175,961	16,664	159,297	4/3/2023	9/7/2023	4/1/2023	9/13/2023
75086	G7MAINS	MX6678695	MX6678695 - MEA-DECLARATION DR-INDEPENDENCE-4 I	94,687	94,687	$	94,687	32,909	61,779	8/1/2023	12/28/2023	8/1/2023	12/25/2023
75086	G7MAINS	MX6735987	MX6735987 - CRESTVW HL; VILLA MADONNA DR; 4" IP	96,135	96,135	$	96,135	60,883	35,252	3/17/2023	8/17/2023	3/1/2023	9/19/2023
75086	G7MAINS	MX6877874	MX6877874 - MEA - EDGEWOOD; SUTTER DR; 4IN PL	13,152	13,152	$	13,152	11,204	1,948	2/14/2023	6/29/2023	2/1/2023	6/19/2023
75086	G7MAINS	MX7843275	MX7843275 - MEA - MANHATTAN BLVD-DAYTON-250 FT	22,295	22,295	$	22,295	17,848	4,447	6/5/2023	10/26/2023	6/1/2023	11/22/2023
75086	G7MAINS	MX8153338	MX8153338 - MEA - BROMLEY; WOODHAVEN CT; 2" PL	7,452	7,452	$	7,452	597	6,855	6/8/2023	10/26/2023	6/1/2023	10/8/2023
75086	G7MAINS	MX8197104	MX8197104 - JT-G-REDWOOD LIVING APARTMENTS	46,704	46,704	$	72,560	95,066	(22,506)	3/26/2021	12/30/2022	4/1/2021	12/19/2022
75086	G7MAINS	MX8327384	MX8327384 - MAE- MEMORIAL POINT APPROACH - SOUT	218,724	218,724	$	218,724	103,571	115,152	3/21/2023	8/17/2023	3/1/2023	8/2/2023
75086	G7MREG118	MX2217622	MX2217622 - STATION 873 - 5TH & PHILADELPHIA	238,192	238,192	$	417,159	87,907	329,252	9/22/2017	11/30/2025	10/1/2017	
75086	G7PUBIMP	MX0722354	MX0722354 - CANCEL -BARRS BRANCH BRIDGE PROJECT	140	140	$	140	-	140	9/7/2023	3/28/2024	10/1/2023	
75086	G7PUBIMP	MX2781786	MX2781786 - CANCEL_KYTC 19-9001 I-275 GRAVES RD	(104,794)	(104,794)	$	-	70,083	(70,083)	12/9/2020	11/22/2023	6/1/2021	
75086	G7PUBIMP	MX3359474	MX3359474 - KYTC - RICHWOOD RD STI - BEAVERLICK	159,258	159,258	$	479,297	24,088	455,209	12/13/2021	12/31/2024	12/1/2021	6/22/2022
75086	G7PUBIMP	MX4199889	MX4199889 - US-25 WALTON - 4" PL - STI	13,410	13,410	$	149,033	38,705	110,328	7/25/2022	3/30/2023	8/1/2022	2/16/2023
75086	G7PUBIMP	MX4966474	MX4966474 - 7639 TURFWAY - FLORENCE - 8" PL - S	(2,009)	(2,009)	$	83,010	3,294	79,717	6/27/2022	3/30/2023	7/1/2022	3/1/2023
75086	G7PUBIMP	MX6266002	MX6266002 - US27/MARSHALL LN. TO JOHNS HILL RD.	(789)	(789)	$	17,924	31,832	(13,909)	2/4/2022	1/12/2023	8/1/2022	12/25/2022
75086	G7PUBIMP	MX6798234	MX6798234 - KYTC 06-8916 HOUSTON RD-ERLANGER-ST	387,459	387,459	$	403,061	142,183	260,879	10/21/2022	1/11/2024	11/1/2022	3/19/2024
75086	G7PUBIMP	MX8637896	MX8637896 - CC STI -BLOSSOM LN- SOUTHGATE -8" P	339,835	339,835	$	339,835	128,671	211,163	3/30/2023	9/4/2023	4/1/2023	9/4/2023
75086	G7PUBIMP	MX8840782	MX8840782 - CANCEL INSTALL STREET IMPROVEMENT	(7)	(7)	$	(0)	-	(0)	2/6/2020	12/7/2018	2/1/2020	
75086	G7PUBIMP	MX9077703	MX9077703 - 0014.00 US-25 AT MT. ZION ROAD STI	92,925	92,925	$	92,925	32,071	60,854	4/24/2023	6/9/2023	5/1/2023	8/9/2023
75086	G7PUBIMP	MX9121402	MX9121402 - KYTC 06-423 FROGTOWN-UNION-STI	36,326	36,326	$	36,326	24,603	11,723	7/13/2023	2/29/2024	7/1/2023	2/19/2024
75086	G7PUBIMP	MX9244894	MX9244894 - KYTC - MT.ZION RD KY536 STI	79,198	79,198	$	1,090,372	1,026,778	63,594	11/8/2019	6/30/2023	1/1/2020	7/27/2021
75086	G7PUBIMP	MX9568282	MX9568282 - STI-TAYLOR MILL RD SIDEWALK-TAYLOR	37,497	37,497	$	37,497	38,707	(1,211)	10/19/2023	4/30/2024	10/1/2023	3/11/2024
75086	G7PUBIMP	MX9853572	MX9853572 - GRAVES AND NORTHBEND ROUNDABOUT PRO	(268,600)	(268,600)	$	1,109	109,422	(108,313)	2/16/2021	12/28/2023	2/1/2021	2/14/2022
75086	G7PUBIMP	MX9856643	MX9856643 - CANCEL-KYTC - KY-536 DONALDSON RD	(39,332)	(39,332)	$	-	-	-	9/6/2022	12/31/2024	11/1/2022	
75086	G7PUBIMP	MX9948553	MX9948553 - WILBERS LN - FORT THOMAS - 2" PE -	(32,384)	(32,384)	$	93,599	75,861	17,739	7/13/2021	12/16/2024	7/1/2021	2/21/2023
75086	G7PUINEW	INSREGREL	INSREGREL - INSTALL OR REMOVE REGULATOR/RELIEF	16,889	16,889	$	1,489,365	800,000	689,365	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	SETMETER	SETMETER - SET OR REMOVE METER	1,564,512	1,564,512	$	13,998,339	2,250,000	11,748,339	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGLG	AGECHGLG - KENTUCKY AGE CHANGE LARGE METER	262,497	262,497	$	1,022,003	350,000	672,003	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGSM	AGECHGSM - KENTUCKY AGE CHANGE SMALL METER	1,138,940	1,138,940	$	8,735,916	14,500,000	(5,764,084)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRLG	CHGMTRLG - CHANGE LARGE METER KENTUCKY	(15)	(15)	$	165,014	725,000	(559,986)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRSM	CHGMTRSM - CHANGE SMALL METER KENTUCKY	208,547	208,547	$	3,305,405	1,250,000	2,055,405	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGREGREL	CHGREGREL - CHANGE REGULATOR/RELIEF KENTUCKY	14,553	14,553	$	182,578	800,000	(617,422)	3/3/2015	12/31/2050	4/1/2015	
75086	G7REG0026	MX7281967	MX7281967 - REG 0026 UPHIL AND HIGHWAY - REG SW	837	837	$	3,249	48,954	(45,705)	7/7/2020	3/31/2021	8/1/2020	1/20/2021
75086	G7REG0057	MX7281845	MX7281845 - CANCEL -REG 0057 SARATOGA 11TH - OR	(2,700)	(2,700)	$	(60)	44,954	(45,013)	7/7/2020	3/31/2021	7/1/2020	
75086	G7REG0089	AW3224	AW3224 - REG 0427 EMPIRE DR	66,988	66,988	$	889,427	732,000	157,427	12/30/2020	10/30/2025	7/1/2021	
75086	G7REG0089	AW3246	AW3246 - REG 0427 EMPIRE DR LAND	33,948	33,948	$	97,257	82,500	14,757	1/2/2021	3/31/2026	4/1/2021	
75086	G7REG010	AW3280	AW3280 - REG 0010 STEVENSON AND LEXINGTON RE	(1,378)	(1,378)	$	26,175	58,000	(31,825)	1/6/2021	3/31/2022	6/1/2021	11/2/2021
75086	G7REG013	AW3273	AW3273 - REG 0013 SIXTEENTH AND HOLMAN REPAI	677	677	$	22,853	39,300	(16,447)	1/6/2021	3/31/2022	7/1/2021	11/24/2021
75086	G7REG021	AW3278	AW3278 - REG 0021 GRAND AND S FT THOMAS REPA	1,348	1,348	$	15,759	56,400	(40,641)	1/6/2021	3/31/2022	7/1/2021	10/23/2021
75086	G7REG026	AW3184	AW3184 - REG 0437 UPHILL & HIGHWAY	327,140	327,140	$	1,749,704	507,300	1,242,404	12/28/2020	3/31/2023	12/1/2021	2/8/2023
75086	G7REG0359	AW4715	AW4715 - REG 0359 - TAYLOR MILL RD N - RS UP	4,780	4,780	$	69,531	37,100	32,431	10/28/2021	3/30/2023	1/1/2022	2/18/2023
75086	G7REG045	AW3228	AW3228 - REG 0432 TENTH & BRIGHTON	1,921,780	1,921,780	$	2,251,191	660,800	1,590,391	12/30/2020	3/31/2021	11/1/2021	7/11/2023
75086	G7REG045	AW3356	AW3356 - CANCEL- REG0432 TENTH-BRIGHTON LAND	(9,215)	(9,215)	$	(712)	82,500	(83,212)	1/13/2021	3/31/2023	9/1/2021	
75086	G7REG051	AW3919	AW3919 - REG 0051 WALNUT AND ELECTRIC REPAIR	921	921	$	31,754	175,200	(143,446)	5/25/2021	3/31/2022	8/1/2021	11/23/2021
75086	G7REG053	MX9751457	MX9751457 - REG 0053 - OVERTON AND NINTH - REG	2,186	2,186	$	65,189	43,954	21,236	2/8/2021	3/31/2022	6/1/2021	10/28/2021
75086	G7REG057	AW3180	AW3180 - REG 0431 SARATOGA & ELEVENTH	2,175,190	2,175,190	$	2,645,398	796,400	1,848,998	12/28/2020	3/31/2023	11/1/2021	11/8/2023
75086	G7REG057	AW3354	AW3354 - CANCEL-REG431 SARATOGA-ELEVENTH ROW	(11,300)	(11,300)	$	(3,198)	82,500	(85,698)	1/13/2021	3/31/2023	6/1/2021	
75086	G7REG059	AW3177	AW3177 - REG 0059 HIGHLAND AND GRAND RS REPL	515,315	515,315	$	3,286,812	746,000	2,540,812	12/28/2020	9/30/2022	6/1/2021	2/9/2023

75086	G7REG059	AW3353	AW3353 - REG 0059 HIGHLAND AND GRAND LAND	2,551	2,551	$	90,448	82,500	7,948	1/13/2021	9/30/2022	4/1/2021	2/9/2023
75086	G7REG069	AW3287	AW3287 - REG 0069 JEFFERSON AND HAWTHORNE RE	(1,100)	(1,100)	$	20,991	56,400	(35,409)	1/6/2021	3/31/2022	7/1/2021	11/14/2021
75086	G7REG073	AW3286	AW3286 - REG 0073 GRAVES AND HULBERT REPAIR	820	820	$	44,634	58,000	(13,366)	1/6/2021	3/31/2022	6/1/2021	11/28/2021
75086	G7REG074	AW4985	AW4985 - REG 0074 - MCALPIN N OF HOPE - RELI	100,625	100,625	$	909,142	135,940	773,202	3/1/2022	8/31/2022	5/1/2022	10/7/2022
75086	G7REG074	MXA751466	MXA751466 - CANCEL - REG 0074 - MCALPIN N - R	(13,054)	(13,054)	$	-	9,702	(9,702)	6/21/2022	9/20/2022	6/1/2022	
75086	G7REG093	AW3284	AW3284 - REG 0093 ALEXANDRIA AND BLOSSUM REP	3,358	3,358	$	38,250	61,000	(22,750)	1/6/2021	3/31/2022	7/1/2021	11/20/2021
75086	G7REG095	AW3283	AW3283 - REG 0095 BAUM AND BURNET	202	202	$	36,472	402,900	(366,428)	1/6/2021	3/31/2022	8/1/2021	11/20/2021
75086	G7REG097	AW3282	AW3282 - REG 0097 HOME AND MAIN REPAIR	1,129	1,129	$	39,707	73,500	(33,793)	1/6/2021	3/31/2022	7/1/2021	1/13/2022
75086	G7REG74K	AW3285	AW3285 - REG 0074 MCALPIN N OF HOPE LN REPAI	549	549	$	39,334	54,100	(14,766)	1/6/2021	3/31/2022	7/1/2021	12/24/2021
75086	G7REPL	28051	28051 - SMALL REPL KY	354,339	354,339	$	1,958,069	-	1,958,069	4/13/2000	12/31/2050	12/1/1999	
75086	G7REPL	AW6197	AW6197 - CANCEL- ROW SCHOOL RD - WALTON	2,169	2,169	$	4,128	25,000	(20,872)	10/6/2022	6/17/2023	11/1/2022	
75086	G7REPL	MX0506978	MX0506978 - KYTC MT ZION - INDEPENDENCE - 12" P	92,484	92,484	$	92,484	43,338	49,146	10/12/2023	2/20/2024	10/1/2023	2/7/2024
75086	G7REPL	MX3269023	MX3269023 - KYTC - HANDS PIKE - EDGEWOOD - 4" P	(23,358)	(23,358)	$	258,583	12,424	246,160	6/27/2022	12/31/2024	7/1/2022	11/18/2022
75086	G7REPL	MX4962663	MX4962663 - ALEXANDRIA PK - ALEXANDRIA- 8" SIZE	232,290	232,290	$	387,434	93,664	293,770	8/10/2022	5/11/2023	8/1/2022	5/3/2023
75086	G7REPL	MX6589218	MX6589218 - SCHOOL RD - WALTON - 4" PL - RPL	152,319	152,319	$	152,319	31,267	121,052	3/17/2023	11/30/2023	3/1/2023	11/29/2023
75086	G7REPL	MX7352150	MX7352150 - AVALON SQUARE - WEAVER RD - FLORENC	72,692	72,692	$	72,692	45,572	27,120	5/3/2023	9/21/2023	5/1/2023	10/3/2023
75086	G7REPL	T9340	T9340 - CANCEL RPL WATERWORKS RD. INLET	(54)	(54)	$	(2,701)	28,103	(30,804)	7/14/2017	9/1/2018	4/1/2018	
75086	G7REPL	T9341	T9341 - CANCEL RPL WATERWORKS RD. OUTLET	(53)	(53)	$	(2,989)	28,103	(31,091)	7/14/2017	9/1/2018	4/1/2018	
75086	G7RGPI	MX9217475	MX9217475 - GARVEY AVE. PRI, ELSMERE, 9400' 8"	37,404	37,404	$	1,512,645	507,691	1,004,954	8/16/2021	12/1/2022	9/1/2021	11/21/2022
75086	G7RRPI	MX9219249	MX9219249 - RICHARDSON RD PRESSURE IMP 7300' OF	45,142	45,142	$	77,418	765	76,653	10/21/2022	3/12/2026	11/1/2022	
75086	G7SERVMC	8MCR70	8MCR70 - CANCEL_REPLACE M-C 8" AND GREATER	(210)	(210)	$	(210)	-	(210)	5/5/2010	12/31/2050	3/1/2013	
75086	G7SERVMC	AW6981	AW6981 - SERVICE ABANDONMENTS - IAP	12,192	12,192	$	12,192	-	12,192	5/2/2023	12/31/2050	5/1/2023	
75086	G7SERVMC	CMRP70	CMRP70 - REPLACE C-M PLASTIC 2 INCH AND UNDE	251,035	251,035	$	13,231,230	-	13,231,230	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVMC	CMRS70	CMRS70 - 2" OR LESS STEEL C-M REPLACE	1,448	1,448	$	11,809	1,000,000	(988,191)	1/13/2016	12/31/2050	3/1/2016	
75086	G7SERVMC	LCMRP70	LCMRP70 - GREATER THAN 2" C-M REPL PLASTIC	14,954	14,954	$	90,495	2,500,000	(2,409,505)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRP70	LMCRP70 - GREATER THAN 2" M-C REPL PLASTIC	136,184	136,184	$	674,467	2,500,000	(1,825,533)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVMC	LMCRS70	LMCRS70 - GREATER THAN 2" M-C REPL STEEL	233	233	$	16,527	1,000,000	(983,473)	1/13/2016	12/31/2050	11/1/2016	
75086	G7SERVMC	MCRP70	MCRP70 - REPLACE (NON-AMRP) M-C PLASTIC 2 IN	1,589,253	1,589,253	$	23,621,807	-	23,621,807	7/1/2008	12/31/2050	7/1/2008	12/20/2009
75086	G7SERVMC	MCRS70	MCRS70 - REPLACE M-C STEEL 2 INCH AND UNDER	33,042	33,042	$	624,811	-	624,811	7/1/2008	12/31/2050	7/1/2008	
75086	G7SERVNEW	CMNEWP70	CMNEWP70 - NEW C-M PLASTIC 2 INCH AND UNDER KY	509,263	509,263	$	8,686,272	1	8,686,271	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	CMNEWS70	CMNEWS70 - 2" OR LESS STEEL NEW C-M	14,935	14,935	$	297,439	5,000,000	(4,702,561)	1/13/2016	12/31/2050	5/1/2016	
75086	G7SERVNEW	LCMNEWP70	LCMNEWP70 - GREATER THAN 2" C-M PLASTIC	27,715	27,715	$	271,528	2,500,000	(2,228,472)	1/13/2016	12/31/2050	2/1/2016	
75086	G7SERVNEW	LCMNEWS70	LCMNEWS70 - GREATER THAN 2" C-M STEEL	17,507	17,507	$	17,507	1,000,000	(982,493)	3/10/2017	12/31/2050	7/1/2019	
75086	G7SERVNEW	LMCNEWP70	LMCNEWP70 - GREATER THAN 2" M-C PLASTIC	183,193	183,193	$	730,835	2,500,000	(1,769,165)	1/13/2016	12/31/2050	3/1/2016	
75086	G7SERVNEW	LMCNEWS70	LMCNEWS70 - GREATER THAN 2" M-C STEEL	53,394	53,394	$	163,532	2,500,000	(2,336,468)	1/13/2016	12/31/2050	4/1/2016	
75086	G7SERVNEW	MCNEWP70	MCNEWP70 - NEW M-C PLASTIC 2 INCH AND UNDER KY	2,339,381	2,339,381	$	22,904,625	1	22,904,624	12/31/2010	12/31/2050	1/1/2011	
75086	G7SERVNEW	MCNEWS70	MCNEWS70 - NEW M-C STEEL 2 INCH AND UNDER KY	99,085	99,085	$	367,016	1	367,015	12/31/2010	12/31/2050	4/1/2011	
75086	G7SHOW2	MX8547529	MX8547529 - CHARTER - SHOWCASE CINEMAS RPL 1500	1,431,508	1,431,508	$	1,431,508	417,337	1,014,171	3/11/2023	7/21/2023	3/1/2023	10/20/2023
75086	G7STA011	AW3227	AW3227 - STA 0949 DAYTON VALVE HOUSE	332,436	332,436	$	1,412,676	1,062,400	350,276	12/30/2020	10/30/2025	11/1/2021	
75086	G7STA011	AW3250	AW3250 - STA 0949 DAYTON VALVE HOUSE LAND	502	502	$	26,610	82,500	(55,890)	1/2/2021	11/29/2025	6/1/2021	
75086	G7STA014	AW3251	AW3251 - CANCEL_STA 0014 EAST ALEXANDRIAPIKE	(57)	(57)	$	19	82,500	(82,481)	1/3/2021	3/31/2023	6/1/2021	
75086	G7STA014	MX5466775	MX5466775 - CHARTER - EAST ALEXANDRIA PIKE	352,188	352,188	$	352,188	129,996	222,192	11/22/2022	12/29/2023	3/1/2023	11/20/2023
75086	G7STA064	AW3217	AW3217 - STA 0940 GLECOE TB	704,166	704,166	$	1,099,115	510,900	588,215	12/30/2020	3/31/2021	11/1/2021	9/27/2023
75086	G7STA064	AW3268	AW3268 - STA 0940 STA GLENCOE TB LAND	54,158	54,158	$	61,325	82,500	(21,175)	1/5/2021	3/31/2023	8/1/2021	9/27/2023
75086	G7STA276	AW3212	AW3212 - STA 0276 MARY INGLES HWY RS ABANDON	(1,547)	(1,547)	$	86,581	553,900	(467,319)	12/30/2020	3/31/2021	11/1/2021	11/18/2022
75086	G7STA276	AW3689	AW3689 - CANCEL-STA 0276 MARY IGLES HWY LAND	(3,091)	(3,091)	$	341	82,500	(82,159)	2/26/2021	3/31/2023	6/1/2021	
75086	G7STA280	AW3213	AW3213 - STA 0938 TAYLOR MILL & LONE OAK	2,062,159	2,062,159	$	2,714,635	562,000	2,152,635	12/30/2020	9/30/2023	11/1/2021	9/8/2023
75086	G7STA280	AW3272	AW3272 - STA0938 TAYLOR MILL & LONE OAK LAND	3,596	3,596	$	143,383	82,500	60,883	1/5/2021	3/31/2023	8/1/2021	9/8/2023
75086	G7STA286	AW3216	AW3216 - STA 0929 RILEY RD	2,007,912	2,007,912	$	4,099,944	635,200	3,464,744	12/30/2020	3/31/2021	9/1/2021	6/28/2023
75086	G7STA286	AW3271	AW3271 - STA 0929 RILEY RD LAND	5,338	5,338	$	87,055	82,500	4,555	1/5/2021	3/31/2023	6/1/2021	6/28/2023
75086	G7STA338	AW3192	AW3192 - STA 0941 GUBSER MILL	184,144	184,144	$	601,743	538,800	62,943	12/28/2020	12/30/2025	9/1/2021	
75086	G7STA338	AW3690	AW3690 - STA 0941 GUBSER MILL LAND	10,799	10,799	$	48,400	82,500	(34,100)	2/27/2021	10/25/2025	6/1/2021	
75086	G7STA444	AW3186	AW3186 - STA 0948 THIRD & CRESCENT	69,031	69,031	$	637,909	948,400	(310,491)	12/28/2020	11/27/2025	11/1/2021	
75086	G7STA444	AW3230	AW3230 - STA 0948 THIRD & CRESCENT LAND	35,411	35,411	$	53,659	82,500	(28,841)	12/31/2020	11/27/2025	8/1/2021	
75086	G7STA535	AW3299	AW3299 - STA 0535 DRY RIDGE EAST REPAIR	6,469	6,469	$	70,997	56,400	14,597	1/7/2021	8/31/2022	6/1/2021	12/2/2022
75086	G7STA793	AW3188	AW3188 - STA 0942 CAMP ERNST RD	2,990,403	2,990,403	$	3,690,112	887,300	2,802,812	12/28/2020	9/30/2023	11/1/2021	1/18/2024
75086	G7STA793	AW3767	AW3767 - STA 0942 CAMP ERNST RD LAND	41,976	41,976	$	108,915	82,500	26,415	3/16/2021	3/31/2023	6/1/2021	1/18/2024
75086	G7STA822	AW3189	AW3189 - STA 0822 COX RD RS REPAIR	(64,550)	(64,550)	$	188,430	541,600	(353,170)	12/28/2020	12/31/2022	11/1/2021	11/18/2022
75086	G7STA822	AW3685	AW3685 - CANCEL 0822 - COX RD. RS REP - LAND	(4,516)	(4,516)	$	-	82,500	(82,500)	2/26/2021	12/31/2022	6/1/2021	
75086	G7STA876	AW6684	AW6684 - ROW WARSAW TB RS REPLACEMENT - LAND	48,325	48,325	$	48,325	15,000	33,325	2/15/2023	11/30/2023	3/1/2023	9/29/2023
75086	G7STA876	MX6800938	MX6800938 - STA 876 WARSAW TOWN BORDER- STATION	2,010,707	2,010,707	$	2,347,536	252,984	2,094,552	1/10/2018	9/30/2022	1/1/2018	9/29/2023
75086	G7TAM00B	AW2146	AW2146 - LINE AM00B RETROFIT REPL	5,044	5,044	$	14,822,828	6,528,636	8,294,192	5/19/2020	10/15/2022	5/1/2020	9/17/2022
75086	G7TOOLS	28073	28073 - PURCHASE GAS TOOLS BLANKET	201,289	201,289	$	1,282,067	-	1,282,067	4/13/2000	12/31/2015	12/1/1999	
75086	G7TOOLS	AW4691	AW4691 - CGI UPGRADE KENTUCKY	10,418	10,418	$	346,112	120,000	226,112	10/22/2021	6/30/2022	12/1/2021	
75086	G7UL02PH2	V9444	V9444 - UL60 PIPELINE PHASE II - PIPE	53,563	53,563	$	20,998,995	22,514,005	(1,515,010)	6/12/2019	3/30/2022	10/1/2019	11/18/2021
75086	G7UL57	AW4824	AW4824 - STA0917 UL61 CHAMBERS RD TO DIXIE	3,249,466	3,249,466	$	3,722,694	873,000	2,849,694	12/9/2021	1/31/2024	2/1/2022	12/26/2023
75086	G7UL57	AW4840	AW4840 - UL61 CHAMBERS RD TO DIXIE HWY- LAND	10,440	10,440	$	111,854	82,500	29,354	12/14/2021	1/31/2023	2/1/2022	12/26/2023
75086	G7UL57	MX9221113	MX9221113 - UL57 DIXIE HWY REG RPL MAE 9700' OF	1,037,129	1,037,129	$	1,037,129	382,587	654,542	12/6/2022	2/28/2024	1/1/2023	12/19/2023
75086	OM75086	GCPBUDKY	GCPBUDKY - BUDGET ONLY - KENT GAS CAP	6,635	6,635	$	6,635	-	6,635	6/18/2018	12/31/2050	5/1/2023	
75086	SG000723F	SG723SW	SG723SW - DEE AMI OPERATIONS TOOL	66	66	$	32,589	26,599	5,990	3/3/2020	7/30/2022	3/1/2020	7/31/2022
75086	SG001117F	SG001117	SG001117 - DEE LMR CONSOLES	(1,631)	(1,631)	$	97,462	124,921	(27,459)	8/25/2021	3/31/2023	10/1/2021	11/30/2022
75086	SG001135F	CGRREPLA	CGRREPLA - CGR REPLACE DEK GAS	31,246	31,246	$	31,246	-	31,246	3/6/2023	12/31/2050	4/1/2023	
75087	CUSTCONN	315986F	315986F - CUSTOMER CONNECT- R6-8 SCOPE	22	22	$	461,877	53,917	407,960	3/30/2021	6/30/2022	4/1/2021	7/6/2022
75087	CUSTCONN	315986HW8	315986HW8 - CUSTOMER CONNECT- HARDWARE PROJ 6	(12)	(12)	$	37,330	67,100	(29,770)	9/27/2021	6/30/2022	10/1/2021	9/15/2022
75087	CUSTCONN	400109	400109 - CUST ENHANCEMENT AND OPTIMIZATION	239,515	239,515	$	370,084	480,680	(110,596)	6/20/2022	1/19/2024	7/1/2022	1/26/2024
75087	CUSTCONN	400109M	400109M - MY ACCOUNT MODERNIZATION	41,873	41,873	$	41,873	135,363	(93,490)	6/9/2023	3/31/2025	6/1/2023	1/16/2025
75087	FPIT	307482003	307482003 - CUSTOMER MOBILE APP - PHASE 4	8,146	8,146	$	172,003	24,891	147,112	12/30/2021	3/31/2023	1/1/2022	3/31/2023
75087	FPIT	400055004	400055004 - INSPECTION PORTAL 2021	2,343	2,343	$	11,814	10,727	1,087	12/16/2020	7/3/2023	1/1/2022	7/31/2023
75087	FPIT	400055005	400055005 - BUILDER PORTAL 2021	3,086	3,086	$	15,391	17,824	(2,433)	12/10/2020	9/30/2023	1/1/2021	9/30/2023
75087	FPIT	400055015	400055015 - ATLANTIS (CUSTOMER ANALYTICS ENGINE	12,444	12,444	$	25,281	22,832	2,449	12/29/2021	12/30/2023	1/1/2022	1/1/2024
75087	FPIT	400055016	400055016 - TITAN (VOICE OF THE CUSTOMER ENGAGE	2,187	2,187	$	15,045	11,104	3,941	12/20/2021	10/31/2023	1/1/2022	10/31/2023
75087	FPIT	400055017	400055017 - DIGITAL ASSISTANT PLATFORM 2022 ENH	5,248	5,248	$	27,368	15,150	12,218	12/20/2021	6/30/2023	1/1/2022	7/4/2023
75087	FPIT	400055022	400055022 - BUSINESS OUTBOUND NOTIFICATION PLAT	(19)	(19)	$	-	5,949	(5,949)	5/19/2022	3/31/2023	10/1/2022	3/31/2023
75087	FPIT	400055023	400055023 - USAGE ALERTS PHASE 2	17,190	17,190	$	17,190	23,299	(6,109)	12/15/2022	6/29/2024	1/1/2023	6/30/2024
75087	FPIT	400055024	400055024 - SERVICE NAVIGATOR	15,943	15,943	$	15,943	22,425	(6,482)	12/20/2022	6/30/2024	1/1/2023	7/31/2024
75087	FPIT	400055025	400055025 - DIGITAL CARE PLATFORM	33,315	33,315	$	33,315	25,411	7,904	3/14/2023	3/31/2024	3/1/2023	3/31/2024
75087	FPIT	400055026	400055026 - INSPECTOR PORTAL PHASE 3	3,442	3,442	$	3,442	2,491	951	6/28/2023	3/29/2024	7/1/2023	3/31/2024

75087	FPIT	400055029	400055029 - IVR VOICE AUTHENTICATION	55,107		55,107		$ 55,107	77,856	(22,749)	10/19/2023	6/29/2025	10/1/2023	1/31/2025
75087	FPIT	400055030	400055030 - SAP & BUSINESS CUSTOMER WEB PORTAL	24,275		24,275		$ 24,275	212,277	(188,002)	11/1/2023	9/30/2025	11/1/2023	7/31/2025
75087	FPIT	400055031	400055031 - D-E.COM/MY ACCOUNT WEB	1,593		1,593		$ 1,593	22,654	(21,061)	10/31/2023	6/29/2025	11/1/2023	7/15/2025
75087	FPIT	400055032	400055032 - CUSTOMER - MOBILE APPLICATION	7,756		7,756		$ 7,756	42,720	(34,964)	10/31/2023	7/30/2025	11/1/2023	7/15/2025
75087	FPIT	CO2200002	CO2200002 - UTILITY ASSISTANCE MODERN ARCHITECT	1,144		1,144		$ 1,995	3,296	(1,301)	6/30/2022	12/29/2022	7/1/2022	3/15/2023
75087	FPIT	CO2300002	CO2300002 - GIFT CARD INVENTORY MODERN ARCHITEC	1,117		1,117		$ 1,117	1,823	(706)	5/31/2023	10/30/2024	6/1/2023	1/30/2025
75087	FPIT	CS2100010	CS2100010 - CONTACT CENTER WORK FROM HOME	1,178		1,178		$ 2,318	4,849	(2,531)	1/26/2022	11/28/2022	2/1/2022	1/6/2023
75087	FPIT	CS2200002	CS2200002 - IVR ENHANCEMENTS 2022	287		287		$ 4,043	20,162	(16,119)	5/5/2022	5/1/2023	5/1/2022	4/30/2023
75087	FPIT	CS2200005	CS2200005 - UPLAND RIGHT ANSWER LICENSE PURCHAS	(4,206)		(4,206)		$ 7,983	7,962	21	8/3/2022	1/29/2023	12/1/2022	5/31/2023
75087	FPIT	CS2200006	CS2200006 - VERINT UPGRADE	24,239		24,239		$ 79,193	80,257	(1,064)	11/4/2022	3/31/2024	11/1/2022	3/31/2024
75087	FPIT	CS2200007	CS2200007 - FND LICENSES ADDITIONAL ENDPOINTS	(5)		(5)		$ 7,823	7,591	232	11/1/2022	3/30/2023	12/1/2022	3/22/2023
75087	FPIT	CS2200008	CS2200008 - AVAYA PLATFORM UPGRADE - SERVER	31,153		31,153		$ 45,669	44,473	1,196	11/14/2022	3/31/2024	11/1/2022	3/31/2024
75087	FPIT	CS2300001	CS2300001 - CCO REMOTE WORKSTATION EQUIPMENT	7,332		7,332		$ 7,332	8,282	(950)	2/3/2023	1/31/2024	3/1/2023	1/31/2024
75087	FPIT	TC2300028	TC2300028 - 3 YR NEWS GOTHIC FONT LICENSE	2,259		2,259		$ 2,259	2,277	(18)	6/6/2023	9/24/2023	7/1/2023	9/26/2023
75087	FPIT	TC2300036	TC2300036 - SAP CUSTOMER SYSTEM CHANGES AND ENH	9,337		9,337		$ 9,337	23,896	(14,559)	8/7/2023	8/29/2024	8/1/2023	8/31/2024
75087	FPIT	TC2300037	TC2300037 - SAP ENABLE NOW APPLICATION	5,771		5,771		$ 5,771	5,061	710	8/9/2023	3/30/2024	8/1/2023	3/31/2024
75088	CY1900015	349395006	349395006 - ITOT OT SIEM PHASE 2 HW WORKSTREAM	(54,263)		(54,263)		$ -	5,497	(5,497)	4/13/2020	10/28/2022	5/1/2020	
75088	CY1900015	349395SW6	349395SW6 - ITOT OT SIEM SW WORKSTREAM	(75,187)		(75,187)		$ -	6,089	(6,089)	12/9/2021	10/28/2022	12/1/2021	
75088	FPITKG	TC210HW57	TC210HW57 - CIOPS NERC CIP CYBERARK HW	(286)		(286)		$ -	304	(304)	12/10/2021	9/30/2024	1/1/2022	
75088	FPITKG	TC210SW57	TC210SW57 - CIOPS NERC CIP CYBERARK IMPLEMENTAT	(1,699)		(1,699)		$ 70	3,357	(3,287)	12/10/2021	3/31/2024	2/1/2022	12/1/2023
				100,543,300	71,817,091	28,726,209	29%							

Duke Energy Kentucky Natural Gas
Year 2024

Business Unit	Funding Project	Project No.	Project Title/Description	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Percent of Budget	Total Actual Project Cost	Total Budget Project Cost	Variance in Dollars	Date Original Budget Start	Date Original Budget End	Date Actual Start	Date Actual End
75086	4000156F	04000156	04000156 - DEE EAM NEXTGEN GIS	414,387		414,387			581,229	599,758	(18,529)	12/17/2022	12/31/2026	1/1/2023	
75086	75086	ARCOS24	ARCOS24 - DEE ARCOS REPORTS AND ANALYTICS	60,040		60,040			60,040	60,040	(0)	5/14/2024	9/30/2024	5/1/2024	7/31/2024
75086	DVV2023	400154001	400154001 - MIDWEST GAS UPLIFT - KENTUCKY	86,574		86,574			86,574	97,995	(11,421)	12/8/2023	12/29/2025	1/1/2024	
75086	FMDT2020	MDTGAS20	MDTGAS20 - INSTALL WIN 7 PANASONIC TOUGHBOOKS	(58,669)		(58,669)			522,867	403,995	118,872	10/10/2019	3/31/2021	12/1/2019	3/31/2021
75086	FP00ISENT	IT2400036	IT2400036 - EMISSSIONS PHASE II	75,590		75,590			75,590	193,878	(118,288)	11/13/2024	3/31/2026	11/1/2024	
75086	FP00ISENT	IT2400064	IT2400064 - NGBU DIGITAL MOBILE PORTFOLIO	65,877		65,877			65,877	155,769	(89,892)	11/12/2024	3/31/2026	11/1/2024	
75086	FPIT	349472020	349472020 - SLATE - EAM WORK MGMT SCHEDULING TO	7,100		7,100			52,675	22,340	30,335	3/18/2022	6/30/2024	3/1/2022	6/30/2024
75086	FPIT	349472021	349472021 - FMA ENHANCEMENTS	368		368			9,748	4,713	5,035	5/18/2022	3/31/2026	6/1/2022	
75086	FPIT	349472023	349472023 - SMALLWORLD ENHANCEMENTS	4,326		4,326			26,657	15,341	11,316	9/29/2022	3/30/2025	11/1/2022	3/31/2024
75086	FPIT	349472028	349472028 - NEW FMA ENHANCEMENTS	10,469		10,469			22,233	9,670	12,563	4/14/2023	3/31/2026	4/1/2023	
75086	FPIT	349472029	349472029 - MAXIMO INTEGRATIONS AND OTHER ENHAN	17,054		17,054			37,470	19,914	17,556	4/6/2023	3/31/2026	4/1/2023	
75086	FPIT	349472030	349472030 - ESRI UPGRADE TO 10.9	350		350			23,261	6,738	16,523	4/21/2023	3/30/2024	4/1/2023	3/31/2024
75086	FPIT	349472031	349472031 - MATERIAL ISSUE LIGHTING APPLICATION	631		631			1,547	4,516	(2,969)	10/20/2023	6/30/2024	10/1/2023	6/30/2024
75086	FPIT	349472032	349472032 - EAM - ARGUS ENHANCEMENTS	13,731		13,731			13,731	8,290	5,441	1/30/2024	3/31/2026	2/1/2024	
75086	FPIT	349472033	349472033 - EAM MOBILEMAX & LIGHTING SUPPORT	18,329		18,329			18,329	4,834	13,495	12/22/2023	3/31/2026	1/1/2024	
75086	FPIT	349472034	349472034 - EAM DATA PRODUCTS MADE	5,111		5,111			5,111	31,355	(26,244)	2/20/2024	3/31/2026	2/1/2024	
75086	FPIT	349472S14	349472S14 - NEW ESRI INTEGRATIONS AND INFRA	76		76			59,972	532,359	(472,387)	2/9/2021	11/30/2023	3/1/2021	3/6/2024
75086	FPIT	400149HW2	400149HW2 - ESCA - ITOT CYBER CARBON BLACK HW	1,501		1,501			2,177	2,282	(105)	8/9/2023	3/31/2026	8/1/2023	
75086	FPIT	400149SW2	400149SW2 - ESCA - ITOT CYBER CARBON BLACK SW	2,175		2,175			2,175	4,067	(1,892)	8/8/2023	3/31/2026	1/1/2024	
75086	FPIT	400161002	400161002 - CISCO LICENSE SPA 2024	25,766		25,766			25,766	28,490	(2,724)	6/18/2024	1/30/2025	6/1/2024	10/1/2024
75086	FPIT	IT2200155	IT2200155 - GAS SUPPLY - AUTOMATING CONFIRMATIO	4,220		4,220			29,389	67,905	(38,516)	12/28/2022	6/30/2024	1/1/2023	10/31/2023
75086	FPIT	IT2200157	IT2200157 - FUTURE STATE 811 5 STATE LOCATE	2,416		2,416			72,130	71,696	434	12/5/2022	4/30/2024	12/1/2022	4/30/2024
75086	FPIT	IT2200160	IT2200160 - NGBU-AI FRAMEWORK	113,319		113,319			177,403	185,732	(8,328)	12/13/2022	3/30/2027	1/1/2023	
75086	FPIT	IT2200165	IT2200165 - NGBU TRACEABILITY PLATFORM	46,423		46,423			92,028	125,985	(33,957)	12/1/2022	3/31/2026	1/1/2023	
75086	FPIT	IT2200175	IT2200175 - LOTO PROCEDURES DEVONWAY SOLUTIONS	1,145		1,145			12,516	23,704	(11,188)	12/21/2022	8/31/2024	1/1/2023	8/31/2024
75086	FPIT	IT2300049	IT2300049 - GTIS EDI SOLUTION	16,512		16,512			43,457	48,240	(4,783)	8/17/2023	7/30/2024	8/1/2023	7/20/2024
75086	FPIT	IT2300096	IT2300096 - TIMP DATA INTEGRATION AND ALIGNMENT	95,329		95,329			95,329	75,811	19,518	11/30/2023	6/29/2026	1/1/2024	
75086	FPIT	IT2300097	IT2300097 - TEMPORARY GAS ORDER ENTRY SYSTEM (T	11,832		11,832			11,832	15,803	(3,971)	3/7/2024	3/31/2025	3/1/2024	12/31/2024
75086	FPIT	IT2300098	IT2300098 - MAJOR PROJECTS DIGITAL INSPECTION	34,072		34,072			34,072	41,810	(7,738)	1/3/2024	5/28/2025	1/1/2024	5/24/2025
75086	FPIT	IT2300102	IT2300102 - GTIS 3-YEAR PLAN / EDI PLATFORM	91,048		91,048			91,048	336,772	(245,724)	11/30/2023	6/29/2026	1/1/2024	
75086	FPIT	IT2300103	IT2300103 - NGBU DATA FABRICS BUILD	34,638		34,638			34,638	229,894	(195,256)	2/6/2024	3/31/2027	2/1/2024	
75086	FPIT	IT2400006	IT2400006 - PCS INSPECTION TOOL REPLACEMENT	20,611		20,611			20,611	50,039	(29,428)	2/18/2024	3/31/2025	2/1/2024	3/31/2025
75086	FPIT	IT2400017	IT2400017 - MICROSOFT PRODUCTIVITY SUITE FIVE	142,932		142,932			142,932	115,668	27,264	5/7/2024	8/28/2024	5/1/2024	8/30/2024
75086	FPIT	IT2400024	IT2400024 - BEACON PLUME INVESTIGATION WORK	26,872		26,872			26,872	22,730	4,142	6/5/2024	4/30/2025	6/1/2024	3/31/2025
75086	FPIT	IT2400042	IT2400042 - BEACON MIDWEST COMPLIANCE WORK ORDE	3,430		3,430			3,430	90,096	(86,666)	8/9/2024	6/29/2025	10/1/2024	12/31/2024
75086	FPIT	LTHGIRFS	LTHGIRFS - LIGHTHOUSE: GAS IRIS	136,945		136,945			565,961	218,641	347,320	5/20/2020	3/1/2025	6/1/2020	4/16/2025
75086	FPIT	LTHGVISTO	LTHGVISTO - LIGHTHOUSE INITIATIVE - GAS VISTO	61,425		61,425			121,230	88,003	33,227	5/25/2023	9/30/2024	6/1/2023	9/30/2024
75086	FPIT	LTHNGBUDP	LTHNGBUDP - LIGHTHOUSE INITIATIVE: NGBU	93,365		93,365			93,365	91,438	1,927	12/5/2023	2/28/2025	1/1/2024	4/1/2025
75086	FPIT	PH2ASPAHW	PH2ASPAHW - ESCA-OT ASSET,PATCH & VULNERABILITY	3,256		3,256			3,527	3,196	331	9/1/2023	3/31/2026	10/1/2023	
75086	FPIT	PH2ASPASW	PH2ASPASW - ESCA-OT ASSET,PATCH & VULNERABILITY	50,368		50,368			75,711	323,116	(247,405)	9/1/2023	3/31/2026	9/1/2023	
75086	FPIT	TC210SW57	TC210SW57 - CIOPS NERC CIP CYBERARK IMPLEMENTAT	164		164			3,309	3,357	(48)	3/27/2023	3/31/2024	3/1/2023	3/1/2024
75086	FPIT	TC2400041	TC2400041 - BROADCOM VMWARE CLOUD FOUNDATION SU	581,093		581,093			581,093	73,156	507,937	12/19/2024	9/28/2025	12/1/2024	
75086	FUNCTOHKY	107GASCK	107GASCK - GAS CAPITAL OVERHEAD	(2,476,523)		(2,476,523)			198,290	-	198,290	7/1/2008	12/31/2050	7/1/2008	
75086	G701660	AW4645	AW4645 - EMERGENT AM01 COVINGTON LEVEE PH 1	39,575		39,575			5,449,701	3,601,200	1,848,501	10/1/2021	1/30/2023	10/1/2021	2/28/2023
75086	G701662	AW4673	AW4673 - EMERGENT - CASING 34 - TAYLOR MILL	15,828		15,828			3,012,507	3,207,100	(194,593)	10/13/2021	2/28/2023	11/1/2021	1/7/2023
75086	G712237	MX4669122	MX4669122 - HEBRON LOOP PH 2 PRESSURE IMPROVEME	73,335		73,335			181,982	765	181,217	3/1/2021	3/4/2027	3/1/2021	
75086	G73MILES	T1437	T1437 - STA 249: THREE MILE RD	95,433		95,433			25,538,717	15,406,228	10,132,489	1/5/2017	8/28/2020	1/1/2017	9/15/2020
75086	G74092	MX3645041	MX3645041 - CHARTER - BRISTOW RD. PRESSURE IMP	1,037,685		1,037,685			1,198,466	2,366	1,196,100	10/13/2022	7/24/2025	12/1/2022	10/28/2024
75086	G74238	MX3848219	MX3848219 - CHARTER - PATTY LN-RPL-2" & 4"PL-87	95,517		95,517			95,517	540,783	(445,267)	12/22/2023	10/2/2025	5/1/2024	
75086	G74381	AW5096	AW5096 - DRY RIDGE - EXPOSED MAIN	467		467			47,362	33,500	13,862	2/17/2022	8/31/2022	3/1/2022	6/17/2022
75086	G74964	MX5762350	MX5762350 - CHARTER - ST RT 536 - INDEPENDANCE	1,073,024		1,073,024			1,538,175	842,183	695,992	2/23/2022	1/31/2024	3/1/2022	2/1/2023
75086	G75449	AW5471	AW5471 - LN AM07 SCCDA DIGS	5,383		5,383			741,930	1,642,099	(900,168)	5/26/2022	12/31/2022	6/1/2022	11/27/2022
75086	G75498	MX0458440	MX0458440 - CHARTER-AMSTERDAM RD- VILLA HILLS-	11,912		11,912			69,400	18,171	51,230	9/15/2023	1/29/2024	9/1/2023	1/3/2024
75086	G75498	MX5370534	MX5370534 - CHARTER-LP03 INSTALL PRESSURE IMPRO	1,725		1,725			221,508	765	220,743	7/8/2022	3/30/2023	10/1/2022	3/6/2023
75086	G75498	MX6650945	MX6650945 - CHARTER-AMSTERDAM RD- VILLA HILLS-P	1,040,409		1,040,409			1,114,429	251,700	862,729	12/20/2022	2/27/2025	2/1/2023	1/7/2025
75086	G75629	AW5648	AW5648 - LN AM07 ECDA DIGS	7,307		7,307			2,029,436	1,466,970	562,465	7/1/2022	12/31/2022	7/1/2022	1/20/2023
75086	G75683	MX4850228	MX4850228 - TOEBBEN DR - FLORENCE - 12" PL & 8"	475		475			420,681	49,862	370,819	7/14/2022	12/29/2022	7/1/2022	12/26/2022
75086	G75723	MX2532997	MX2532997 - CHARTER-RICHARD KNOCK HWY-PIMP-8" P	124,845		124,845			124,845	143,363	(18,518)	1/31/2024	6/26/2025	2/1/2024	5/14/2025
75086	G75723	MX6588233	MX6588233 - CANCEL-RICHARD KNOCK HWY-WALTON-MA	(25,430)		(25,430)			-	-	-	3/21/2023	8/30/2025	5/1/2023	
75086	G75734	AW6846	AW6846 - KENTUCKY - CORROSION REMEDIATION	344,659		344,659			402,659	180,000	222,659	3/24/2023	9/30/2025	7/1/2023	
75086	G75920	AW5953	AW5953 - LN AM07 STATION ECDA DIGS	4,275		4,275			845,579	734,404	111,175	7/29/2022	12/31/2022	8/1/2022	1/20/2023
75086	G75924	AW5965	AW5965 - LN AM00B ECDA DIGS	4,080		4,080			894,160	1,098,620	(204,460)	8/3/2022	12/31/2022	8/1/2022	1/31/2023
75086	G75979	MX4329859	MX4329859 - CHARTER-KYTC 06-445.00 MINEOLA PK-E	25,532		25,532			1,177,131	697,744	479,388	9/12/2022	3/28/2024	10/1/2022	12/6/2023
75086	G75995	AW6478	AW6478 - LINE AM07 - CASING 50 - HYDROTEST	255,492		255,492			548,322	2,386,600	(1,838,278)	12/30/2022	10/1/2024	2/1/2023	9/10/2024
75086	G76300	AW6368	AW6368 - EMERGENT - AM07 EXPOSED MAIN (KY)	55		55			1,349,137	1,348,700	437	11/16/2022	12/30/2023	11/1/2022	1/9/2024
75086	G76444	MX6909455	MX6909455 - KYTC 06-444 DONALDSON-ERLANGER-STI	479,409		479,409			2,316,774	1,219,782	1,096,992	4/5/2023	9/1/2024	4/1/2023	5/29/2024
75086	G76446	MX1322454	MX1322454 - CHARTER-KYTC-162.40-BRISTOW RD-STI-	1,520,404		1,520,404			1,633,776	786,870	846,906	10/7/2022	10/29/2025	10/1/2022	3/7/2025
75086	G76451	MX8051147	MX8051147 - CHARTER-SPARTA PIKE-EXPOSED MAIN RE	943		943			180,750	9,490	171,260	5/2/2023	3/31/2025	9/1/2023	2/9/2024
75086	G76569	AW6597	AW6597 - EMERGENT - 6-9025 KY MAIN RELOCATE	3,802,316		3,802,316			4,361,775	3,971,500	390,275	2/2/2023	7/15/2024	2/1/2023	8/2/2024
75086	G77046	MX9473869	MX9473869 - CHARTER-EMERGENT - MADISON PIKE - E	10,104		10,104			222,890	267,037	(44,147)	7/27/2023	1/13/2024	7/1/2023	12/21/2023
75086	G77138	500000144	500000144 - THREE MILE - VRG CONTROL VALVE REPL	4,330		4,330			14,287	22,770	(8,483)	6/29/2023	1/31/2024	8/1/2023	4/27/2024
75086	G77762	500000547	500000547 - INTERNAL CORR COUPON INSTALL KY	21,906		21,906			21,906	13,891	8,015	6/17/2024	3/24/2025	10/1/2024	3/6/2025
75086	G77799	MX0356982	MX0356982 - CHARTER-KYTC- 162.10 BRISTOW RD FRO	166,843		166,843			166,843	278,045	(111,201)	1/18/2024	2/5/2026	2/1/2024	
75086	G78143	500000493	500000493 - OC-TC ENERGY FOSTER INTERCONNECTSCA	43,475		43,475			43,475	74,946	(31,471)	4/10/2024	7/30/2024	4/1/2024	9/7/2024
75086	G78373	AW8410	AW8410 - OC-REG 0149 - ERLANGER M&R 149 UPGR	2,138,549		2,138,549			2,138,549	11,169,500	(9,030,951)	6/25/2024	3/31/2026	7/1/2024	
75086	G78478	500000576	500000576 - OC - MIDWEST - ERX INSTALL KY	17,551		17,551			17,551	36,087	(18,536)	9/6/2024	1/31/2025	10/1/2024	3/12/2025
75086	G78502	AW78502	AW78502 - EMERGENCY CHARTER 24" AM07 CUT OUT	161,478		161,478			161,478	99,000	62,478	8/6/2024	12/5/2024	8/1/2024	11/8/2024
75086	G7AM00ACR	AW3397	AW3397 - LINE AM00A CORROSION REMEDIATION	1,558		1,558			195,075	180,372	14,703	1/20/2021	3/31/2022	12/1/2021	3/20/2022
75086	G7AM00BVL	V5471	V5471 - AM00B & UL06 VALVE AUTOMATION	157,561		157,561			629,862	1,830,100	(1,200,238)	11/22/2021	12/30/2023	4/1/2022	12/6/2023
75086	G7AM07CUT	AW1330	AW1330 - AM07 CUTOUT FIDELITY	4,813		4,813			1,612,523	1,236,780	375,743	10/23/2019	12/30/2019	10/1/2019	2/2/2020
75086	G7AM07DIG	V8815	V8815 - LINE AM07 INTEGRITY DIGS	3,525		3,525			1,310,515	923,350	387,165	4/2/2019	12/30/2019	6/1/2019	12/31/2019
75086	G7AM07IL2	AW4685	AW4685 - LINE AM07 PIPELINE REPLACEMENT PHAS	40,506,360		40,506,360			47,921,113	33,015,500	14,905,613	10/18/2021	2/28/2025	11/1/2021	2/6/2025
75086	G7AM07IL2	AW5957	AW5957 - CANCEL_LINE AM07 PHASE 2 - STATION	(2,432,309)		(2,432,309)			-	9,656,000	(9,656,000)	8/1/2022	2/28/2025	10/1/2022	
75086	G7AM07IL2	AW7013	AW7013 - ROW - PIPELINE REPLACEMENT - PH2	158,777		158,777			345,934	4,284,600	(3,938,666)	5/18/2023	4/18/2025	9/1/2023	2/6/2025

75086	G7AM07IL3	AW6387	AW6387 - LINE AM07 - PIPE REPLACEMENT - PH 3	3,179,242	3,179,242	4,035,307	40,828,200	(36,792,893)	11/23/2022	12/31/2025	1/1/2023	
75086	G7AM07IL3	AW6388	AW6388 - LINE AM07 PHASE 3 - LAND	2,026,491	2,026,491	2,119,792	4,060,000	(1,940,208)	11/28/2022	12/31/2025	9/1/2023	
75086	G7AM07IL3	AW7772	AW7772 - LINE AM07 PHASE 3 - STATION	895,028	895,028	895,028	4,905,200	(4,010,172)	12/18/2023	12/31/2025	1/1/2024	
75086	G7AM07IL4	AW7866	AW7866 - LINE AM07 PHASE 4 - PIPE	1,228,269	1,228,269	1,228,269	60,559,700	(59,331,431)	1/29/2024	3/30/2027	2/1/2024	
75086	G7AM07IL4	AW7883	AW7883 - LINE AM07 PHASE 4 - LAND	991	991	991	7,551,100	(7,550,109)	1/31/2024	3/30/2027	11/1/2024	
75086	G7AM07ILI	0233100	0233100 - LINE AM07 PIPELINE REPLACEMENT PHAS	(963,380)	(963,380)	25,239,831	37,717,000	(12,477,169)	12/9/2020	12/31/2023	12/1/2020	3/18/2024
75086	G7AM07ILI	AW3074	AW3074 - LINE AM07 PIPELINE REPLACE LAND	(71,753)	(71,753)	5,578,303	6,089,500	(511,197)	12/3/2020	12/31/2023	2/1/2021	3/18/2024
75086	G7AM07ILI	AW3138	AW3138 - LINE AM07 PIPELINE REPLACEMENT-STN	9,090,245	9,090,245	18,757,284	6,278,300	12,478,984	12/18/2020	4/30/2024	5/1/2021	9/28/2024
75086	G7ASRP	CMSP70	CMSP70 - ASRP CURB TO METER 3" OR LESS	268,884	268,884	9,217,729	20,388,002	(11,170,273)	3/4/2015	12/31/2019	7/1/2015	
75086	G7ASRP	MCSP70	MCSP70 - ASRP MAIN TO CURB 3" OR LESS	2,606,336	2,606,336	46,571,065	19,954,384	26,616,681	3/4/2015	12/31/2019	7/1/2015	
75086	G7CAS106	V7737	V7737 - CASING#106 AM07 & MARTHA LAYNE	4,765	4,765	1,994,499	1,749,344	245,155	11/28/2018	12/30/2019	12/1/2018	1/23/2020
75086	G7CAS42	V7739	V7739 - CASING#42 ABANDON- AM07 & HULBERT	9,387	9,387	1,707,520	1,939,294	(231,774)	11/28/2018	11/30/2019	12/1/2018	11/15/2019
75086	G7CAS49	V7902	V7902 - CASING #49 ABANDON - AM07 & I-75	18,029	18,029	7,354,093	6,131,715	1,222,378	12/14/2018	2/28/2020	1/1/2019	2/23/2020
75086	G7CORREM	AW5064	AW5064 - KENTUCKY - CORROSION REMEDIATION	37,718	37,718	251,255	272,000	(20,745)	2/10/2022	9/30/2025	8/1/2022	
75086	G7EDGE	39171904	39171904 - CANCEL-ROW- EDGEWOOD PRESSURE IMP	(36,524)	(36,524)	-	40,000	(40,000)	6/7/2022	1/31/2023	8/1/2022	
75086	G7EDGE	MX9171904	MX9171904 - EDGEWOOD PRESSURE IMP	83,776	83,776	651,960	108,826	543,134	9/22/2022	7/29/2023	9/1/2022	7/24/2023
75086	G7EMAM07	AW5092	AW5092 - EMERGENT - LINE AM07 - EXPOSED MAIN	78,725	78,725	2,726,793	1,319,200	1,407,593	2/15/2022	6/30/2023	4/1/2022	9/30/2023
75086	G7ENCC	AW3484	AW3484 - ERLANGER CASINGS 2021	1,534	1,534	215,355	181,502	33,853	1/27/2021	3/31/2022	12/1/2021	4/13/2022
75086	G7ERGEMER	AW4046	AW4046 - EMERGENCY ERLANGER GAS CUT OUT	490	490	292,278	95,000	197,278	7/6/2021	10/30/2021	7/1/2021	11/6/2021
75086	G7ERLCP	AW1656	AW1656 - ERLANGER MAG ANODES	34,484	34,484	1,628,781	2,442,882	(814,101)	1/21/2020	12/31/2026	4/1/2020	
75086	G7ERLCP19	V9157	V9157 - 2019 ERLANGER OPS MAG ANODES	3,176	3,176	393,520	350,812	42,709	5/8/2019	7/30/2020	5/1/2019	9/8/2020
75086	G7ESPEP	MX9171927	MX9171927 - ELSMERE PRESSURE IMP	9,672	9,672	2,489,909	327,968	2,161,941	4/25/2022	7/29/2023	5/1/2022	7/5/2023
75086	G7EUL47	V6391	V6391 - LINE UL47 SCHEDULED DIGS	916	916	990,338	724,400	265,938	10/10/2018	3/30/2019	10/1/2018	3/14/2019
75086	G7HARRPK	AW4778	AW4778 - ROW - HARRIS PIKE UL45 EXT	29,073	29,073	167,431	926,800	(759,369)	11/16/2021	11/30/2026	7/1/2022	
75086	G7HARRPK	AW4796	AW4796 - HARRIS PIKE UL45 EXT - PRESSURE IMP	71,964	71,964	744,111	7,884,400	(7,140,289)	11/19/2021	11/30/2026	2/1/2022	
75086	G7HICKSP	MX5739585	MX5739585 - HICKS PIKE PRESSURE IMPROVEMENT PRO	3,597	3,597	754,585	254,017	500,568	4/20/2021	2/24/2022	5/1/2021	2/2/2022
75086	G7HOPECH	MX1415972	MX1415972 - HOPEFUL CHURCH RD. PRI, FLORENCE 13	3,403,375	3,403,375	3,425,096	2,073,615	1,351,481	12/21/2022	6/26/2025	2/1/2023	6/17/2025
75086	G7IMPRPL	MX1996777	MX1996777 - AM07 EXPOSURE-HORSEBRANCH RD. SEGME	1,693	1,693	799,208	436,475	362,733	9/11/2017	7/31/2019	10/1/2017	9/10/2019
75086	G7IMPRPL	T1525	T1525 - AM02 EXPOSED MAIN IN SOUTHGATE, KY	4,708	4,708	4,708	351,130	(346,422)	1/12/2017	9/30/2018	1/1/2017	11/24/2018
75086	G7INTDIG	AW2017	AW2017 - LINE UL06 INTEGRITY DIGS	5,118	5,118	1,331,122	2,024,700	(693,578)	4/9/2020	1/30/2021	4/1/2020	1/5/2021
75086	G7INTDIG	AW2018	AW2018 - LINE UL47 INTEGRITY DIGS	2,501	2,501	814,003	748,000	66,003	4/9/2020	1/30/2021	4/1/2020	10/9/2020
75086	G7ISREF	KYWSREF24	KYWSREF24 - KY WORKSTATION REFRESH 2024	1,100,724	1,100,724	1,100,724	200,000	900,724	2/12/2024	2/28/2026	6/1/2024	
75086	G7LGMR	C9571	C9571 - CANCEL 2 STA 781-NUNN & UNV/CWA	13,268	13,268	12,980	-	12,980	4/10/2007	12/31/2050	4/1/2007	5/5/2008
75086	G7LGMR	MX0671045	MX0671045 - REG 101 - COVERT RUN & TAYLOR	899	899	168,875	81,443	87,432	12/6/2018	8/30/2019	3/1/2019	10/27/2019
75086	G7LGMR	MX2218039	MX2218039 - INSTALL SCADA EQ-THREE MILE RD STA	1,427	1,427	602,589	411,228	191,361	9/21/2017	7/10/2020	10/1/2017	9/15/2020
75086	G7LGMR	MX2335804	MX2335804 - STA 872 - OAKLAND VALVE HOUSE	51,679	51,679	13,843,277	4,268,943	9,574,334	10/6/2017	8/15/2019	11/1/2017	9/19/2019
75086	G7LNUL57	AW0832	AW0832 - LINE UL57 MONOLITHIC INSULATORS	4,301	4,301	1,033,032	564,646	468,386	7/26/2019	12/25/2020	3/1/2020	12/3/2020
75086	G7LUL02	AW2880	AW2880 - LINE UL02 - MAOP REPLACEMENT	20,536	20,536	3,262,607	1,717,200	1,545,407	10/7/2020	3/31/2022	10/1/2020	1/5/2022
75086	G7MAINS	AW6146	AW6146 - CANCEL_ROW LAKELAND PARK DR; LIM	(4,252)	(4,252)	-	25,000	(25,000)	9/20/2022	12/31/2023	10/1/2022	
75086	G7MAINS	AW6147	AW6147 - CANCEL-ROW MEA -STANBERY RIDGE	(418)	(418)	-	25,000	(25,000)	9/20/2022	9/9/2023	10/1/2022	
75086	G7MAINS	AW6415	AW6415 - CANCEL-TBC ROW MEA-DECLARATION DR	(2,240)	(2,240)	4,146	25,000	(20,854)	12/5/2022	7/14/2023	1/1/2023	
75086	G7MAINS	AW6482	AW6482 - CANCEL_LIS RD; CONSTANCE; 6" PL	(4,176)	(4,176)	-	25,000	(25,000)	1/6/2023	8/25/2023	2/1/2023	
75086	G7MAINS	AW6483	AW6483 - CANCEL_CRESTVW HL; VILLA MADONNA DR	(4,240)	(4,240)	(13)	25,000	(25,013)	1/6/2023	4/28/2023	2/1/2023	
75086	G7MAINS	AW6484	AW6484 - CANCEL_OLD LEXINGTON PIKE_RICHWOOD	(675)	(675)	-	25,000	(25,000)	1/6/2023	10/13/2023	2/1/2023	
75086	G7MAINS	AW6694	AW6694 - CANCEL_ROW MEA - MANHATTAN BLVD-	(2,778)	(2,778)	(8)	25,000	(25,008)	2/20/2023	6/9/2023	3/1/2023	
75086	G7MAINS	AW8571	AW8571 - 526 JOHNS HILL RD - RENEW	3,151	3,151	3,151	25,000	(21,849)	8/30/2024	6/9/2025	12/1/2024	
75086	G7MAINS	AW8633	AW8633 - 211 KY HIGHWAY W 36 - MAE	3,749	3,749	3,749	25,000	(21,251)	9/26/2024	5/5/2025	12/1/2024	
75086	G7MAINS	AW8689	AW8689 - PETERSBURG RD - MAE - 8" PL - 3,300	3,178	3,178	3,178	25,000	(21,822)	10/4/2024	5/5/2025	12/1/2024	
75086	G7MAINS	AW8766	AW8766 - DISTRIBUTION DR - MAE - 4" PL - 730	1,221	1,221	1,221	25,000	(23,779)	11/5/2024	9/20/2025	12/1/2024	
75086	G7MAINS	C9770	C9770 - CANCEL 2 STA 781-INLET/CWA	9,935	9,935	9,827	-	9,827	5/6/2007	12/31/2050	5/1/2007	5/5/2008
75086	G7MAINS	D1230	D1230 - CANCEL 2 844337/CHRIS AMPHER	7,034	7,034	5,409	-	5,409	7/23/2007	12/31/2050	9/1/2007	8/12/2008
75086	G7MAINS	G8058	G8058 - CANCEL 2 JT EMAX 3298935 ARCADIA	17,910	17,910	18,249	49,594	(31,345)	7/13/2012	11/30/2014	7/1/2013	2/26/2014
75086	G7MAINS	MEAPJT70	MEAPJT70 - JOINT TRENCH PLASITC MAIN EXTENSION	1,443,646	1,443,646	8,678,584	10,000,000	(1,321,416)	1/13/2016	12/31/2050	2/1/2016	
75086	G7MAINS	MX0245370	MX0245370 - REDWOOD LIVING APARTMENTS - APPROAC	1,520	1,520	133,048	53,406	79,643	9/7/2021	5/29/2022	9/1/2021	4/20/2022
75086	G7MAINS	MX0458305	MX0458305 - CULL RD - MAE- 6" PL-650'	332,219	332,219	332,219	59,164	273,055	2/29/2024	11/7/2024	3/1/2024	10/30/2024
75086	G7MAINS	MX0556249	MX0556249 - FARM TAP PROJ; CALIFORNIA CROSSROAD	2,326	2,326	273,224	123,394	149,830	1/14/2019	10/24/2019	5/1/2019	1/3/2020
75086	G7MAINS	MX0602140	MX0602140 - FARM TAP PROJ; ENZWEILER RD	797	797	200,882	83,366	117,516	9/1/2020	10/17/2021	9/1/2020	10/6/2021
75086	G7MAINS	MX0742327	MX0742327 - MEA - BEECHWOOD RD; FT MITCHEL; 4"	85,909	85,909	97,675	58,680	38,995	11/29/2023	4/18/2024	12/1/2023	4/17/2024
75086	G7MAINS	MX0840009	MX0840009 - JT-G- BALLYSHANNON SECTION 5 PHASE	46,522	46,522	46,603	50,461	(3,858)	11/7/2023	8/19/2024	12/1/2023	7/31/2024
75086	G7MAINS	MX0864994	MX0864994 - MADONNA MANOR PH 2 MEA, VILLA HILLS	1,233	1,233	114,527	72,524	42,003	9/24/2021	12/21/2021	10/1/2021	5/13/2022
75086	G7MAINS	MX0964990	MX0964990 - 425' PLASTIC GAS MAIN EXTENSION. SA	493	493	70,340	26,397	43,943	7/19/2021	12/24/2024	8/1/2021	2/2/2022
75086	G7MAINS	MX1356700	MX1356700 - FARM TAP PROJ; WINTERS LN HIGHLAND	1,041	1,041	255,288	147,466	107,822	6/27/2019	12/26/2019	7/1/2019	3/11/2020
75086	G7MAINS	MX1921442	MX1921442 - FARM TAP PROJECT REDSTONE RD - ALEX	889	889	195,801	74,424	121,377	3/24/2021	10/7/2024	4/1/2021	11/30/2021
75086	G7MAINS	MX1957438	MX1957438 - FARM TAP PROJ; GRANDVIEW RD	2,710	2,710	497,581	161,979	335,602	9/29/2020	12/16/2021	9/1/2020	1/10/2022
75086	G7MAINS	MX1957677	MX1957677 - FARM TAP PROJECT; UPPER LICK BRANCH	1,519	1,519	156,448	88,638	67,810	10/12/2021	6/16/2022	10/1/2021	5/8/2022
75086	G7MAINS	MX1958084	MX1958084 - FARM TAP PROJ; FLAGG SPRINGS PIKE	3,336	3,336	578,321	541,626	36,695	2/5/2020	5/22/2020	2/1/2020	10/30/2020
75086	G7MAINS	MX2043872	MX2043872 - FARM TAP PROJ; BARRS BRANCH RD	1,059	1,059	159,504	83,718	75,786	8/20/2021	6/23/2022	8/1/2021	5/29/2022
75086	G7MAINS	MX2061333	MX2061333 - STONEWATER PHASE B1 APPROACH MAIN	1,239	1,239	160,395	128,083	32,312	2/10/2022	8/4/2022	2/1/2022	7/21/2022
75086	G7MAINS	MX2061362	MX2061362 - JT-G-THE RESERVE AT BELLEVUE	531	531	81,168	46,815	34,353	12/16/2021	3/1/2023	1/1/2022	12/14/2022
75086	G7MAINS	MX2143681	MX2143681 - MAINE AVE - MAE - 2IN PL - 238'	39,700	39,700	39,700	22,071	17,629	3/7/2024	8/8/2024	3/1/2024	7/21/2024
75086	G7MAINS	MX2271880	MX2271880 - MEA ~800 FT; 494 JONES RD	1,020	1,020	243,949	163,070	80,879	7/30/2019	2/27/2020	8/1/2019	5/13/2020
75086	G7MAINS	MX2291390	MX2291390 - MEA-PINNACLE OF FORTH MITCHELL APPR	15,172	15,172	15,172	10,941	4,231	2/1/2024	7/7/2024	2/1/2024	5/30/2024
75086	G7MAINS	MX2291478	MX2291478 - THE RESERVES OF EDGEWOOD - APP MAE	20,059	20,059	20,059	15,291	4,768	5/20/2024	10/17/2024	5/1/2024	9/23/2024
75086	G7MAINS	MX2331188	MX2331188 - MEA, MASON ROAD FARM TAP-TAYLOW MIL	5,436	5,436	613,958	240,393	373,564	9/15/2021	8/25/2022	10/1/2021	8/2/2022
75086	G7MAINS	MX2698978	MX2698978 - E MT ZION RD; INDEPENDENCE; 6" PL;	3,154	3,154	530,856	161,397	369,458	7/21/2022	2/26/2023	7/1/2022	2/21/2023
75086	G7MAINS	MX2700925	MX2700925 - BRECKENRIDGE; ALEXANDRIA; 4" PL; MA	858	858	117,707	76,343	41,365	5/18/2022	11/17/2022	5/1/2022	11/8/2022
75086	G7MAINS	MX3119117	MX3119117 - CARPENTER RD-MAE-2"PL-200'	71,769	71,769	71,769	33,685	38,084	5/10/2024	2/20/2025	5/1/2024	2/18/2025
75086	G7MAINS	MX3164809	MX3164809 - RICHARD KNOCK HWY-MAE-8" PL-578'-0	173,120	173,120	173,120	68,945	104,175	7/31/2024	5/29/2025	10/1/2024	5/14/2025
75086	G7MAINS	MX3277149	MX3277149 - BILL WENTZ-MAE-2"PL-75'	18,855	18,855	18,855	14,087	4,768	5/13/2024	9/26/2024	5/1/2024	9/12/2024
75086	G7MAINS	MX3351619	MX3351619 - HIGHLAND AVE AND WOODLAND PL MAE -	(5)	(5)	33,262	19,811	13,451	12/10/2021	5/19/2022	12/1/2021	3/27/2022
75086	G7MAINS	MX3471260	MX3471260 - DOLWICK DR - MAE - 4" PL - 275' - 1	38,815	38,815	38,815	23,780	15,034	7/30/2024	1/13/2025	8/1/2024	12/23/2024
75086	G7MAINS	MX3880107	MX3880107 - SERVICE RD; WALTON; 6" PL; MEA	706	706	82,320	54,841	27,479	4/20/2022	9/15/2022	5/1/2022	9/5/2022
75086	G7MAINS	MX3955327	MX3955327 - LOCK RD-BUTLER-1200 FT 4 INCH PL MA	967	967	173,440	66,243	107,197	7/15/2022	12/29/2022	7/1/2022	12/20/2022
75086	G7MAINS	MX4018013	MX4018013 - JOHNS HILL RD MEA	964	964	210,928	73,344	137,584	11/13/2019	1/3/2020	11/1/2019	6/18/2020
75086	G7MAINS	MX4034314	MX4034314 - MEA-KY 16 & KY 17-4 IN PL-1220 FT-6	44,473	44,473	44,473	120,009	(75,536)	11/6/2024	6/26/2025	11/1/2024	6/25/2025
75086	G7MAINS	MX4105546	MX4105546 - MAN O WAR BLVD - MAE - 4" PL - 1100	140,415	140,415	140,415	46,333	94,081	9/10/2024	3/13/2025	9/1/2024	2/19/2025
75086	G7MAINS	MX4151648	MX4151648 - JT-G-WILLOW GREEN	34	34	34	60,213	(60,178)	10/15/2024	9/18/2025	10/1/2024	
75086	G7MAINS	MX4296108	MX4296108 - RICE PK; UNION; 4" PL; MEA	545	545	107,782	79,193	28,589	6/7/2022	11/17/2022	6/1/2022	11/16/2022
75086	G7MAINS	MX4318038	MX4318038 - CITYVIEW APP MAIN - MAE - 6"PL - 80	60,402	60,402	60,402	35,365	25,037	9/11/2024	2/13/2025	9/1/2024	2/10/2025

75086	G7MAINS	MX4355391	MX4355391 - ~1,600 FT MEA; 300 RICHARD KNOCK HW	1,660	1,660	252,926	225,972	26,954	5/27/2020	8/25/2020	6/1/2020	11/30/2020
75086	G7MAINS	MX4735611	MX4735611 - W 3RD ST & W 4TH ST-NEWPORT-2194 FT	489,695	489,695	651,207	268,126	383,081	10/25/2023	5/9/2024	10/1/2023	5/21/2024
75086	G7MAINS	MX4875568	MX4875568 - FARM TAP PROJECT; E ALEXANDRIA / CA	7,546	7,546	1,059,966	1,255,100	(195,134)	3/3/2020	9/11/2020	3/1/2020	12/26/2020
75086	G7MAINS	MX5095081	MX5095081 - EAST FROGTOWN RD; RICHWOOD; 6" PL;	371	371	169,122	71,068	98,054	8/18/2022	3/30/2023	8/1/2022	2/20/2023
75086	G7MAINS	MX5112893	MX5112893 - 211 KY HIGHWAY W 36 - MAE - 4" PL -	3,511	3,511	3,511	-	3,511	10/16/2024	1/1/2026	11/1/2024	
75086	G7MAINS	MX5190163	MX5190163 - FROGTOWN CONNECTOR; RICHWOOD ; 4" P	548	548	55,525	2,851	52,674	8/3/2022	1/12/2023	8/1/2022	1/1/2023
75086	G7MAINS	MX5543296	MX5543296 - OLD LEXINGTON PIKE; RICHWOOD ; 8" P	675	675	2,087,158	465,508	1,621,650	12/15/2022	1/4/2024	2/1/2023	1/1/2024
75086	G7MAINS	MX5653109	MX5653109 - FARM TAP PROJ; CROSBY PKWY/MAGELLAN	4,570	4,570	951,574	194,197	757,377	9/29/2020	7/13/2023	10/1/2020	11/15/2023
75086	G7MAINS	MX5709799	MX5709799 - LAKELAND PARK DR; LIMABURG ; 6" PL;	4,501	4,501	206,780	28,079	178,701	12/20/2022	5/18/2023	1/1/2023	5/18/2023
75086	G7MAINS	MX5751969	MX5751969 - MEA - STANBERY RIDGE-FORT THOMAS-47	1,177	1,177	114,151	24,699	89,452	10/4/2022	3/23/2023	10/1/2022	3/21/2023
75086	G7MAINS	MX6085790	MX6085790 - INSTALL GAS ONLY APPROACH MAIN - NE	20,570	20,570	20,570	73,074	(52,504)	12/3/2024	3/6/2025	12/1/2024	1/2/2025
75086	G7MAINS	MX6108586	MX6108586 - JT-G-ENCLAVE SUBDIVISION	93,675	93,675	151,822	87,609	64,214	1/19/2023	11/16/2023	2/1/2023	3/12/2024
75086	G7MAINS	MX6108813	MX6108813 - PARKVIEW ESTATES APP - UNION - 8" &	864	864	266,748	134,092	132,656	10/26/2022	3/23/2023	11/1/2022	4/10/2023
75086	G7MAINS	MX6212508	MX6212508 - ELLIS RD; CONSTANCE; 6" PL; MEA	4,176	4,176	96,080	73,565	22,514	6/14/2023	11/9/2023	6/1/2023	10/30/2023
75086	G7MAINS	MX6678695	MX6678695 - MEA-DECLARATION DR-INDEPENDENCE-4 I	12,947	12,947	107,634	32,909	74,725	8/1/2023	12/28/2023	8/1/2023	12/25/2023
75086	G7MAINS	MX6684040	MX6684040 - ~1825 FTMEA; WRIGHT BLVD	1,328	1,328	144,758	117,730	27,027	10/2/2020	12/18/2020	10/1/2020	3/8/2021
75086	G7MAINS	MX6735987	MX6735987 - CRESTVW HL; VILLA MADONNA DR; 4" IP	4,240	4,240	100,375	60,883	39,492	3/17/2023	8/17/2023	3/1/2023	9/19/2023
75086	G7MAINS	MX7231229	MX7231229 - STONEWATER APPROACH MAIN	5,575	5,575	583,659	201,666	381,993	12/15/2020	12/18/2021	12/1/2020	8/14/2021
75086	G7MAINS	MX7843275	MX7843275 - MEA - MANHATTAN BLVD-DAYTON-250 FT	2,778	2,778	25,073	17,848	7,225	6/5/2023	10/26/2023	6/1/2023	11/22/2023
75086	G7MAINS	MX8327384	MX8327384 - MAE- MEMORIAL POINT APPROACH - SOUT	3,928	3,928	222,652	103,571	119,080	3/21/2023	8/17/2023	3/1/2023	8/2/2023
75086	G7MAINS	MX8505395	MX8505395 - ~350 FT MEA; 351 KENTON LANDS	818	818	67,183	32,684	34,499	12/1/2020	2/28/2021	12/1/2020	6/28/2021
75086	G7MAINS	MX8745338	MX8745338 - JT-G-THE PINNACLE OF FORT MITCHELL	86,560	86,560	86,560	48,277	38,283	9/22/2023	8/21/2024	2/1/2024	8/19/2024
75086	G7MAINS	MX9801147	MX9801147 - ELIJAH CREEK LOOP; NEYER DEVELOPMEN	1,331	1,331	159,650	88,033	71,617	11/30/2021	7/7/2022	12/1/2021	6/27/2022
75086	G7MAINS	MXA201375	MXA201375 - JT-G-THE MEADOWS AT GRAND GARDEN PH	141,229	141,229	141,229	47,841	93,389	1/11/2024	8/15/2024	1/1/2024	8/28/2024
75086	G7MASOINT	AW3449	AW3449 - DUKE MASON INTERCONNECT (KY)	147,718	147,718	1,039,080	2,000,000	(960,920)	1/26/2021	12/30/2021	1/1/2021	3/5/2022
75086	G7MREG118	MX2217622	MX2217622 - STATION 873 - STH & PHILADELPHIA	39,604	39,604	456,763	87,907	368,856	9/22/2017	11/30/2025	10/1/2017	
75086	G7PRESIM	MX1640159	MX1640159 - ELIJAH CREEK PRESSURE IMPROVEMENT P	5,183	5,183	866,787	760,042	106,746	6/4/2019	2/26/2020	6/1/2019	1/15/2020
75086	G7PUBIMP	2781786	2781786 - KYTC 19-9001 I-275 GRAVES RD	(540)	(540)	(540)	70,083	(70,622)	9/13/2024	11/22/2023	9/1/2024	12/14/2024
75086	G7PUBIMP	B1252	B1252 - CANCEL- BULLITSVILLE RD CONN/CWA	(26)	(26)	(6,971)	-	(6,971)	6/28/2002	12/31/2050	7/1/2002	
75086	G7PUBIMP	MX0129552	MX0129552 - CHAPMAN LN. - ROAD RECONSTRUCTION -	1,238	1,238	138,598	73,593	65,006	3/30/2021	2/17/2025	4/1/2021	6/29/2022
75086	G7PUBIMP	MX0503657	MX0503657 - JOYCE AVE STI-NEWPORT KY - 300' OF	736	736	142,397	50,389	92,008	6/22/2021	11/19/2024	6/1/2021	1/27/2022
75086	G7PUBIMP	MX0722354	MX0722354 - CANCEL -BARRS BRANCH BRIDGE PROJECT	(140)	(140)	-	-	-	9/7/2023	3/28/2024	10/1/2023	
75086	G7PUBIMP	MX0783884	MX0783884 - PLEASANT VALLEY ROAD/CAMP ERNST ROA	7,510	7,510	1,986,329	1,689,689	296,640	4/26/2018	8/25/2018	5/1/2018	1/22/2019
75086	G7PUBIMP	MX1844009	MX1844009 - KYTC 06-445.00 MINEOLA PK (CHANNEL	255,181	255,181	255,181	34,558	220,623	2/22/2024	8/1/2024	3/1/2024	7/29/2024
75086	G7PUBIMP	MX2334412	MX2334412 - KYTC STI-SHORLAND RR XING-WALTON	6,944	6,944	6,944	-	6,944	1/17/2024	11/6/2025	3/1/2024	
75086	G7PUBIMP	MX2338415	MX2338415 - EAST 1ST-STI-2"PL-163'	35,295	35,295	35,295	21,816	13,478	3/25/2024	8/29/2024	4/1/2024	8/19/2024
75086	G7PUBIMP	MX2442598	MX2442598 - BROMLEY-CR. SPRINGS RD (KY 2373)	2,468	2,468	252,045	90,736	161,309	8/2/2021	2/6/2022	8/1/2021	1/31/2022
75086	G7PUBIMP	MX2698762	MX2698762 - DOH PENDELTON/CAMPBELL INSTALL STRE	2,097	2,097	313,269	99,384	213,885	9/20/2019	4/3/2020	12/1/2019	7/9/2020
75086	G7PUBIMP	MX2719627	MX2719627 - RPL - DIXIE HWY - FORT MITCHELL- 4"	12,173	12,173	12,173	85,946	(73,773)	2/16/2024	9/12/2024	2/1/2024	10/7/2024
75086	G7PUBIMP	MX2781786	MX2781786 - CANCEL_KYTC 19-9001 I-275 GRAVES RD	(1,077)	(1,077)	(1,077)	70,083	(71,160)	12/9/2020	11/22/2023	6/1/2021	
75086	G7PUBIMP	MX3198076	MX3198076 - DAVIS LN-STI-4"PL-150'	1,147	1,147	1,147	14,807	(13,660)	3/27/2024	7/18/2024	4/1/2024	7/15/2024
75086	G7PUBIMP	MX3359474	MX3359474 - KYTC - RICHWOOD RD STI - BEAVERLICK	3,210	3,210	482,507	24,088	458,419	12/13/2021	12/31/2024	12/1/2021	6/22/2022
75086	G7PUBIMP	MX3584545	MX3584545 - NARROWS RD-STI-8"PL-2,145'	525,913	525,913	525,913	131,449	394,465	6/13/2024	4/13/2025	6/1/2024	3/20/2025
75086	G7PUBIMP	MX4039676	MX4039676 - ROSSFORD BRIDGE REPLACEMENT - STI -	19,162	19,162	19,162	22,892	(3,731)	10/24/2024	2/27/2025	10/1/2024	2/11/2025
75086	G7PUBIMP	MX4199889	MX4199889 - US-25 WALTON - 4" PL - STI	1,048	1,048	150,081	38,705	111,376	7/25/2022	3/30/2023	8/1/2022	2/16/2023
75086	G7PUBIMP	MX4966474	MX4966474 - 7639 TURFWAY - FLORENCE - 8" PL - S	966	966	83,977	3,294	80,683	6/27/2022	3/30/2023	7/1/2022	3/1/2023
75086	G7PUBIMP	MX5108455	MX5108455 - KENTABOO DR - FLORENCE - 4" PL - ST	421	421	63,400	4,544	58,856	6/21/2022	11/10/2022	6/1/2022	10/28/2022
75086	G7PUBIMP	MX5793857	MX5793857 - KYTC - DONALDSON & COX AVE - GO ARO	12,414	12,414	12,414	19,661	(7,247)	11/6/2024	3/6/2025	11/1/2024	2/19/2025
75086	G7PUBIMP	MX6628393	MX6628393 - PLEASANT VALLEY 2020 RELOCATION	1,522	1,522	391,214	399,033	(7,819)	5/18/2020	10/29/2020	6/1/2020	11/17/2020
75086	G7PUBIMP	MX6798234	MX6798234 - KYTC 06-8916 HOUSTON RD-ERLANGER-ST	54,716	54,716	457,777	142,183	315,594	10/21/2022	1/11/2024	11/1/2022	3/19/2024
75086	G7PUBIMP	MX7599942	MX7599942 - INSTALL STREET IMPROVEMENT PROJECT	743	743	165,800	99,125	66,675	8/2/2019	2/27/2020	8/1/2019	2/29/2020
75086	G7PUBIMP	MX7832792	MX7832792 - BROOKWOOD DR. SOUTH - EDGEWOOD - 4"	890	890	133,124	75,946	57,178	9/9/2020	5/21/2021	3/1/2021	9/7/2021
75086	G7PUBIMP	MX8637896	MX8637896 - CC STI -BLOSSOM LN- SOUTHGATE -8" P	(36,746)	(36,746)	303,089	128,671	174,417	3/30/2023	9/4/2023	4/1/2023	9/4/2023
75086	G7PUBIMP	MX9121402	MX9121402 - KYTC 06-423 FROGTOWN-UNION-STI	252,695	252,695	289,021	24,603	264,418	7/13/2023	2/29/2024	7/1/2023	2/19/2024
75086	G7PUBIMP	MX9244894	MX9244894 - KYTC - MT ZION RD KY536 STI	13,631	13,631	1,104,003	1,026,778	77,225	11/8/2019	6/30/2023	1/1/2020	7/27/2021
75086	G7PUBIMP	MX9568282	MX9568282 - STI-TAYLOR MILL RD SIDEWALK-TAYLOR	21,374	21,374	58,871	38,707	20,164	10/19/2023	4/30/2024	10/1/2023	3/11/2024
75086	G7PUBIMP	MX9853572	MX9853572 - GRAVES AND NORTHBEND ROUNDABOUT PRO	1,504	1,504	2,613	109,422	(106,809)	2/16/2021	12/28/2023	2/1/2021	2/14/2022
75086	G7PUBIMP	MX9948553	MX9948553 - WILBERS LN - FORT THOMAS - 2" PE -	924	924	94,523	75,861	18,662	7/13/2021	12/16/2024	7/1/2021	2/21/2023
75086	G7PUBIMP	S8867	S8867 - STI 10873483 MT ZION RD	11,431	11,431	2,416,415	447,690	1,968,724	7/26/2016	1/30/2020	1/1/2017	12/21/2019
75086	G7PUINEW	INSREGREL	INSREGREL - INSTALL OR REMOVE REGULATOR/RELIEF	19,289	19,289	1,508,654	800,000	708,654	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINEW	SETMETER	SETMETER - SET OR REMOVE METER	1,579,519	1,579,519	15,577,858	2,250,000	13,327,858	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGLG	AGECHGLG - KENTUCKY AGE CHANGE LARGE METER	530,054	530,054	1,552,057	350,000	1,202,057	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	AGECHGSM	AGECHGSM - KENTUCKY AGE CHANGE SMALL METER	754,856	754,856	9,490,772	14,500,000	(5,009,228)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRLG	CHGMTRLG - CHANGE LARGE METER KENTUCKY	19,899	19,899	184,912	725,000	(540,088)	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGMTRSM	CHGMTRSM - CHANGE SMALL METER KENTUCKY	78,990	78,990	3,384,395	1,250,000	2,134,395	3/3/2015	12/31/2050	4/1/2015	
75086	G7PUINMR	CHGREGREL	CHGREGREL - CHANGE REGULATOR/RELIEF KENTUCKY	39,857	39,857	222,435	800,000	(577,565)	3/3/2015	12/31/2050	4/1/2015	
75086	G7REG0048	MX7282035	MX7282035 - REG 0048 FIFTH AND PHILADELPHIA - R	162	162	12,965	48,954	(35,988)	7/14/2020	3/31/2021	8/1/2020	10/28/2020
75086	G7REG0089	AW3224	AW3224 - REG 0427 EMPIRE DR	47,684	47,684	937,111	732,000	205,111	12/30/2020	10/30/2025	7/1/2021	
75086	G7REG0089	AW3246	AW3246 - REG 0427 EMPIRE DR LAND	6,375	6,375	103,632	82,500	21,132	1/2/2021	3/31/2026	4/1/2021	
75086	G7REG026	AW3184	AW3184 - REG 0437 UPHILL & HIGHWAY	9,453	9,453	1,759,156	507,300	1,251,856	12/28/2020	3/31/2023	12/1/2021	2/8/2023
75086	G7REG045	AW3228	AW3228 - REG 0432 TENTH & BRIGHTON	490	490	2,251,682	660,800	1,590,882	12/30/2020	3/31/2021	11/1/2021	7/11/2023
75086	G7REG045	AW3356	AW3356 - CANCEL- REG0432 TENTH-BRIGHTON LAND	712	712	-	82,500	(82,500)	1/13/2021	3/31/2023	9/1/2021	
75086	G7REG053	MX9751457	MX9751457 - REG 0053 - OVERTON AND NINTH - REG	(2,186)	(2,186)	63,003	43,954	19,050	2/8/2021	3/31/2022	6/1/2021	10/28/2021
75086	G7REG057	AW3180	AW3180 - REG 0431 SARATOGA & ELEVENTH	6,613	6,613	2,652,011	796,400	1,855,611	12/28/2020	3/31/2023	11/1/2021	11/8/2023
75086	G7REG057	AW3354	AW3354 - CANCEL-REG431 SARATOGA-ELEVENTH ROW	3,198	3,198	-	82,500	(82,500)	1/13/2021	3/31/2023	6/1/2021	
75086	G7REG059	AW3177	AW3177 - REG 0059 HIGHLAND AND GRAND RS REPL	19,506	19,506	3,306,318	746,000	2,560,318	12/28/2020	9/30/2022	6/1/2021	2/9/2023
75086	G7REG074	AW4985	AW4985 - REG 0074 - MCALPIN N OF HOPE - RELI	5,257	5,257	914,399	135,940	778,459	3/1/2022	8/31/2022	5/1/2022	10/7/2022
75086	G7REPL	28051	28051 - SMALL REPL KY	547,583	547,583	2,505,652	-	2,505,652	4/13/2000	12/31/2050	12/1/1999	
75086	G7REPL	AW6197	AW6197 - CANCEL- ROW SCHOOL RD - WALTON	(4,128)	(4,128)	-	25,000	(25,000)	10/6/2022	6/17/2023	11/1/2022	
75086	G7REPL	MX0506978	MX0506978 - KYTC MT ZION - INDEPENDENCE - 12" P	59,757	59,757	152,241	43,338	108,902	10/12/2023	2/20/2024	10/1/2023	2/7/2024
75086	G7REPL	MX1379992	MX1379992 - WEST 13TH ST RPL PROJECT, NEWPORT,	2,743	2,743	341,646	44,019	297,627	9/13/2021	4/15/2024	9/1/2021	9/28/2022
75086	G7REPL	MX2163251	MX2163251 - CANCEL HIGHLAND AVE WOODLAND PL	5	5	0	24,723	(24,723)	9/30/2021	5/12/2022	10/1/2021	
75086	G7REPL	MX3269023	MX3269023 - KYTC - HANDS PIKE - EDGEWOOD - 4" P	1,286	1,286	259,869	12,424	247,445	6/27/2022	12/31/2024	7/1/2022	11/18/2022
75086	G7REPL	MX4342633	MX4342633 - PLEASANT VALLEY STEEL REP (FOUNDERS	2,170	2,170	388,657	166,756	221,901	10/18/2019	2/28/2020	10/1/2019	6/26/2020
75086	G7REPL	MX4962663	MX4962663 - ALEXANDRIA PK - ALEXANDRIA- 8" SIZE	601	601	388,036	93,664	294,371	8/10/2022	5/11/2023	8/1/2022	5/3/2023
75086	G7REPL	MX6589218	MX6589218 - SCHOOL RD - WALTON - 4" PL - RPL	(1,154)	(1,154)	151,165	31,267	119,898	3/17/2023	11/30/2023	3/1/2023	11/29/2023
75086	G7REPL	MX9545566	MX9545566 - RICHWOOD RD REPLACEMENT PROJ KY-338	15,339	15,339	1,727,866	1,413,710	314,156	11/12/2019	6/14/2022	1/1/2020	3/1/2022
75086	G7REPL	MX9817206	MX9817206 - DUVENECK SQUARE RPL/MAE - COVINGTON	(32,322)	(32,322)	383,975	101,692	282,284	4/8/2021	10/1/2024	5/1/2021	12/14/2021
75086	G7RGPI	MX9217475	MX9217475 - GARVEY AVE. PRI, ELSMERE, 9400' 8"	10,633	10,633	1,523,278	507,691	1,015,587	8/16/2021	12/1/2022	9/1/2021	11/21/2022

75086	G7RRPI	MX9219249	MX9219249 - RICHARDSON RD PRESSURE IMP 7300' OF	22,733		22,733		100,152	765	99,386	10/21/2022	3/12/2026	11/1/2022		
75086	G7SERVMC	AW6981	AW6981 - SERVICE ABANDONMENTS - IAP	249,298		249,298		261,489	-	261,489	5/2/2023	12/31/2050	5/1/2023		
75086	G7SERVMC	C9839	C9839 - CANCEL 2 PP896043/CWA	9,454		9,454		9,355	-	9,355	5/17/2007	12/31/2050	5/1/2007	9/22/2007	
75086	G7SERVMC	CMRP70	CMRP70 - REPLACE C-M PLASTIC 2 INCH AND UNDE	785,211		785,211		14,016,442	-	14,016,442	7/1/2008	12/31/2050	7/1/2008		
75086	G7SERVMC	CMRS70	CMRS70 - 2" OR LESS STEEL C-M REPLACE	8,692		8,692		20,501	1,000,000	(979,499)	1/13/2016	12/31/2050	3/1/2016		
75086	G7SERVMC	LCMRP70	LCMRP70 - GREATER THAN 2" C-M REPL PLASTIC	189,596		189,596		280,091	2,500,000	(2,219,909)	1/13/2016	12/31/2050	4/1/2016		
75086	G7SERVMC	LCMRS70	LCMRS70 - GREATER THAN 2" C-M STEEL REPLACEME	229		229		229	1,000,000	(999,771)	3/10/2017	12/31/2050	9/1/2017		
75086	G7SERVMC	LMCRP70	LMCRP70 - GREATER THAN 2" M-C REPL PLASTIC	65,112		65,112		739,579	2,500,000	(1,760,421)	1/13/2016	12/31/2050	4/1/2016		
75086	G7SERVMC	LMCRS70	LMCRS70 - GREATER THAN 2" M-C REPL STEEL	37,161		37,161		53,689	1,000,000	(946,311)	1/13/2016	12/31/2050	11/1/2016		
75086	G7SERVMC	MCRP70	MCRP70 - REPLACE (NON-AMRP) M-C PLASTIC 2 IN	1,137,483		1,137,483		24,759,290	-	24,759,290	7/1/2008	12/31/2050	7/1/2008	12/20/2009	
75086	G7SERVMC	MCRS70	MCRS70 - REPLACE M-C STEEL 2 INCH AND UNDER	145,727		145,727		770,538	-	770,538	7/1/2008	12/31/2050	7/1/2008		
75086	G7SERVNEW	CMNEWP70	CMNEWP70 - NEW C-M PLASTIC 2 INCH AND UNDER KY	774,222		774,222		9,460,494	1	9,460,493	12/31/2010	12/31/2050	1/1/2011		
75086	G7SERVNEW	CMNEWS70	CMNEWS70 - 2" OR LESS STEEL NEW C-M	9,020		9,020		306,459	5,000,000	(4,693,541)	1/13/2016	12/31/2050	5/1/2016		
75086	G7SERVNEW	LCMNEWP70	LCMNEWP70 - GREATER THAN 2" C-M PLASTIC	117,859		117,859		389,387	2,500,000	(2,110,613)	1/13/2016	12/31/2050	2/1/2016		
75086	G7SERVNEW	LCMNEWS70	LCMNEWS70 - GREATER THAN 2" C-M STEEL	38,091		38,091		55,598	1,000,000	(944,402)	3/10/2017	12/31/2050	7/1/2019		
75086	G7SERVNEW	LMCNEWP70	LMCNEWP70 - GREATER THAN 2" M-C PLASTIC	78,481		78,481		809,315	2,500,000	(1,690,685)	1/13/2016	12/31/2050	3/1/2016		
75086	G7SERVNEW	LMCNEWS70	LMCNEWS70 - GREATER THAN 2" M-C STEEL	124,141		124,141		287,673	2,500,000	(2,212,327)	1/13/2016	12/31/2050	4/1/2016		
75086	G7SERVNEW	MCNEWP70	MCNEWP70 - NEW M-C PLASTIC 2 INCH AND UNDER KY	2,128,696		2,128,696		25,033,321	1	25,033,320	12/31/2010	12/31/2050	1/1/2011		
75086	G7SERVNEW	MCNEWS70	MCNEWS70 - NEW M-C STEEL 2 INCH AND UNDER KY	38,335		38,335		405,350	1	405,349	12/31/2010	12/31/2050	4/1/2011		
75086	G7SHOW2	MX8547529	MX8547529 - CHARTER - SHOWCASE CINEMAS RPL 1500	(47,513)		(47,513)		1,383,995	417,337	966,658	3/11/2023	7/21/2023	3/1/2023	10/20/2023	
75086	G7STA011	AW3227	AW3227 - STA 0949 DAYTON VALVE HOUSE	182,334		182,334		1,595,010	1,062,400	532,610	12/30/2020	10/30/2025	11/1/2021		
75086	G7STA014	AW3251	AW3251 - CANCEL_STA 0014 EAST ALEXANDRIAPIKE	(19)		(19)		-	82,500	(82,500)	1/3/2021	3/31/2023	6/1/2021		
75086	G7STA014	MX5466775	MX5466775 - CHARTER - EAST ALEXANDRIA PIKE	7,879		7,879		360,067	129,996	230,071	11/22/2022	12/29/2023	3/1/2023	11/20/2023	
75086	G7STA0375	AW3193	AW3193 - STA 0375 ELECTRIC AVE RS REPLACEMEN	20,394		20,394		2,283,680	829,000	1,454,680	12/28/2020	4/22/2022	5/1/2021	5/9/2022	
75086	G7STA064	AW3217	AW3217 - STA 0940 GLECOE TB	2,415		2,415		1,101,531	510,900	590,631	12/30/2020	3/31/2021	11/1/2021	9/27/2023	
75086	G7STA064	AW3268	AW3268 - STA 0940 STA GLENCOE TB LAND	7,680		7,680		69,005	82,500	(13,495)	1/5/2021	3/31/2023	8/1/2021	9/27/2023	
75086	G7STA0836	AW3191	AW3191 - STA 0838 ROSSFORD AVE RS REPLACEMEN	21,247		21,247		2,687,134	539,500	2,147,634	12/28/2020	4/30/2022	5/1/2021	5/22/2022	
75086	G7STA276	AW3212	AW3212 - STA 0276 MARY INGLES HWY RS ABANDON	(85,455)		(85,455)		1,126	553,900	(552,774)	12/30/2020	3/31/2021	11/1/2021	11/18/2022	
75086	G7STA276	AW3689	AW3689 - CANCEL-STA 0276 MARY IGLES HWY LAND	(341)		(341)		-	82,500	(82,500)	2/26/2021	3/31/2023	6/1/2021		
75086	G7STA280	AW3213	AW3213 - STA 0938 TAYLOR MILL & LONE OAK	442		442		2,715,078	562,000	2,153,078	12/30/2020	9/30/2023	11/1/2021	9/8/2023	
75086	G7STA280	AW3272	AW3272 - STA0938 TAYLOR MILL & LONE OAK LAND	67,569		67,569		210,952	82,500	128,452	1/5/2021	3/31/2023	8/1/2021	9/8/2023	
75086	G7STA286	AW3216	AW3216 - STA 0929 RILEY RD	10,690		10,690		4,110,633	635,200	3,475,433	12/30/2020	3/31/2021	9/1/2021	6/28/2023	
75086	G7STA338	AW3192	AW3192 - STA 0941 GUBSER MILL	3,383		3,383		605,126	538,800	66,326	12/28/2020	12/30/2025	9/1/2021		
75086	G7STA338	AW3690	AW3690 - STA 0941 GUBSER MILL LAND	2,204		2,204		50,604	82,500	(31,896)	2/27/2021	10/25/2025	6/1/2021		
75086	G7STA444	AW3186	AW3186 - STA 0948 THIRD & CRESCENT	2,890		2,890		640,799	948,400	(307,601)	12/28/2020	11/27/2025	11/1/2021		
75086	G7STA444	AW3230	AW3230 - STA 0948 THIRD & CRESCENT LAND	1,292		1,292		54,951	82,500	(27,549)	12/31/2020	11/27/2025	8/1/2021		
75086	G7STA793	AW3188	AW3188 - STA 0942 CAMP ERNST RD	298,602		298,602		3,988,714	887,300	3,101,414	12/28/2020	9/30/2023	11/1/2021	1/18/2024	
75086	G7STA793	AW3767	AW3767 - STA 0942 CAMP ERNST RD LAND	37,912		37,912		146,827	82,500	64,327	3/16/2021	3/31/2023	6/1/2021	1/18/2024	
75086	G7STA822	AW3189	AW3189 - STA 0822 COX RD RS REPAIR	1,888		1,888		190,318	541,600	(351,282)	12/28/2020	12/31/2022	11/1/2021	11/18/2022	
75086	G7STA876	MX6800938	MX6800938 - STA 876 WARSAW TOWN BORDER- STATION	84,092		84,092		2,431,628	252,984	2,178,644	1/10/2018	9/30/2022	1/1/2018	9/29/2023	
75086	G7TAM00B	AW2146	AW2146 - LINE AM00B RETROFIT REPL	130,262		130,262		14,953,090	6,528,636	8,424,454	5/19/2020	10/15/2022	5/1/2020	9/17/2022	
75086	G7TAM00B	AW3634	AW3634 - LINE AM00B ILI RETROFIT-LAND	1,948		1,948		404,165	127,500	276,665	2/17/2021	10/15/2022	10/1/2021	9/17/2022	
75086	G7TOOLS	28073	28073 - PURCHASE GAS TOOLS BLANKET	721,242		721,242		2,003,309	-	2,003,309	4/13/2000	12/31/2015	12/1/1999		
75086	G7TOOLS	AW4691	AW4691 - CGI UPGRADE KENTUCKY	3,776		3,776		349,888	120,000	229,888	10/22/2021	6/30/2022	12/1/2021		
75086	G7TUL06	AW1592	AW1592 - LINE UL06 - PIPELINE REPLACEMENTS	53,029		53,029		9,832,360	10,253,358	(420,998)	1/5/2020	12/30/2021	2/1/2020	12/3/2021	
75086	G7TUL06	AW2021	AW2021 - LINE UL06 - PIPELINE REPLACEMENTS L	449		449		122,119	115,000	7,119	4/13/2020	12/31/2021	7/1/2020	12/3/2021	
75086	G7UL02PH1	V8191	V8191 - UL60 PIPELINE PHASE 1 (PIPE)	167,246		167,246		38,803,147	26,326,195	12,476,952	1/23/2019	3/30/2021	1/1/2019	2/25/2021	
75086	G7UL02PH1	V8352	V8352 - UL60 PIPELINE P1 - LAND RIGHTS PROJ	15,637		15,637		4,912,530	1,941,000	2,971,530	2/11/2019	3/30/2021	3/1/2019	2/25/2021	
75086	G7UL02PH2	AW3877	AW3877 - UL60 PIPELINE PHASE II - STATION	53,799		53,799		4,764,465	1,004,152	3,760,313	4/29/2021	3/30/2022	5/1/2021	11/18/2021	
75086	G7UL02PH2	V9444	V9444 - UL60 PIPELINE PHASE II - PIPE	73,116		73,116		21,072,111	22,514,005	(1,441,894)	6/12/2019	3/30/2022	10/1/2019	11/18/2021	
75086	G7UL02PH2	V9445	V9445 - UL60 PIPELINE PHASE II- LAND RIGHTS	4,614		4,614		2,557,284	733,000	1,824,284	6/12/2019	2/2/2022	7/1/2019	11/18/2021	
75086	G7UL57	AW4824	AW4824 - STA0917 UL61 CHAMBERS RD TO DIXIE	161,761		161,761		3,884,455	873,000	3,011,455	12/9/2021	1/31/2024	2/1/2022	12/26/2023	
75086	KYCIBS05	D3212	D3212 - CANCEL 2 KY CIBS MOD 341 CLOSE	1,808		1,808		1,808	-	1,808	4/1/2008	12/31/2008	3/1/2008	5/31/2006	
75086	OM75086	GCPBUDKY	GCPBUDKY - BUDGET ONLY - KENT GAS CAP	10,154		10,154		16,789	-	16,789	6/18/2018	12/31/2050	5/1/2023		
75086	SG001135F	CGRREPLA	CGRREPLA - CGR REPLACE DEK GAS	30,212		30,212		61,458	-	61,458	3/6/2023	12/31/2050	4/1/2023		
75087	CUSTCONN	400109	400109 - CUST ENHANCEMENT AND OPTIMIZATION	(27)		(27)		370,056	480,680	(110,624)	6/20/2022	1/19/2024	7/1/2022	1/26/2024	
75087	CUSTCONN	400109M	400109M - MY ACCOUNT MODERNIZATION	18,844		18,844		60,717	135,363	(74,646)	6/9/2023	3/31/2025	6/1/2023	1/16/2025	
75087	FPIT	400055015	400055015 - ATLANTIS (CUSTOMER ANALYTICS ENGINE	152		152		25,432	22,832	2,600	12/29/2021	12/30/2023	1/1/2022	1/1/2024	
75087	FPIT	400055023	400055023 - USAGE ALERTS PHASE 2	4,348		4,348		21,539	23,299	(1,760)	12/15/2022	6/29/2024	1/1/2023	6/30/2024	
75087	FPIT	400055024	400055024 - SERVICE NAVIGATOR	7,317		7,317		23,260	22,425	835	12/20/2022	6/30/2024	1/1/2023	7/31/2024	
75087	FPIT	400055025	400055025 - DIGITAL CARE PLATFORM	2,606		2,606		35,921	25,411	10,510	3/14/2023	3/31/2024	3/1/2023	3/31/2024	
75087	FPIT	400055026	400055026 - INSPECTOR PORTAL PHASE 3	23		23		3,465	2,491	974	6/28/2023	3/29/2024	7/1/2023	3/31/2024	
75087	FPIT	400055029	400055029 - IVR VOICE AUTHENTICATION	5,031		5,031		60,137	77,856	(17,719)	10/19/2023	6/29/2025	10/1/2023	1/31/2025	
75087	FPIT	400055030	400055030 - SAP & BUSINESS CUSTOMER WEB PORTAL	157,508		157,508		181,783	212,277	(30,494)	11/1/2023	9/30/2025	11/1/2023	7/31/2025	
75087	FPIT	400055031	400055031 - D-E.COM/MY ACCOUNT WEB	18,794		18,794		20,387	22,654	(2,267)	10/31/2023	6/29/2025	11/1/2023	7/15/2025	
75087	FPIT	400055032	400055032 - CUSTOMER - MOBILE APPLICATION	60,946		60,946		68,702	42,720	25,982	10/31/2023	7/30/2025	11/1/2023	7/15/2025	
75087	FPIT	400055038	400055038 - CONTACT CENTER PLATFORM MODERNIZATI	92,867		92,867		92,867	573,597	(480,730)	5/16/2024	3/31/2026	5/1/2024		
75087	FPIT	400055039	400055039 - NUANCE LICENSES	21,583		21,583		21,583	21,907	(324)	5/20/2024	9/29/2024	7/1/2024	10/1/2024	
75087	FPIT	400055040	400055040 - MODERN CUSTOMER AUTHENTICATION	28,435		28,435		28,435	49,003	(20,568)	6/4/2024	3/31/2026	6/1/2024		
75087	FPIT	400055041	400055041 - NEW MYACCOUNT PLATFORM	24,362		24,362		24,362	109,160	(84,798)	6/7/2024	3/31/2026	6/1/2024		
75087	FPIT	400055045	400055045 - EONS LICENSES	7,821		7,821		7,821	3,641	4,180	12/9/2024	3/31/2025	12/1/2024	3/31/2025	
75087	FPIT	CO2300002	CO2300002 - GIFT CARD INVENTORY MODERN ARCHITEC	(1,117)		(1,117)		-	1,823	(1,823)	5/31/2023	10/30/2024	6/1/2023	1/30/2025	
75087	FPIT	CS2200008	CS2200008 - AVAYA PLATFORM UPGRADE - SERVER	(4,329)		(4,329)		41,340	44,473	(3,133)	11/14/2022	3/31/2024	11/1/2022	3/31/2024	
75087	FPIT	CS2300001	CS2300001 - CCO REMOTE WORKSTATION EQUIPMENT	44		44		7,376	8,282	(906)	2/3/2023	1/31/2024	3/1/2023	1/31/2024	
75087	FPIT	IT2400022	IT2400022 - SAP CUSTOMER SYSTEM CHANGES	23,438		23,438		23,438	33,919	(10,481)	5/8/2024	6/29/2025	5/1/2024	6/30/2025	
75087	FPIT	TC2300036	TC2300036 - SAP CUSTOMER SYSTEM CHANGES AND ENH	8,144		8,144		17,481	23,896	(6,415)	8/7/2023	8/29/2024	8/1/2023	8/31/2024	
75087	FPIT	TC2300037	TC2300037 - SAP ENABLE NOW APPLICATION	540		540		6,311	5,061	1,250	8/9/2023	3/30/2024	8/1/2023	3/31/2024	
75088	FPITKG	TC210SW57	TC210SW57 - CIOPS NERC CIP CYBERARK IMPLEMENTAT	(70)		(70)		3,074	3,357	(283)	12/10/2021	3/31/2024	2/1/2022	12/1/2023	
				91,160,343	81,572,239	9,588,104	11%								

Calculation of Capital Construction Project Slippage Factor

(in millions)

Year	Annual Actual Cost	Annual Original Budget	Variance in Dollars	Variance as Percent	Slippage Factor
2020	$ 81	$ 64	$ (17)	-26%	126%
2021	$ 69	$ 67	$ (2)	-3%	103%
2022	$ 75	$ 69	$ (5)	-8%	108%
2023	$ 101	$ 72	$ (29)	-40%	140%
2024	$ 91	$ 82	$ (10)	-12%	112%
5-Year Average Slippage Factor (Mathematic Average of the Yearly Slippage Factors / 5 years)					118%

Note:

Budgets pulled from previously published Regulated O&M and Capital Reports (ROCRs)

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-026

REQUEST:

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

RESPONSE:

For the actual months (September 2024 through February 2025) during the base period, labor is charged directly to expense or capital as deemed appropriate at that time. Any labor loadings (e.g., payroll taxes, clearing accounts, depreciation, etc.) on the direct labor cost is allocated to capital or expense based on the same proportion as the direct labor.

For the forecasted months (March 2025 through August 2025) of the base period, labor is budgeted directly to expense or capital as was deemed appropriate at the time the budget was developed. Any labor loadings (e.g., payroll taxes, clearing accounts, depreciation, etc.) on the direct labor cost is allocated to capital or expense based on the same proportion as the direct labor.

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

PERSON RESPONSIBLE: Claire C. Hudson
Linda L. Miller

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-027

REQUEST:

Provide a calculation of the rate or rates used to capitalize interest during construction for the three most recent calendar years. Explain each component entering into the calculation of the rate(s).

RESPONSE:

Please see the following attachments:

2022: STAFF-DR-01-027 Attachment 1.

2023: STAFF-DR-01-027 Attachment 2.

2024: STAFF-DR-01-027 Attachment 3.

PERSON RESPONSIBLE: Sharif S. Mitchell

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of January 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	84,571,000			0.177	x	85.50%	=	0.00151		
Long-Term Debt										
0.00	679,220,943	45.26%	x	3.513	x	14.50%	=	0.00231	0.38	33.04
Preferred Stock										
	0	0.00%	x	0.00	x	14.50%	=	0.00000		
Common Equity										
0.00	821,642,470	54.74%	x	9.700	x	14.50%	=	0.00770	0.77	66.96
Total Capitalization	1,500,863,413	100.00%								
AFUDC Rates								0.01152	**1.15**	100.00
CWIP (W)										
0.00	98,914,285									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of February 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	92,235,000			0.215	x	100.00%	=	0.00215		
Long-Term Debt										
0.00	679,242,183	44.84%	x	3.885	x	0.00%	=	0.00000	0.21	100.00
Preferred Stock										
	0	0.00%	x	0.00	x	0.00%	=	0.00000		
Common Equity										
0.00	835,704,980	55.16%	x	9.700	x	0.00%	=	0.00000	0.00	0.00
Total Capitalization	1,514,947,163	100.00%								
AFUDC Rates								0.00215	**0.21**	100.00
CWIP (W)										
0.00	86,667,394									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of March 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	79,899,000			0.293	x	100.00%	=	0.00293		
Long-Term Debt										
0.00	729,265,861	46.42%	x	3.625	x	0.00%	=	0.00000	0.29	100.00
Preferred Stock										
	0	0.00%	x	0.00	x	0.00%	=	0.00000		
Common Equity										
0.00	841,778,129	53.58%	x	9.700	x	0.00%	=	0.00000	0.00	0.00
Total Capitalization	1,571,043,990	100.00%								
AFUDC Rates								0.00293	**0.29**	100.00
CWIP (W)										
0.00	78,184,570									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of April 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	52,384,000			0.395	x	66.02%	=	0.00261		
Long-Term Debt										
0.00	729,298,211	46.29%	x	3.643	x	33.98%	=	0.00573	0.83	31.92
Preferred Stock										
	0	0.00%	x	0.00	x	33.98%	=	0.00000		
Common Equity										
0.00	846,141,103	53.71%	x	9.700	x	33.98%	=	0.01770	1.77	68.08
Total Capitalization	1,575,439,313	100.00%								
AFUDC Rates								0.02604	**2.60**	100.00
CWIP (W)										
0.00	79,342,790									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of May 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	37,649,000			0.509	x	48.15%	=	0.00245		
Long-Term Debt										
0.00	729,322,173	46.19%	x	3.654	x	51.85%	=	0.00875	1.12	29.32
Preferred Stock										
	0	0.00%	x	0.00	x	51.85%	=	0.00000		
Common Equity										
0.00	849,627,954	53.81%	x	9.700	x	51.85%	=	0.02706	2.70	70.68
Total Capitalization	1,578,950,127	100.00%								
AFUDC Rates								0.03826	**3.82**	100.00
CWIP (W)										
0.00	78,187,362									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of June 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	44,170,000			0.832	x	55.36%	=	0.00460		
Long-Term Debt										
0.00	729,347,123	46.10%	x	3.674	x	44.64%	=	0.00756	1.22	34.37
Preferred Stock										
	0	0.00%	x	0.00	x	44.64%	=	0.00000		
Common Equity										
0.00	852,918,770	53.90%	x	9.700	x	44.64%	=	0.02334	2.33	65.63
Total Capitalization	1,582,265,892	100.00%								
AFUDC Rates								0.03550	**3.55**	100.00
CWIP (W)										
0.00	79,784,147									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of July 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	41,497,000			1.321	x	52.76%	=	0.00697		
Long-Term Debt										
0.00	779,100,896	47.81%	x	3.732	x	47.24%	=	0.00843	1.54	39.19
Preferred Stock										
	0	0.00%	x	0.00	x	47.24%	=	0.00000		
Common Equity										
0.00	850,462,845	52.19%	x	9.700	x	47.24%	=	0.02391	2.39	60.81
Total Capitalization	1,629,563,742	100.00%								
AFUDC Rates								0.03931	**3.93**	100.00
CWIP (W)										
0.00	78,649,157									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of August 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	5,281,000			2.158	x	6.99%	=	0.00151		
Long-Term Debt										
0.00	779,039,859	47.58%	x	3.755	x	93.01%	=	0.01662	1.81	27.68
Preferred Stock										
	0	0.00%	x	0.00	x	93.01%	=	0.00000		
Common Equity										
0.00	858,334,362	52.42%	x	9.700	x	93.01%	=	0.04729	4.73	72.32
Total Capitalization	1,637,374,222	100.00%								
AFUDC Rates								0.06542	**6.54**	100.00
CWIP (W)										
0.00	75,557,104									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of September 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	26,591,000			2.546	x	33.27%	=	0.00847		
Long-Term Debt										
0.00	779,067,101	47.35%	x	3.806	x	66.73%	=	0.01203	2.05	37.61
Preferred Stock										
	0	0.00%	x	0.00	x	66.73%	=	0.00000		
Common Equity										
0.00	866,098,998	52.65%	x	9.700	x	66.73%	=	0.03408	3.40	62.39
Total Capitalization	1,645,166,099	100.00%								
AFUDC Rates								0.05458	**5.45**	100.00
CWIP (W)										
0.00	79,925,528									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of October 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	48,360,000			2.866	x	54.52%	=	0.01562		
Long-Term Debt										
0.00	779,095,224	47.17%	x	3.908	x	45.48%	=	0.00838	2.40	50.74
Preferred Stock										
	0	0.00%	x	0.00	x	45.48%	=	0.00000		
Common Equity										
0.00	872,475,071	52.83%	x	9.700	x	45.48%	=	0.02331	2.33	49.26
Total Capitalization	1,651,570,295	100.00%								
AFUDC Rates								0.04731	**4.73**	100.00
CWIP (W)										
0.00	88,694,336									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of November 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	70,899,000			3.456	x	72.89%	=	0.02519		
Long-Term Debt										
0.00	779,123,412	47.17%	x	3.946	x	27.11%	=	0.00505	3.02	68.48
Preferred Stock										
	0	0.00%	x	0.00	x	27.11%	=	0.00000		
Common Equity										
0.00	872,495,832	52.83%	x	9.700	x	27.11%	=	0.01389	1.39	31.52
Total Capitalization	1,651,619,244	100.00%								
AFUDC Rates								0.04413	**4.41**	100.00
CWIP (W)										
0.00	97,266,665									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of December 2022

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	72,712,000			4.144	x	76.03%	=	0.03151		
Long-Term Debt										
0.00	779,151,535	47.05%	x	3.966	x	23.97%	=	0.00447	3.60	74.69
Preferred Stock										
	0	0.00%	x	0.00	x	23.97%	=	0.00000		
Common Equity										
0.00	876,847,086	52.95%	x	9.700	x	23.97%	=	0.01231	1.22	25.31
Total Capitalization	1,655,998,621	100.00%								
AFUDC Rates								0.04829	**4.82**	100.00
CWIP (W)										
0.00	95,632,575									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of January 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	75,401,000			4.526	x	80.44%	=	0.03641		
Long-Term Debt										
0.00	779,156,541	46.96%	x	4.114	x	19.56%	=	0.00378	4.02	80.08
Preferred Stock										
	0	0.00%	x	0.00	x	19.56%	=	0.00000		
Common Equity										
0.00	880,194,488	53.04%	x	9.700	x	19.56%	=	0.01006	1.00	19.92
Total Capitalization	1,659,351,029	100.00%								
AFUDC Rates								0.05025	**5.02**	100.00
CWIP (W)										
0.00	93,739,557									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of February 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	59,097,000			4.592	x	59.28%	=	0.02722		
Long-Term Debt										
0.00	779,184,729	46.69%	x	4.097	x	40.72%	=	0.00779	3.50	62.50
Preferred Stock										
	0	0.00%	x	0.00	x	40.72%	=	0.00000		
Common Equity										
0.00	889,777,390	53.31%	x	9.700	x	40.72%	=	0.02106	2.10	37.50
Total Capitalization	1,668,962,119	100.00%								
AFUDC Rates								0.05607	**5.60**	100.00
CWIP (W)										
0.00	99,687,436									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of March 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	57,062,000			4.729	x	53.01%	=	0.02507		
Long-Term Debt										
0.00	779,212,186	46.50%	x	4.127	x	46.99%	=	0.00902	3.41	58.39
Preferred Stock										
	0	0.00%	x	0.00	x	46.99%	=	0.00000		
Common Equity										
0.00	896,604,524	53.50%	x	9.700	x	46.99%	=	0.02439	2.43	41.61
Total Capitalization	1,675,816,710	100.00%								
AFUDC Rates								0.05848	**5.84**	100.00
CWIP (W)										
0.00	107,647,856									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of April 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	55,422,000			4.979	x	48.04%	=	0.02392		
Long-Term Debt										
0.00	779,214,322	46.28%	x	4.176	x	51.96%	=	0.01004	3.40	55.74
Preferred Stock										
	0	0.00%	x	0.00	x	51.96%	=	0.00000		
Common Equity										
0.00	904,377,626	53.72%	x	9.700	x	51.96%	=	0.02708	2.70	44.26
Total Capitalization	1,683,591,948	100.00%								
AFUDC Rates								0.06104	**6.10**	100.00
CWIP (W)										
0.00	115,369,176									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of May 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	72,819,000			5.188	x	63.82%	=	0.03311		
Long-Term Debt										
0.00	779,277,893	46.26%	x	4.183	x	36.18%	=	0.00700	4.01	68.08
Preferred Stock										
	0	0.00%	x	0.00	x	36.18%	=	0.00000		
Common Equity										
0.00	905,150,403	53.74%	x	9.700	x	36.18%	=	0.01886	1.88	31.92
Total Capitalization	1,684,428,296	100.00%								
AFUDC Rates								0.05897	**5.89**	100.00
CWIP (W)										
0.00	114,105,210									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of June 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	84,180,000			5.236	x	73.05%	=	0.03825		
Long-Term Debt										
0.00	779,307,117	46.20%	x	4.190	x	26.95%	=	0.00522	4.35	75.65
Preferred Stock										
	0	0.00%	x	0.00	x	26.95%	=	0.00000		
Common Equity										
0.00	907,646,957	53.80%	x	9.700	x	26.95%	=	0.01406	1.40	24.35
Total Capitalization	1,686,954,074	100.00%								
AFUDC Rates								0.05753	**5.75**	100.00
CWIP (W)										
0.00	115,236,533									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of July 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	92,416,000			5.341	x	80.14%	=	0.04280		
Long-Term Debt										
0.00	779,336,938	45.94%	x	4.244	x	19.86%	=	0.00387	4.67	81.93
Preferred Stock										
	0	0.00%	x	0.00	x	19.86%	=	0.00000		
Common Equity										
0.00	917,041,032	54.06%	x	9.700	x	19.86%	=	0.01041	1.03	18.07
Total Capitalization	1,696,377,970	100.00%								
AFUDC Rates								0.05708	**5.70**	100.00
CWIP (W)										
0.00	115,316,464									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of August 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	112,543,000			5.351	x	99.04%	=	0.05299		
Long-Term Debt										
0.00	779,366,824	45.83%	x	4.232	x	0.96%	=	0.00019	5.32	99.25
Preferred Stock										
	0	0.00%	x	0.00	x	0.96%	=	0.00000		
Common Equity										
0.00	921,378,469	54.17%	x	9.700	x	0.96%	=	0.00050	0.04	0.75
Total Capitalization	1,700,745,293	100.00%								
AFUDC Rates								0.05368	**5.36**	100.00
CWIP (W)										
0.00	113,631,646									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of September 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	122,639,000			5.458	x	100.00%	=	0.05458		
Long-Term Debt										
0.00	779,396,709	45.73%	x	4.250	x	0.00%	=	0.00000	5.45	100.00
Preferred Stock										
	0	0.00%	x	0.00	x	0.00%	=	0.00000		
Common Equity										
0.00	924,891,752	54.27%	x	9.700	x	0.00%	=	0.00000	0.00	0.00
Total Capitalization	1,704,288,461	100.00%								
AFUDC Rates								0.05458	**5.45**	100.00
CWIP (W)										
0.00	117,563,703									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of October 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	121,415,000			5.552	x	99.80%	=	0.05541		
Long-Term Debt										
0.00	779,426,531	44.81%	x	4.273	x	0.20%	=	0.00004	5.55	100.00
Preferred Stock										
	0	0.00%	x	0.00	x	0.20%	=	0.00000		
Common Equity										
0.00	960,007,991	55.19%	x	9.700	x	0.20%	=	0.00011	0.00	0.00
Total Capitalization	1,739,434,522	100.00%								
AFUDC Rates								0.05556	**5.55**	100.00
CWIP (W)										
0.00	121,654,087									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of November 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	88,923,000			5.559	x	68.17%	=	0.03790		
Long-Term Debt										
0.00	779,445,156	44.81%	x	4.335	x	31.83%	=	0.00618	4.41	72.18
Preferred Stock										
	0	0.00%	x	0.00	x	31.83%	=	0.00000		
Common Equity										
0.00	960,138,119	55.19%	x	9.700	x	31.83%	=	0.01704	1.70	27.82
Total Capitalization	1,739,583,275	100.00%								
AFUDC Rates								0.06112	**6.11**	100.00
CWIP (W)										
0.00	130,436,081									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month of December 2023

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	110,595,000			5.562	x	82.63%	=	0.04596		
Long-Term Debt										
0.00	779,465,921	44.55%	x	4.331	x	17.37%	=	0.00335	4.93	84.71
Preferred Stock										
	0	0.00%	x	0.00	x	17.37%	=	0.00000		
Common Equity										
0.00	970,352,680	55.45%	x	9.300	x	17.37%	=	0.00896	0.89	15.29
Total Capitalization	1,749,818,601	100.00%								
AFUDC Rates								0.05827	**5.82**	100.00
CWIP (W)										
0.00	133,839,979									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month January 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	91,100,000			5.593	x	79.72%	=	0.04459		
Long-Term Debt										
0.00	704,562,055	38.40%	x	4.177	x	20.28%	=	0.00325	4.78	80.47
Preferred Stock										
	0	0.00%	x	0.00	x	20.28%	=	0.00000		
Common Equity										
0.00	1,130,356,704	61.60%	x	9.300	x	20.28%	=	0.01162	1.16	19.53
Total Capitalization	1,834,918,759	100.00%								
AFUDC Rates								0.05946	**5.94**	100.00
CWIP (W)										
0.00	114,278,398									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month February 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	81,711,000			5.573	x	86.20%	=	0.04804		
Long-Term Debt										
0.00	704,589,805	38.16%	x	4.150	x	13.80%	=	0.00219	5.02	86.25
Preferred Stock										
	0	0.00%	x	0.00	x	13.80%	=	0.00000		
Common Equity										
0.00	1,141,702,361	61.84%	x	9.375	x	13.80%	=	0.00800	0.80	13.75
Total Capitalization	1,846,292,166	100.00%								
AFUDC Rates								0.05823	**5.82**	100.00
CWIP (W)										
0.00	94,791,259									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month March 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	15,717,000			5.523	x	16.49%	=	0.00911		
Long-Term Debt										
0.00	704,617,446	37.94%	x	4.158	x	83.51%	=	0.01317	2.23	31.50
Preferred Stock										
	0	0.00%	x	0.00	x	83.51%	=	0.00000		
Common Equity										
0.00	1,152,350,904	62.06%	x	9.375	x	83.51%	=	0.04859	4.85	68.50
Total Capitalization	1,856,968,350	100.00%								
AFUDC Rates								0.07087	**7.08**	100.00
CWIP (W)										
0.00	95,313,855									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month April 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	13,761,000			5.485	x	13.45%	=	0.00738		
Long-Term Debt										
0.00	704,645,195	37.74%	x	4.157	x	86.55%	=	0.01358	2.10	29.41
Preferred Stock										
	0	0.00%	x	0.00	x	86.55%	=	0.00000		
Common Equity										
0.00	1,162,579,583	62.26%	x	9.375	x	86.55%	=	0.05052	5.04	70.59
Total Capitalization	1,867,224,778	100.00%								
AFUDC Rates								0.07148	**7.14**	100.00
CWIP (W)										
0.00	102,288,445									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month May 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	25,000,000			5.506	x	22.13%	=	0.01218		
Long-Term Debt										
0.00	704,672,891	37.65%	x	4.176	x	77.87%	=	0.01224	2.44	34.91
Preferred Stock										
	0	0.00%	x	0.00	x	77.87%	=	0.00000		
Common Equity										
0.00	1,167,038,233	62.35%	x	9.375	x	77.87%	=	0.04552	4.55	65.09
Total Capitalization	1,871,711,123	100.00%								
AFUDC Rates								0.06994	**6.99**	100.00
CWIP (W)										
0.00	112,960,267									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month June 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	21,496,000			5.501	x	17.91%	=	0.00985		
Long-Term Debt										
0.00	704,700,640	37.23%	x	4.165	x	82.09%	=	0.01273	2.26	31.92
Preferred Stock										
	0	0.00%	x	0.00	x	82.09%	=	0.00000		
Common Equity										
0.00	1,188,090,740	62.77%	x	9.375	x	82.09%	=	0.04831	4.82	68.08
Total Capitalization	1,892,791,380	100.00%								
AFUDC Rates								0.07089	**7.08**	100.00
CWIP (W)										
0.00	120,049,439									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month July 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	18,896,000			5.489	x	16.28%	=	0.00894		
Long-Term Debt										
0.00	928,779,999	43.66%	x	4.620	x	83.72%	=	0.01689	2.58	36.86
Preferred Stock										
	0	0.00%	x	0.00	x	83.72%	=	0.00000		
Common Equity										
0.00	1,198,391,189	56.34%	x	9.375	x	83.72%	=	0.04422	4.42	63.14
Total Capitalization	2,127,171,188	100.00%								
AFUDC Rates								0.07005	**7.00**	100.00
CWIP (W)										
0.00	116,096,613									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month August 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	0			0.000	x	0.00%	=	0.00000		
Long-Term Debt										
0.00	928,809,398	43.50%	x	4.617	x	100.00%	=	0.02008	2.01	27.53
Preferred Stock										
	0	0.00%	x	0.00	x	100.00%	=	0.00000		
Common Equity										
0.00	1,206,392,070	56.50%	x	9.375	x	100.00%	=	0.05297	5.29	72.47
Total Capitalization	2,135,201,467	100.00%								
AFUDC Rates								0.07305	**7.30**	100.00
CWIP (W)										
0.00	114,691,999									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month September 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	0			0.000	x	0.00%	=	0.00000		
Long-Term Debt										
0.00	928,845,651	43.36%	x	4.627	x	100.00%	=	0.02006	2.01	27.50
Preferred Stock										
	0	0.00%	x	0.00	x	100.00%	=	0.00000		
Common Equity										
0.00	1,213,386,708	56.64%	x	9.375	x	100.00%	=	0.05310	5.30	72.50
Total Capitalization	2,142,232,359	100.00%								
AFUDC Rates								0.07316	**7.31**	100.00
CWIP (W)										
0.00	127,167,969									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month October 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	0			0.000	x	0.00%	=	0.00000		
Long-Term Debt										
0.00	928,881,913	46.25%	x	4.624	x	100.00%	=	0.02139	2.14	29.85
Preferred Stock										
	0	0.00%	x	0.00	x	100.00%	=	0.00000		
Common Equity										
0.00	1,079,648,874	53.75%	x	9.375	x	100.00%	=	0.05039	5.03	70.15
Total Capitalization	2,008,530,787	100.00%								
AFUDC Rates								0.07178	**7.17**	100.00
CWIP (W)										
0.00	145,600,517									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month November 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	0			0.000	x	0.00%	=	0.00000		
Long-Term Debt										
0.00	928,850,921	46.13%	x	4.604	x	100.00%	=	0.02124	2.12	29.57
Preferred Stock										
	0	0.00%	x	0.00	x	100.00%	=	0.00000		
Common Equity										
0.00	1,084,560,017	53.87%	x	9.375	x	100.00%	=	0.05050	5.05	70.43
Total Capitalization	2,013,410,939	100.00%								
AFUDC Rates								0.07174	**7.17**	100.00
CWIP (W)										
0.00	159,787,434									

DEK-Gas & Common
Computation of AFUDC Rate
By Order No. 561 Method
For the Month December 2024

	AMOUNT (1)	CAPITALIZATION RATIO (2)		COST RATES (3)		S/W (4)		WEIGHTED COST RATES FOR GROSS AFUDC RATE (5)	RATE TO BE USED GROSS %	RATE TO BE USED GROSS RATIO
Short-Term Debt(S)										
0.00	0			0.000	x	0.00%	=	0.00000		
Long-Term Debt										
0.00	928,887,368	45.99%	x	4.591	x	100.00%	=	0.02112	2.11	29.43
Preferred Stock										
	0	0.00%	x	0.00	x	100.00%	=	0.00000		
Common Equity										
0.00	1,090,737,936	54.01%	x	9.375	x	100.00%	=	0.05063	5.06	70.57
Total Capitalization	2,019,625,304	100.00%								
AFUDC Rates								0.07175	**7.17**	100.00
CWIP (W)										
0.00	140,207,575									

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

CONFIDENTIAL STAFF-DR-01-028
(As to Attachment only)

REQUEST:

State whether any changes have been made to Duke Kentucky's internal accounting manuals, directives, and policies and procedures since Duke Kentucky's most recent rate case. If so, provide each item that was changed and identify the changes.

RESPONSE:

CONFIDENTIAL PROPRIETARY TRADE SECRET (As to Attachment only)

Please see STAFF-DR-01-028 Confidential Attachment.

PERSON RESPONSIBLE: Linda L. Miller

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-028 CONFIDENTIAL ATTACHMENT

FILED UNDER SEAL

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-029

REQUEST:

Provide Duke Kentucky's long-term construction planning program.

RESPONSE:

Planning for future construction projects is the end product of a process of study and analysis through which Duke Energy Kentucky assures itself that it will provide a safe, economical, and reliable system to meet its present and future delivery obligations.

As discussed in the direct testimony of company witness Brian Weisker, blanket projects consist of customer growth projects, equipment replacement projects, government mandated projects, and capital expenditures associated with capital tools and building upgrades. Customer growth projects involve new main installations related to general growth in Duke Energy Kentucky's customer load. Prior-period customer and load growth is used to estimate how much incremental infrastructure will be required in future periods. Government mandated projects consist of street improvement projects and other construction projects Duke Energy Kentucky is required to undertake by permit.

Duke Energy Kentucky develops the blanket capital expenditure budget for these projects through a qualitative and quantitative review of historical data. The Company uses historical average installation footage and determines whether any unusual factors existed during any year. The Company then prepares a five-year future look. Duke Energy Kentucky uses specific cost projections related to a particular project, to the extent that such information is available. For example, government entities notify the Company about

many street improvement projects well in advance, and we prepare the capital budget for these items by incorporating the projected cost for the known parameters of these projects. Specific projects are larger projects that Duke Energy Kentucky can identify in advance which are needed to maintain the integrity of the system, strengthen infrastructure to meet design-day requirements, or are initiated by governmental entities for public improvements. Integrity projects consist of casing projects, corrosion control and general transmission, and distribution integrity projects required to maintain a safe pipeline system. These projects are driven by prior-period O&M work done to inspect the system for safety and reliability. System infrastructure projects are projected by computer modeling when areas of the distribution system have deficient minimum pressure levels. Duke Energy Kentucky budgets for specific projects based on engineering cost estimating methods for labor and material costs, based on the known scope for each project. The costs are generated by historical costing data based on past projects and adjusting to current resource and material trends.

PERSON RESPONSIBLE: Brian R. Weisker

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-030

REQUEST:

Provide a copy of Duke Kentucky's most recent depreciation study. If no such study exists, provide a copy of Duke Kentucky's most recent depreciation schedule. The schedule should include a list of all facilities by account number, service life and accrual rate for each plant item, the methodology that supports the schedule, and the date the schedule was last updated.

RESPONSE:

Please see the depreciation study included as Attachment JJS-1, as part of the Direct Testimony of John J. Spanos filed with the Application.

PERSON RESPONSIBLE: John J. Spanos

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-031

REQUEST:

For each of the following Accounting Standards Codification (ASC), provide the information listed concerning implementation by Duke Kentucky.

a. ASC 410-20, "Asset Retirement Obligations."

(1) The effect on the financial statements.

(2) Whether the base period or forecasted test period includes any impact of the implementation. If so, provide a detailed description of the impact.

b. A schedule comparing the depreciation rates utilized by Duke Kentucky prior to and after the adoption of ASC 410-20. The schedule should identify the assets corresponding to the affected depreciation rates.

c. ASC 715-20, "Defined Benefit Plans - General."

(1) The effect on the financial statements.

(2) Whether the base period or forecasted test period includes any impact of the implementation. If so, provide a detailed description of the impact.

RESPONSE:

a. ASC 410-20:

(1) ASC 410-20 addresses accounting for Asset Retirement Obligations (AROs). In accordance with this accounting guidance, upon identification and valuation of an ARO, a liability and associated capitalized asset retirement cost are recorded. The liability is accreted over the periods remaining until expected settlement of the obligation,

and the asset retirement cost is depreciated over the expected remaining life of the related plant assets. Depreciation and accretion are deferred in accordance with ASC 980-10. At March 31, 2025, Duke Energy Kentucky has recorded $14,706,738 in asset retirement obligations and $4,488,775 of asset retirement costs, net of accumulated depreciation (balances do not include electric utility). As ARO liabilities are settled, the spend is also deferred in accordance with ASC 980-10.

(2) The base period and forecasted test period do not include the ARO Asset balances as these amounts are removed as "adjustments" as shown on Schedule B-2.2 and Schedule B 3.1 which rolls into the total "adjustments" as shown on Schedule B-2 and Schedule B-3. There is no income statement impact in the base period or forecasted test period resulting from Duke Energy Kentucky's accounting per ASC 410-20 Asset Retirement Obligations.

b. Depreciation of the assets associated with the recording of Asset Retirement Obligations is straight-line based on the expected remaining life of the related plant assets. Prior to implementation of ASC 410-20 there would not have been depreciation rates established for such assets as these are specifically identified with the Asset Retirement Obligation and the plant asset(s) associated with the ARO. The following summarizes the assets resulting from the AROs recorded at the gas utility (does not include electric utility) in compliance with ASC 410-20 and includes the gross asset balances at March 31, 2025, and the current annual depreciation rates:

- Gas Mains: $7,026,651; 2.08%
- Telecommunication tower lease (common obligation to remove Duke-owned assets at conclusion of lease): $1,486,982; 31.58%

Depreciation expense for these AROs has been deferred as addressed in response (a)(2) above.

c. ASC 715-20:

(1) ASC 715-20 (Defined Benefit Plans – General) addresses the content and organization of annual disclosures about defined benefit pension plans and other post-retirement benefits as well as disclosures required for interim-period financial reports.

(2) ASC 715-20 (Defined Benefit Plans – General) does not impact amounts recorded in either the base or forecasted test periods.

PERSON RESPONSIBLE: Sharif S. Mitchell – a., b.
Linda L. Miller – c.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-032

REQUEST:

Provide a complete description of Duke Kentucky's Other Post-Employment Benefits package(s) provided to its employees.

RESPONSE:

Please see the Direct Testimony of Shannon A. Caldwell beginning on page 31 under "Please Describe Duke Energy's Post Employment Healthcare Benefits Provided to Employees" and the retiree medical plans attached in response to STAFF-DR-01-042, Attachments 4 – 6.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-033

REQUEST:

Provide a complete description of the financial reporting and ratemaking treatment of Duke Kentucky's pension costs.

RESPONSE:

Duke Energy Kentucky participates in qualified and non-qualified defined benefit retirement plans (Pension) and other post-retirement benefit plans (OPEB) sponsored by Duke Energy Corporation (Duke Energy). The following primary authoritative accounting guidance for Pensions and OPEB is codified as part of the Accounting Standards Codification (ASC) that relates to Compensation – Retirement Benefits (ASC Topic 715):

ASC Subtopic Name	ASC Topic-Subtopic
Retirement Benefits – Defined Benefit Plans - General	715-20
Retirement Benefits – Defined Benefit Plans – Pension	715-30
Retirement Benefits – Defined Benefit Plans – Other Postretirement	715-60

Duke Energy's Pension and OPEB costs are calculated by the company's third-party actuary, Willis Towers Watson (WTW). Duke Energy determines the assumptions to be used by WTW to calculate Pension/OPEB plan obligations and costs based upon a range of assumptions presented by WTW. Upon consummation of the merger with Duke Energy in 2006, Cinergy's benefit plan obligations were re-measured. However, push-down accounting did not apply to Duke Energy Kentucky. As a result, Pension and OPEB costs are calculated on a pre-purchase accounting basis. Duke Energy Kentucky Pension and OPEB costs and obligations are allocated to Duke Energy Kentucky by Duke Energy. A

portion of Duke Energy Kentucky's Pension and OPEB service cost is capitalized as a component of property, plant, and equipment. All other components of Pension and OPEB cost are expensed. Additionally, Duke Energy Kentucky is allocated its proportionate share of Pension and OPEB costs for employees of Duke Energy's shared services affiliate that provides support to Duke Energy Kentucky.

In applying the provisions of ASC 715, Duke Energy is required to recognize the funded status of a benefit plan, measured as the difference between the fair value of plan assets and the benefit obligation, in its statement of financial position. Duke Energy remeasures its Pension and OPEB plan assets and obligations annually on December 31. For a pension plan, the benefit obligation is the projected benefit obligation (PBO). For an OPEB plan, the benefit obligation is the accumulated post-retirement benefit obligation (APBO). Actuarial gains or losses (represent the effect of differences between actuarial assumptions and actual experience) and prior service costs or credits (effect of plan amendments) that arise during the period as a result of re-measurement, represent costs that are probable of future recovery, and are reflected in regulatory assets and/or regulatory liabilities in the statement of financial position. Regulatory assets and/or regulatory liabilities are recognized in the following three categories: qualified pension plans, non-qualified pension plans and OPEB plans. Duke Energy elects to amortize actuarial gains or losses in excess of the corridor of 10 percent of the greater of the market-related value of plan assets or plan projected benefit obligation into Pension and OPEB cost over the average remaining service period of active covered employees. If all or almost all of a plan's participants are inactive, the average remaining life expectancy of the plan's participants is used instead of their average remaining service period. Prior service cost or

credit is amortized over the average remaining service period of active covered employees. If all or almost all of a plan's participants are inactive, the average remaining life expectancy of the plan's participants is used instead of their average remaining service period.

PERSON RESPONSIBLE: Linda L. Miller

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-034

REQUEST:

Provide detailed descriptions of all early retirement plans or other staff reduction programs Duke Kentucky has offered or intends to offer its employees during either the base period or the forecasted test period. Include all cost-benefit analyses associated with these programs.

RESPONSE:

While the Company seeks continuous improvement to address evolving business needs, the Company does not anticipate early retirement or staff reduction programs at this time for the base period or forecasted test year. As businesses need to meet O&M targets, there are some tools under which employees have left or are leaving under during the base period, however none of those employees were in the Duke Energy Kentucky payroll company. Those tools which have been applied to employees in other jurisdictions are described in STAFF-DR-01-034 Attachments 1 through 3.

PERSON RESPONSIBLE: Shannon A. Caldwell

DUKE ENERGY
SEVERANCE PLAN
(Plan No. 587)

SUMMARY PLAN DESCRIPTION

Describing the Plan as in effect on May 1, 2024

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I. INTRODUCTION

The purpose of the Duke Energy Severance Plan (the "DESP") is to provide severance benefits to Eligible Employees of Duke Energy Corporation and its participating affiliates, including Piedmont Natural Gas Company, Inc. ("Piedmont Natural Gas") (individually and collectively, the "Company"). The DESP provides a lump sum severance payment, certain continued health benefits and outplacement assistance (collectively, "DESP Benefits") to Eligible Employees who separate under the DESP.

This document is a Summary Plan Description for the DESP as in effect on May 1, 2024 that describes the eligibility criteria and DESP Benefits available to Eligible Employees who are separated from employment with the Company and its affiliates under circumstances in which the provision of severance benefits is appropriate, as determined by the Company, in its sole discretion. The eligibility criteria for any voluntary window offered under the DESP, as well as the DESP Benefits available to Eligible Employees who request and are approved for separation under any such voluntary window, will be described in a separate Summary Plan Description.

You must read each provision of this Summary Plan Description as a part of the whole summary. A single statement, read out of context, may be misleading. The DESP is intended to be a "welfare plan" subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA).

II. ELIGIBILITY

A. Eligibility Criteria

You are an Eligible Employee for purposes of the DESP only if you are an active employee of the Company and the Company, in its sole discretion, designates you as an Eligible Employee. The Company may designate you as an Eligible Employee in such circumstances as the Company, in its sole discretion, determines make the provision of severance benefits appropriate.

You will not be an Eligible Employee if any of the following applies to you: (i) you are employed in a position governed by a collective bargaining agreement; (ii) you are in temporary, seasonal or fixed-term employment status; (iii) you are an executive officer of the Company; (iv) you are eligible for severance protection under another active severance plan or agreement sponsored by Duke Energy Corporation ("Duke Energy") or a Duke Energy affiliate; (v) you are not designated as an Eligible Employee by the Company or (vi) you are selected for and accept a position with the Company after being designated as an Eligible Employee, but prior to your Release Date, as determined by the Company, in its sole discretion.

B. Requirements for Receiving DESP Benefits

If you are designated as an Eligible Employee, you will be eligible to receive DESP Benefits only if each of the following applies to you:

- you separate from employment in accordance with the terms of the DESP on the Release Date (as defined below) established by the Company for you;
- you sign and do not revoke a waiver of claims against the Company and certain others which becomes effective and irrevocable no later than 53 days following the date you receive such waiver; and
- you meet all other requirements of the DESP.

Note, however, that notwithstanding anything in the DESP or this SPD to the contrary, the waiver requirement described above is not applicable to the outplacement assistance benefits described in Section III(C), and your receipt of the outplacement assistance benefits described in Section III(C) is not conditioned

on your satisfaction of the waiver requirement. You must still satisfy all other applicable DESP requirements to receive the outplacement assistance benefits described in Section III(C).

If (i) you voluntarily separate from employment prior to your Release Date, as determined by the Company, in its sole discretion; (ii) your employment is terminated for cause, as determined by the Company, in its sole discretion, prior to your Release Date; (iii) you are removed from service prior to your Release Date and subsequently terminated for cause, as determined by the Company, in its sole discretion; (iv) you separate and become entitled to severance benefits pursuant to another severance plan or agreement sponsored by Duke Energy or its affiliates, as determined by the Company, in its sole discretion; or (v) you are selected for and accept a position with the Company after being designated as an Eligible Employee, but prior to your Release Date, as determined by the Company, in its sole discretion, you will not be eligible to receive DESP Benefits. However, if you are described in (i), (iv) or (v) above, you will be eligible to receive the outplacement assistance benefits described in Section III(C).

C. Release Date

Your "Release Date" is the date on which you must separate from employment with Duke Energy and its affiliates in order to receive DESP Benefits. Release Dates will be designated by the Company, in its sole discretion, and generally will be no later than 12 months following the date of the notification informing you that you have been designated as an Eligible Employee under the Plan.

III. DESP BENEFITS

As described in more detail below, DESP Benefits include a lump sum severance payment, certain continued health benefits and outplacement assistance.

A. Severance Payment

If you are designated as an Eligible Employee and separate under the DESP in accordance with the terms of the DESP, you will receive a Severance Payment ("Severance Payment") as described below.

1. Formula

The Severance Payment is calculated as of your Release Date in accordance with the following formula:

- two weeks of your Annual Base Pay for each Year of Service (including partial Years of Service).

Your Severance Payment (i) will not be less than 12 weeks of your Annual Base Pay ("Minimum Severance Payment"), and (ii) will not be more than 52 weeks of your Annual Base Pay.

2. Payment

If you separate under the DESP in accordance with the terms of the DESP, you will receive the Severance Payment in the form of a lump sum via check following your Release Date as follows:

- if your Release Date occurs on or before October 31 of a calendar year, you will receive the lump sum payment within 21 calendar days after your waiver becomes effective and irrevocable; and
- if your Release Date occurs after October 31 of a calendar year, you will receive the lump sum payment within 21 calendar days after the later of (i) January 1 of the immediately following calendar year, or (ii) the date that your waiver becomes effective and irrevocable (but no later than 53 days following the date you receive such waiver).

Your Severance Payment is subject to all applicable state and Federal tax withholdings, as well as any other deductions required by law, such as those made in order to comply with any court or administratively ordered wage garnishments.

3. Definitions

For purposes of calculating the amount of the Severance Payment,

"Annual Base Pay" means the following:

- if you are an Eligible Employee paid on a salaried basis, your annual base pay as in effect on your Release Date, excluding any allowances, premiums, bonuses, overtime, benefits or other forms or types of compensation; and

- if you are an Eligible Employee paid on an hourly basis, your hourly base rate of pay as in effect on your Release Date, excluding any allowances, premiums, bonuses, overtime, benefits or other forms of types of compensation, multiplied by (A) 2080 if you are a full-time employee as of your Release Date, as determined by the Company, in its sole discretion or (B) if you are a part-time employee as of your Release Date, as determined by the Company, in its sole discretion, the number of hours you were scheduled to work during the 12-month period ending on your Release Date (which number of hours will be annualized if such period of employment is less than 12 months).

"Year of Service" means the following:

- if you were employed by Duke Energy and its affiliates immediately prior to the merger of Duke Energy and Piedmont Natural Gas contemplated by the Agreement and Plan of Merger dated as of October 24, 2015 (the "Merger"), or you were hired following the Merger by a Company that was affiliated with Duke Energy immediately prior to the Merger, your period of employment with Duke Energy and its affiliates (including the Company) beginning on your most recent date of hire with the Company, or adjusted service date, if earlier, and ending on your Release Date, calculated to the nearest number of full months, divided by 12 and rounded up to the nearest full year (i.e., partial Years of Service are recognized for purposes of the DESP), all as determined in accordance with uniform procedures prescribed by the Company, in its sole discretion, which procedures will be interpreted to avoid duplicative counting of service and will exclude any service with Piedmont Natural Gas and its affiliates before the Merger; and

- if you were employed by Piedmont Natural Gas and its affiliates immediately prior to the Merger, or you were hired following the Merger by a Company that was affiliated with Piedmont Natural Gas immediately prior to the Merger, your period of employment with Piedmont Natural Gas and its affiliates prior to the Merger and with Duke Energy and its affiliates (including the Company) on and after the Merger, beginning on your most recent date of hire with Piedmont Natural Gas and its affiliates, or adjusted service date, if earlier, and ending on your Release Date, calculated to the nearest number of full months, divided by 12 and rounded up to the nearest full year (i.e., partial Years of Service are recognized for purposes of the DESP), all as determined in accordance with uniform procedures prescribed by the Company, in its sole discretion, which procedures will be interpreted to avoid duplicative counting of service and will exclude any service with Duke Energy and its affiliates before the Merger.

If you previously received severance benefits under another severance benefits plan of Duke Energy or any of its affiliates, you will have your "Years of Service" determined beginning with your most recent date of rehire with the Company.

4. An Example – Severance Payment

Here is a closer look at how the Severance Payment will be calculated. Assume you are an Eligible Employee, your Annual Base Pay is $70,000 and you have 22 Years of Service.

1.	Annual Base Pay	$70,000
2.	One week of Annual Base Pay ($70,000/52 weeks)	$1,346.15
3.	Formula benefit for Years of Service 22 x 2 = 44 weeks x $1,346.15	$59,230.60
4.	Minimum Severance Payment ($1,346.15 x 12)	$16,153.80
5.	**Final Severance Payment (greater of lines 3 or 4, but not higher than 52 weeks of Annual Base Pay)**	**$59,230.60**

In this example, your Severance Payment is $59,230.60. You would receive a lump sum payment equal to $59,230.60 (less taxes and other withholdings) following your Release Date as described above.

B. Medical, Dental and Vision Benefits

If you are designated as an Eligible Employee and you separate under the DESP in accordance with the terms of the DESP, continued medical, dental and/or vision coverage under the Company-sponsored medical, dental and/or vision plan in which you are enrolled on your Release Date, as applicable, will be provided during the 6-month period following the termination of your active coverage (the "COBRA Subsidy Period") pursuant to the Federal law known as COBRA for you and your eligible dependents covered on your Release Date at no premium cost to you if you satisfy the following requirements:

- you are enrolled in the medical, dental and/or vision plan coverage, as applicable, on your Release Date; and

- you elect to continue such coverage following the termination of your active coverage in accordance with COBRA.

For these purposes, your eligible dependents are determined in accordance with the terms and provisions of the medical, dental and/or vision plan in which you are enrolled, as applicable. You and your eligible dependents are eligible for COBRA coverage only under the health care plans in which you and your eligible dependents are enrolled on your Release Date.

If you make any changes to your COBRA coverage during the COBRA Subsidy Period during annual enrollment or as a result of a work/life event for which changes are permitted, modified COBRA coverage will be provided at no premium cost to you for the remainder of the COBRA Subsidy Period.

If you are designated as an Eligible Employee and you die before your Release Date, and your eligible dependents enrolled in Company-sponsored medical dental and/or vision coverage at the time of your death elect to continue such coverage following your death under COBRA, COBRA coverage will be provided at no premium cost to your eligible dependents for the COBRA Subsidy Period. If you are receiving Company-provided COBRA coverage under the DESP and you die prior to the expiration of the COBRA Subsidy Period, COBRA coverage will be provided to your eligible dependents covered at the time of your death at no premium cost for the remainder of the COBRA Subsidy Period. You or your eligible dependents will be responsible for paying the applicable premium or portion thereof for any COBRA coverage continued after the expiration of the COBRA Subsidy Period, as the Company will not pay any portion of the premium cost for such period.

C. Outplacement Assistance

If you are designated as an Eligible Employee under the DESP and satisfy all applicable DESP requirements in accordance with the terms of the DESP, the Company will provide you with up to 6 months of outplacement assistance through a vendor selected by Duke Energy, in accordance with its policies in effect from time to time.

D. Special Rehire Severance Payment

If you previously separated and received severance benefits under a severance plan or agreement sponsored by Duke Energy, Piedmont Natural Gas or their affiliates, but you were later rehired by Duke Energy, Piedmont Natural Gas or their affiliates and repaid all or a portion of those severance benefits, and you separate under the DESP in accordance with the terms of the DESP, you may be eligible to receive an additional rehire severance payment (the "Rehire Severance Payment"). The Rehire Severance Payment is in addition to the Severance Payment provided for under the DESP. If you believe that you are eligible for a Rehire Severance Payment, you may contact the Plan Administrator for additional information, including details regarding the amount and payment of the Rehire Severance Payment.

E. Maximums

The sum of your Severance Payment and any Rehire Severance Payment will not be more than 2 times the amount set forth in Box 5 of your Form W-2 for the year immediately preceding the year in which your Release Date occurs (which amount will be annualized if you did not work a full year in the prior year).

IV. OTHER CONSIDERATIONS

A. Other Plans

If you separate under the DESP in accordance with the terms of the DESP, you will be treated as having been involuntarily terminated without cause solely for purposes of determining your rights to a payment under any annual incentive plan sponsored by the Company or its affiliates in which you are participating during the year in which your Release Date occurs.

B. Reemployment and Contingent Worker Assignments

Separation from employment and receipt of benefits under the DESP does not preclude your subsequent rehire. However, Duke Energy, the Company and their affiliates generally will not rehire anyone who separates under the DESP for 12 months after their Release Date. You do not have any right to reemployment or any preferential rights for rehire. Employees who separate under a Company-sponsored severance program, including the DESP, generally are not eligible for staff augmentation contingent worker assignments to the Company for 12 months following their separation from employment.

Following any reemployment with Duke Energy, the Company or its or their affiliates, you shall have no right to additional DESP Benefits and may be required to repay a pro-rated portion of any DESP Benefits you received before your reemployment date, depending upon the amount of your DESP Benefits and the length of the break in service.

C. Tax Information

Your Severance Payment and any Rehire Severance Payment are taxable to you as ordinary income. This document is only a summary. It is not intended to be a complete description of the tax consequences of the DESP. You are urged to consult with your personal tax advisor before making any decisions. The Company will withhold from any payment of DESP Benefits such Federal and state tax withholdings and other deductions reasonably determined to be required by law, such as those made in order to comply with any court or administratively ordered garnishments from certain DESP Benefits. A limited number of

executives could be subject to a 6-month delay in the payment of their Severance Payment and any Rehire Severance Payment to comply with the Internal Revenue Code.

D. Employment Issues

The DESP does not constitute inducement or consideration for the employment of any employee, nor is it a contract between any employee and Duke Energy, the Company or their affiliates. The DESP does not give any employee the right to continued employment. Duke Energy, the Company and their affiliates have the right to hire and terminate any employee at any time, with or without cause, as if the DESP had never been established. The DESP does not provide Eligible Employees with any right not expressly granted by its provisions, and does not provide any benefit (other than outplacement assistance benefits) without the execution of the waiver and release(s) required in Section II(B).

E. WARN and Similar Local Laws

Your Severance Payment will be reduced by any amount paid to you for advance notice of employment loss required by the WARN Act or similar state or local law or both, where you are on excused leave with pay, as well as by any amount that must be paid under any government mandated severance requirement that does not prohibit offsets, but not below the Minimum Severance Payment.

APPENDIX A

This Appendix A includes important information that is required by Federal regulations to be included in the Summary Plan Description for the DESP.

Inquiries and Claims

To file a claim, follow the procedures described here.

Inquiries and questions about the DESP may be addressed to the Plan Administrator at the address provided below under the "DESP Administration" section. If you disagree with your benefits under the DESP, you must file a claim within 12 months of the date your first payment would have been due under the DESP. Any legal action for benefits under the DESP must be brought within 1 year following a final denial of an appeal brought in accordance with the DESP's claims procedures.

Situations That Can Affect Your DESP Benefits

Some situations could cause a loss or delay of your DESP Benefits.

The DESP is designed to provide DESP Benefits to Eligible Employees. Some situations could affect DESP Benefits. These situations include the following:

- Eligibility for the DESP is limited to those Eligible Employees designated by the Company. You may be in a position such that you are not designated as eligible for the DESP. If you are not designated as an Eligible Employee, you will not be eligible for DESP Benefits.
- Eligibility for the Rehire Severance Payment described in Section III(D) is conditioned on you satisfying the eligibility requirements for the Rehire Severance Payment described in that Section. If you do not satisfy the eligibility requirements, you will not be eligible for the Rehire Severance Payment.
- Eligibility for DESP Benefits is subject to strict deadlines. If you do not meet the deadlines, you will not be eligible for DESP Benefits.
- Eligibility for DESP Benefits is conditioned on your satisfying all applicable Plan requirements and separating from employment on a specified date (i.e., your Release Date) in the manner determined by the Company. If you do not comply with these requirements, you will not be eligible for DESP Benefits.
- If you voluntarily separate from employment prior to your Release Date, you will not be eligible for DESP Benefits (other than outplacement assistance benefits).
- If you are designated as an Eligible Employee under the DESP but are terminated for cause prior to your Release Date, as determined by the Company in its sole discretion, you will not be eligible for DESP Benefits.
- If you are designated as an Eligible Employee under the DESP but are removed from service prior to your Release Date and subsequently terminated for cause, as determined by the Company in its sole discretion, you will not be eligible for DESP Benefits.
- If you separate and become entitled to severance benefits pursuant to another severance plan or agreement sponsored or agreed to by the Company or its affiliates, as determined by the Company, in its sole discretion, you will not be eligible to receive DESP Benefits (other than outplacement assistance benefits).
- If you are selected for and accept a position with the Company after being designated as an Eligible Employee, but prior to your Release Date, as determined by the Company, in

its sole discretion, you will not be eligible to receive DESP Benefits (other than outplacement assistance benefits).

Other Important Information About the DESP

- Your DESP Benefits are paid from the general assets of Duke Energy and the Company.
- Your DESP Benefits may not be sold, assigned, transferred or pledged under most circumstances.
- The DESP is intended to be a welfare plan for purposes of ERISA. Your DESP Benefits may be limited to retain the DESP's status as a welfare plan.
- Your DESP Benefits may be limited so as to not be subject to taxation under Section 409A of the Internal Revenue Code.
- If you die before any Severance Payment and/or Rehire Severance Payment under the DESP is paid, such payment(s) will be paid to your estate upon the execution of an effective waiver and release by your estate's representative.
- The DESP may be amended or terminated at any time.
- Any overpayments from the DESP may be recouped from future payments or by other means permitted by law.
- Nothing in the DESP is a commitment of continued employment. Your employment is at-will. Duke Energy's, the Company's and their affiliates' right to terminate or change the terms of your employment remains the same as if the DESP had not been adopted.
- DESP Benefits are paid only if the Plan Administrator or its delegate determines, in its sole discretion, that you are entitled to benefits under the provisions of the DESP.
- As a participant in the DESP, you have certain rights under ERISA. Information about your rights and other important information can be found in the DESP Administration section.
- If you disagree with your DESP Benefits, you must file a claim and provide any required information with the claim before DESP Benefits can be paid. See "Claim Review Process" in the DESP Administration section for information on claim submissions and the review process.
- Any claim for benefits under the DESP must be filed within 12 months of the date your first payment would have been due under the DESP.
- Any legal action for benefits under the DESP must be brought within 1 year following the denial of an appeal brought in accordance with the DESP's claims procedures.

Changes to the DESP

Duke Energy does not expect to continue the DESP indefinitely. Further, Duke Energy reserves the right to amend, modify, eliminate, suspend, or terminate all or part of the DESP (and/or any of its other plans) at any time in its sole discretion.

DESP Administration
Here are details about how the DESP is administered:

Plan Name

The DESP's name is the Duke Energy Severance Plan.

DESP Sponsor

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

Duke Energy Corporation
525 South Tryon Street
Charlotte, North Carolina 28202
980-373-8649
EIN: 20-2777218

Plan Number

The plan number assigned to the DESP is 587.

Funding

The DESP is not funded and no contributions are made to the DESP. Benefits under the DESP are paid from the general assets of Duke Energy and the Company.

Administrator and Administration

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

The Benefits Committee may assign or delegate any of its authority or duties to others. Duke Energy Human Resources is appointed to serve as the Benefits Committee's delegate with respect to the review of initial claims for DESP Benefits. The Benefits Committee has appointed the Duke Energy Claims Committee (the "Claims Committee") to serve as Denied Claim Reviewer for DESP Benefits. The Benefits Committee and the Claims Committee may be contacted as follows:

Duke Energy Benefits Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, North Carolina 28202
(704) 382-4703

Duke Energy Claims Committee
Duke Energy Corporation
525 South Tryon Street – DEP14C
Charlotte, North Carolina 28202
(704) 382-4703

The Benefits Committee (and any delegate thereof) and the Claims Committee, each within its area of authority and responsibility, have the power and discretion to construe and interpret the DESP and to make factual determinations. Benefits under the DESP are paid only if the Benefits Committee or its delegate decides in its sole discretion that the applicant is entitled to benefits under the provisions of the DESP.

Plan Year

The DESP is operated on a calendar-year basis, beginning January 1 and ending December 31.

Agent for Service of Legal Process

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

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

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

Affiliated Employers of Duke Energy That Have Adopted the DESP

Contact the Plan Administrator for information regarding affiliates of Duke Energy that have adopted and are participating in the DESP.

Type of Plan

The DESP is a welfare plan for purposes of ERISA. The DESP provides severance benefits.

Claim Review Process

The DESP has a claim review process that is followed whenever you submit a claim for DESP Benefits. Claims for DESP Benefits, and related appeals, generally must be submitted by certain deadlines, as further described below.

Initial Decision

When you file a claim, Duke Energy Human Resources reviews the claim and makes a decision to either approve or deny the claim (in whole or in part). You will receive a written notice of the claim decision within a reasonable period of time - generally not later than 90 days after receipt of your claim. In some situations, Duke Energy Human Resources may need an extension of time to make a decision (for example, if it needs additional information). If special circumstances require an extension, the period to make a decision may be extended for an additional 90 days. You'll be notified of the extension within the initial 90-day period following receipt of your claim.

If Your Claim is Denied

If your request or claim is denied, in whole or in part, you will receive a written notice that explains:

- the specific reasons for the denial;
- the DESP provisions on which the denial is based;
- a description of any additional material or information needed and an explanation of why it is necessary; and
- an explanation of the DESP's claim review procedures, applicable time limits and your rights to bring a civil action under Section 502(a) of ERISA following a denial on review.

Request for Review if Your Claim is Denied

After receiving the notice, you, your beneficiary, or your legal representative may ask for a full and fair review of the decision by writing to the Claims Committee. You must make this request within 60 days of the date you receive notice of the denied claim. During the 60-day period, you or your

authorized representative will be given reasonable access to all documents and information related to the claim, and you may request copies free of charge. You also can submit written comments, documents, records, and other information to the Claims Committee.

Final Decision

The Claims Committee or its delegate then will review the claim and make a decision based on all comments, documents, records, and other information you've submitted. You'll receive the Claims Committee's final decision within a reasonable period of time - generally not later than 60 days after the Claims Committee receives your request for review. If necessary, the period may be extended for an additional 60 days.

If your request on review is denied, in whole or in part, you will receive a written notice that explains:

- the specific reasons for the denial;
- the DESP provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relating to your claim; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the claims review process. You may not initiate a legal action against the DESP, Duke Energy, the Company, affiliates of Duke Energy or the Company, the Benefits Committee or the Claims Committee until you have completed the claims review process. No legal action may be brought more than 1 year following a denial of an appeal brought in accordance with the DESP's claims procedures. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

Authority to decide initial claims under the DESP and denied claims on review under the DESP includes the full power and discretion to interpret DESP provisions and to make factual determinations, with the decisions, interpretations and factual determinations made by the Claims Committee controlling. Requests for information regarding individual claims, or review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim or to decide the denied claim on review, as applicable.

Your Rights Under ERISA

As a participant in the DESP, you are entitled to certain rights and protections under ERISA, which are listed below:

Receive Information About Your Plan and Benefits

As a participant in the DESP, you have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the DESP and a copy of the latest annual

report (Form 5500 Series) filed by the DESP with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the DESP and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Prudent Actions By Plan Fiduciaries

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

Claim Review

If your claim for DESP Benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial -- all within certain time schedules. For more information on claim review, see the "Claim Review Process" section above.

Enforce Your Rights

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

If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees -- for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the DESP, you should contact the Plan Administrator.

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

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Legal Documents as Final Authority

Although this summary plan description describes the principal features of the DESP that are generally applicable, it is only a summary. The complete provisions of the DESP are set forth in the legal plan document, which is available upon request by contacting the Duke HR Control Center during regular office hours. Descriptions of DESP Benefits should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. In the event of a conflict between this summary plan description or any other communication regarding the DESP and the plan document, the plan document controls. Remember, the DESP may be amended only by proper corporate action and not by oral or written communications about benefits under the DESP.

Management Toolkit

Performance Transition Program (PTP)

Effective: November 2015
Revised: January 2024

IMPORTANT: This document contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with applicable plan documents, the plan documents shall govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, shall be considered a contract for future employment.

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    - Sample Performance Improvement Plan (PIP) with PTP Option Template
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Performance Transition Program (PTP) Overview

As part of our workforce planning and performance management efforts, the Company offers a program designed to address poor performers and provide an option to exit a poorly performing employee in lieu of placing the employee on a formal Performance Improvement Plan (PIP).

This Management Toolkit provides an overview of the process to help facilitate the potential application of the PTP, understand the appropriate use of the PTP and determine employee eligibility.

With approval by the responsible Executive Leadership Team member and the business unit HR Business Partner Director, management may offer a choice to an employee with documented poor performance to either exit the Company under the PTP or to pursue a PIP, under the following conditions:

1. The employee has documented poor performance, including but not limited to: an overall rating of Partially Meets Expectations/Needs Improvement or lower on his or her most recent mid-year or annual performance appraisal; or
2. The employee has not yet had a performance appraisal and has demonstrated serious performance deficiencies; or
3. The employee has met expectations on his or her most recent performance appraisal but whose performance has deteoriated rapidly, or successfully completed a PIP in the past but demonstrated a subsequent decline in performance; AND
4. Management has concerns that the employee may not be successful on a Performance Improvement Plan or has identified other factors supporting a decision to offer the employee an alternative to a PIP.

Employees generally will not be offered a choice when they are subject to termination for misconduct, including but not limited to, theft, harassment, violations of Company policy, or other similar misconduct, or when they have failed to successfully complete a PIP within the previous twelve months.

Employees who choose to separate under the PTP in lieu of a PIP will be eligible for a transition payment, health care supplement, and outplacement services as described below, if they meet certain requirements, including separating from employment when designated by management, and signing and not revoking a waiver and release of claims acceptable to the Company. Those benefits are:

1. Transition payment provided as a lump sum payment equivalent to the amount of 12 weeks of the employee's regular base pay, and

2. Health care supplement provided as a lump sum payment equivalent to the premium cost of three months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by the Company in its sole discretion.

3. Six (6) months of outplacement services through a vendor selected by the Company in accordance with the Company's policies in effect from time to time as of his or her separation from Duke Energy.

When management has obtained appropriate approvals to offer this alternative, the employee should be provided with the "PIP With PTP Option" template included in this Toolkit instead of the PIP standard template.

PTP Process

The following describes the process to pursue this option:

Steps	Description	Objectives
1	Gather Information	• Identify employees that are not performing in accordance with previously communicated expectations • Gather and review documentation relating to the employee's poor performance, including prior performance appraisals.
2	Decide whether to offer PIP with PTP Option and seek approvals.	• Determine (i) the likelihood of success on a PIP and (ii) risk to the Company if the PTP is not offered. • Decide whether to seek approval to offer the PTP Option. • Obtain required approvals.
3	Consult with the Employee Relations Control Center	• Provide a completed PTP ERCC Template to Severance@duke-energy.com • Forward approval emails from ELT and HR Director • ERCC will send PTP letter agreement back to HR Representative
3	Meet with employee to offer the Performance Transition Program	• Offer the PTP Option to the employee using the standard script provided below.
4	Implement the PIP (if chosen by employee) or separate under PTP	• Employee selects between PIP or PTP Option • If PIP selected, employee continues under terms of the PIP • If a PTP is selected, the employee terminates under the PTP provisions

Manager Script for 1-on-1 Meeting w/ Employee to Offer Proposed PIP with PTP Option

This script should be used to offer poor performers the choice between continuing their employment under the terms of a PIP, or separating from employment under the PTP Option. The completed form should be returned to your HR Representative.

Employee ID: _____ Employee Name: _____

Date: _____ Employee Job Title: _____ Department: _____

- Thank you for taking the time to meet with me today.
- Over the past several months, there has been a decline in your performance and I'd like to discuss with you how we can address this. *(Add specific examples of poor performance here.)*
- When there are performance concerns, the Company typically offers the employee a Performance Improvement plan or PIP. The PIP is a tool to assist an employee with improving and sustaining personal performance to a satisfactory level in areas that are critical to meeting the demands of his/her position.
- A PIP is a joint effort involving a written understanding between an employee and a supervisor/manager regarding specific ways to improve less than satisfactory performance in a specific time period.
- In this case, we would place you on a PIP for 90 days.
- The PIP is not corrective action; however, your failure to adhere to the expectations outlined in the PIP may result in corrective action up to and including discharge.
- Upon successful completion of a PIP, you are expected to sustain a level of satisfactory performance for 12 months or you could be removed from your position pending an investigation.
- At times, the Company also may offer a second option to consider if you do not feel that you will be successful in the PIP program. The second option would involve your separation from the Company under a Performance Transition Program in lieu of a PIP.
- The PTP Program offers an opportunity for a transition payment, health care supplement, and outplacement services if all program requirements are met.
    - The Transition payment would be provided as a lump sum payment equivalent to the amount of12 weeks of your regular base pay, and
    - The health care supplement would be a second payment equivalent to (ii) three (3) months of the cost of medical/dental/vision coverage under COBRA for you and your covered dependents, based on your existing coverage as of your release date which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion.
    - The PTP Program also offers six (6) months of outplacement services through a vendor selected by the Company in accordance with the Company's policies in effect from time to time.

- To participate in the PTP Program in lieu of a PIP, you would be required to separate from your employment when released, and sign and not revoke a Waiver and Release of Claims against the Company.

- *(Provide the employee with a copy of the completed PIP document and PTP Letter here)*.

- This is an important decision, and I understand if you need more time to think it over. Let's plan to reconvene in a few days so that we can agree on a decision and discuss next steps.

- *Manager/Supervisor to take the action item to schedule the follow up discussion.*

Performance Improvement Plan with PTP Option - EXAMPLE

Employee Name: _____ Employee Job Title: _____

Date: _____ Supervisor Name: _____

As previously discussed on <insert date/s>, there are a number of performance areas you need to immediately improve in order to meet the requirements of your role of <Title>. You have not met the expectations of a <Title> role in the following areas including, but not limited to:

<include explanation of how the employee has not met the requirements; for example.:
- Work Execution
- Communication
- Interpersonal Skills

In order to meet the requirements of the position you currently hold, you are being placed on a Performance Improvement Plan (PIP) and you are expected to achieve the following performance standards:

Improvement Area	Performance Standard	Improvement Measure	Deadline
Work Execution	Work activities will be efficiently performed in a quality manner, demonstrating commitment and effective follow-through.	• Produce quality work by ensuring that the schedule is accurately and adequately developed to 80% loaded prior to weekly commitment meeting. • Use priority work list, such as 1s, 2s, and 3s and/or the ranked list of work from the scheduling application. • Make note of those items discussed in the daily and weekly meetings and include them in the schedule. • Reduce time spent on personal activities, such as phone calls and internet usage, in order to focus more time on work-related responsibilities. • Keep supervision informed on a weekly basis of work activities/situations	
Communication	Verbal communications will improve to an effective level.	• Communicate schedule to all team members in a timely and on-going manner. Team members include: (list titles) • Ensure that schedule has been communicated to Operations between (specify times) on a daily basis. • Encourage (titles) to complete their assigned tasks based on the schedule and in a timely and positive manner. • Improve the weekend schedules for all groups in order to reflect productive work.	

Interpersonal Skills	Establish positive relationships with team members.	• Be receptive to feedback by actively listening with the intent to understand. • Increase interaction with (titles) in order to improve relationships.	

It is your responsibility to successfully manage your job performance in order to meet the expectations of your PIP. To support your efforts, I will continue to meet with you on a regular basis to provide feedback regarding your performance against these performance standards. Unless prevented by business circumstances, our meetings will be held _____<insert: weekly or bi-weekly >. The goal of these meetings is to monitor your PIP progress and ensure your continued understanding of Duke Energy's expectations for your performance as a _____ <Title>.

You will also be required to complete the following formal training as part of the PIP: _____ <insert training>. During the period of time that you are on a PIP, you are generally not permitted to transfer to another position, subject to any local law requirements.

If you have any questions or are not clear regarding these expectations, please do not hesitate to ask for clarification. Significant progress against these performance standards is expected on an immediate and sustained basis with full correction of the deficiencies noted above by the end of the PIP's 90 day duration, on _____<PIP end date>.

If at any time it appears that you are not making significant progress, further action, up to and including the termination of your employment, will follow in accordance with applicable law. It is expected that once satisfactory performance is achieved, it will be maintained during the course of your employment. Please be aware that notwithstanding the PIP, your employment with Duke Energy continues to be terminable in accordance with applicable law and the terms and conditions of your employment.

You are encouraged to contact the Company's Employee Assistance Program provider, at _____(name)_____, at _____(phone number) for assistance with any personal issues that may be impacting work.

Employee Acknowledgement

I have discussed this plan with my supervisor/ manager and I understand the expectations as described. I understand that the intent of this plan is to assist me with being successful in my current position; however, if my performance does not improve and does not result in sustained acceptable performance, management will determine the appropriate corrective action, up to and including termination at any time during or following the performance improvement plan.

_____ _____
(Employee's signature) (Date)

_____ _____
(Supervisor's signature) (Date)

Performance Transition Program Option. In the event that you do not believe you will complete this PIP successfully or otherwise do not desire to pursue a PIP, you are eligible for an alternate option called the Performance Transition Program (PTP). Accordingly, you may elect to separate from your employment in lieu of a PIP with a transition payment and outplacement services, as described below, if you meet certain requirements, including separating from employment when designated by management, and signing and not revoking a waiver and release of claims acceptable to the Company. The PTP benefits are fully described in the attached Letter Agreement. As a brief overview, those benefits include the following:

1. Transition payment in the amount of 12 weeks of the employee's regular base pay, and
2. A health care supplement equivalent to the premium cost of 3 months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by the Company in its sole discretion.
3. Six (6) months of outplacement services through a vendor selected by the Company in accordance with the Company's policies in effect from time to time (including the Duke Energy Corporation 409A Policy).

Please complete the attached "Letter Agreement" form to communicate your decision whether to pursue a PIP or to separate from employment under the PTP.

PTP LETTER AGREEMENT TEMPLATE- to be completed by Severance Control Center

(place on Company letterhead)

[INSERT DATE]

Dear _____[INSERT EMPLOYEE NAME] Empid _____

As an alternative to acknowledging the terms of the Performance Improvement Plan "PIP" provided to you on _____ [INSERT DATE], [INSERT APPLICABLE PAYROLL COMPANY] (the "Company") is offering you the opportunity to separate from employment with the Company and its affiliates (collectively, "Duke Energy") on _____ [INSERT DATE] (the "Separation Date") under the Performance Transition Program (PTP) and receive the following benefits if you agree to the terms of this Letter Agreement, separate under the PTP on your Separation Date in accordance with this Letter Agreement and sign and do not revoke a waiver of claims against the Company and certain other entities and individuals substantially in the form attached hereto as Attachment I (the "Waiver");

1. Separation Pay. In addition to the amounts set forth below, if you separate under the PTP in accordance with the terms of this Letter Agreement, the Company agrees to pay you:

    a. A transition payment provided as a lump sum cash payment equal to $_____ [INSERT TRANSITION PAYMENT AMOUNT] (the "Transition Payment").; and

    b. A health care supplement payment provided as a lump sum cash payment equal to $_____ [INSERT HEALTH CARE SUPPLEMENT AMOUNT], which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion.

    Payment will be made within 60 days after the Separation Date, provided that you have first executed, returned and not revoked the attached Waiver. You will not be eligible to receive the payment described above if you fail to complete these actions regarding the Waiver within the stated 60-day period. The Company will have the right to deduct from any payment made to you pursuant to this Letter Agreement such taxes as are, in the reasonable opinion of the Company, required to be withheld with respect to such payment, as well as any other deductions required by law, such as those made in order to comply with any court or administratively ordered wage garnishments. No amounts paid to you pursuant to this Letter Agreement will be considered when determining your benefits under the Company's other benefit plans (e.g., 401(k) plan, defined benefit pension plan, etc.).

2. Outplacement Services. If you separate under the PTP in accordance with the terms of this Letter Agreement, the Company will make outplacement services available to you for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

3. Benefits after Separation. Following your Separation Date, you will not be entitled to any other benefits or compensation from the Company, any of its affiliates or any of their respective benefit plans or arrangements, other than as expressly set forth below:

    a. Base Salary and Vacation Pay. Within 30 days of your Separation Date, the Company agrees to pay you your base salary for services through the Separation Date and for all of your unused, accrued vacation for the calendar year in which your Separation Date occurs.

b. Retirement Benefits. Your rights with respect to retirement benefits will be determined pursuant to the terms of the Duke Energy Retirement Savings Plan and/or the Duke Energy Retirement Cash Balance Plan, each as amended from time to time.

c. Welfare Benefits. Your rights with respect to welfare benefits (e.g., COBRA and/or retiree healthcare coverage) will be determined pursuant to the terms of the Duke Energy Active Health & Welfare Benefit (Financed) Plans, the Duke Energy Active Health & Welfare Benefit Plans, the Duke Energy Retiree Health & Welfare Benefit (Financed) Plans and the Duke Energy Retiree Health & Welfare Benefit Plans, each as amended from time to time.

Nothing herein shall modify or otherwise affect such benefit plans or arrangements.

I. Election

Please select from the following:

☐ I would like to proceed with the PIP. I have discussed the PIP with my management and I understand the expectations as described in the PIP. I understand that the intent of the PIP is to assist me with being successful in my current position; however, if my performance does not improve and does not result in sustained acceptable performance, management will determine the appropriate corrective action, up to and including termination of my employment at any time during or following the PIP. I also acknowledge that I will not be eligible for a transition payment if I am not successful on the PIP.

☐ I would like to separate under the PTP. I understand this will result in my separation from employment with [INSERT APPLICABLE PAYROLL COMPANY] and its affiliates on the Separation Date specified above and that this election is irrevocable. This election is entirely voluntary.

_____ _____
(Employee's signature) (Date)

_____ _____
(Supervisor's signature) (Date)

Note: Please return completed forms to the HRBP by [INSERT DATE].

SAMPLE WAIVER AND RELEASE OF CLAIMS

UNDER THE DUKE ENERGY PERFORMANCE TRANSITION PROGRAM

This Waiver and Release of Claims (the "Agreement"), delivered on **Date,** is entered into by and between Duke Energy Corporation and its subsidiaries and affiliates and any predecessors and successors thereto (individually and collectively referred to as the "Company"), and **Name.** ("Employee") pursuant to the Performance Transition Program (the "Program") with the mutual exchange of promises as consideration.

WHEREAS, Employee is eligible to separate from employment on **Termination Date** (the "Separation Date") and receive severance benefits described below provided Employee enters into and does not revoke this Agreement; and

WHEREAS, the Company is willing to provide the Employee the severance benefits described below, provided Employee enters into and does not revoke this Agreement.

THEREFORE, the Company and Employee agree as follows:

1. Program Benefits. In exchange for Employee separating from employment with the Company on his or her Separation Date in accordance with the Program and entering into and not revoking this Agreement, the Company agrees to provide the Employee the following:

   a. Transition Payment. A lump sum cash payment equal to **Lump Sum**, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Agreement.

   b. Health Care Supplement. A lump sum cash payment equal to **COBRA amount**, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Agreement.

   c. Outplacement Services. Outplacement services for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy.

2. Basis for Entitlement. Employee acknowledges and agrees that Employee would not be entitled to the benefits described in Paragraph 1 absent Employee's separation from employment on his or her Separation Date and execution and non-revocation of this Agreement in accordance with the Program. Employee further acknowledges that he or she is not entitled to a pension enhancement under the Program.

3. Adequate Consideration. Employee acknowledges and agrees that this Agreement provides good, valuable and sufficient consideration for Employee's obligations under this Agreement.

4. Release by Employee. Employee, of the Employee's own free will, voluntarily waives and releases the Company, its employee benefit, pension, welfare, and other plans or programs (including any and all fiduciaries thereof), and any of the Company's respective current or former officers, directors, agents, employees, attorneys, insurers, plan administrators, predecessors, successors or assigns from any and all rights or claims that Employee has, or

may have, as of the date of the execution of this Agreement, based on or arising out of the employment relationship or the termination of the employment relationship, other than those rights or claims set forth below in Paragraph 5. The rights and claims so waived and released shall include, but not be limited to:

a. Those arising under any federal, state or local statute, ordinance, common law (including, but not limited to, claims of breach of promise, breach of contract, promissory estoppel, intentional or negligent infliction of emotional distress, defamation, tortious interference with a business relationship or contract and wrongful discharge), or claims in equity or public policy; and
b. Those arising under any law based on any protected status or employment, including but not limited to, sex, age, race, color, religion, handicap or disability, national origin, pregnancy, discrimination, retaliation, or whistleblower (including, but not limited to, any rights or claims arising under Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1991, the Americans with Disabilities Act, the Rehabilitation Act, the Older Workers Benefits Protection Act of 1990, the Equal Pay Act of 1963, the Employee Retirement Income Security Act of 1974, the Age Discrimination in Employment Act of 1967, the Family and Medical Leave Act, the Genetic Information Nondiscrimination Act, the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Indiana Discrimination on Account of Age Act, the Indiana Civil Rights Statute, the Kentucky Civil Rights Statute, the Ohio Civil Rights Statute, the North Carolina Equal Employment Practices Act, the North Carolina Persons with Disabilities Protection Act, the North Carolina Retaliatory Employment Discrimination Act, the South Carolina Human Affairs Law, the Florida Civil Rights Act, the Florida Whistleblower Act, the Texas Labor Code Chapter 21, the Tennessee Human Rights Act, and every other local, state, or federal law, regulation, or other legal authority concerning employment rights or claims); and
c. Those arising under the civil rights laws of any state or municipality; and
d. Any claim for compensatory damages, punitive damages, attorneys' fees, expenses and litigation costs; and
e. Any grievance, charge or other claim arising under the applicable collective bargaining agreement, National Labor Relations Act, or other similar labor laws, regulations, and authority.

Employee acknowledges that he or she has been paid for all hours worked during his or her employment with the Company and has received all other payments owed to him or her by the Company as of his or her Separation Date. In addition, Employee acknowledges that he or she has received all leave to which he or she may have been entitled to under the Family and Medical Leave Act or applicable state law during his or her employment with the Company.

5. Claims Not Waived. Notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release any workers' compensation or unemployment compensation claims filed prior to the date of execution of this Agreement, or claims against the Company arising out of possible exposure to asbestos during Employee's employment with the Company at a facility or facilities owned by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release Employee's rights or claims to accrued or vested benefits under an employee benefit plan or program maintained by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release claims that may arise after the date of execution of this Agreement, including, but not limited to, claims that may arise under an employee benefit plan or program maintained by the Company.

6. Acknowledgement of Reporting and Compliance. Employee acknowledges and agrees that it is the policy of the Company to comply with all applicable federal, state and local laws and regulations. Employee affirms that he or she has reported all compliance issues and violations of federal, state and local law or regulation or Company policy of which he or she had knowledge during the term of his or her employment, if any. Employee represents and acknowledges that he or she has no further or additional knowledge or information regarding compliance issues or possible violations of federal, state or local law or regulations or Company policy other than what Employee may have previously reported, if any, including, but not limited to, any and all outstanding nuclear safety concerns Employee has involving any nuclear power plant owned or operated by the Company. Nothing in this Agreement shall be construed to prohibit, restrict or otherwise discourage Employee from participating in "protected activity" as defined in 10 CFR 50.7 and Section 211 of the Energy Reorganization Act of 1974, including, but not limited to reporting any suspected instance of illegal activity of any nature, any nuclear safety concern, any workplace safety concern, any public safety concern, or any other matter within the United States Nuclear Regulatory Commission's ("NRC") regulatory responsibilities to the NRC, the United States Department of Labor, or any other federal or state governmental agency. This Agreement further does not prohibit Employee from participating in any way in any state or federal administrative, judicial, or legislative proceeding or investigation.

7. Promise Not to Sue. Employee agrees not to institute a lawsuit against the Company asserting any of the claims that are released in Paragraph 4 of this Agreement. **Employee acknowledges that signing this Agreement means that Employee has waived not only his or her right to recover in a lawsuit, claim or other action brought by him or her as described herein, but also in any claim, lawsuit or other action brought on his or her behalf (including any claim of age discrimination) against the Company based on or arising out of the employment relationship or the termination of the employment relationship up to the date this Agreement is signed. This does not mean that Employee is precluded from filing a charge of discrimination with the Equal Employment Opportunity Commission ("EEOC"), or other state commission or otherwise participating in proceedings before the EEOC or those commissions; however, if Employee does file such a charge, he or she shall be entitled to no monies, pay, compensation or relief of any type from the Company as a result of the charge.**

8. Confidentiality. Employee shall not, at any time, directly or indirectly, use any trade secrets or confidential information of the Company for Employee's benefit or the benefit of any other person or, directly or indirectly, disclose any such trade secrets or confidential information of the Company to any other person. Employee acknowledges that the Program Benefits described in Paragraph 1 of this Agreement are not subject to this confidentiality provision. The Company and Employee agree to keep the terms and conditions of this Agreement confidential except to the extent the terms and conditions are required to be disclosed by any judicial or administrative federal, state or local agency. Employee may also disclose the terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality.

9. Cooperation with Litigation. Upon the Company's request, Employee agrees to render reasonable assistance to the Company in connection with any litigation or investigation relating to the Company's business. Such assistance shall include, but not be limited to, providing information, attending meetings, assisting with discovery, giving depositions and making court appearances. Employee agrees to promptly notify the Chief Legal Officer of the Company of any requests for information or testimony that Employee receives in connection with any litigation or investigation relating to the Company's business; provided however, that this reporting requirement will not apply in the context of "protected activity", as defined in Paragraph 6 of this Agreement.

10. Consultation with Attorney Advised. **Employee is advised to consult with an attorney prior to executing this Agreement.** Employee acknowledges being given that advice. Employee represents that he or she has read and fully understands all of the provisions of this Agreement. Employee represents that he or she is voluntarily signing this Agreement.

11. Due Care - Time Frame for Acceptance. **Employee acknowledges that he or she has received a copy of this Agreement and has been given a period of twenty-one (21) days from his or her Separation Date within which to freely and voluntarily consider and sign this Agreement.**
    a. To enter into this Agreement, Employee must execute it by signing, dating and returning it to the **Employee Relations Control Center, Attn: Lindsay Walles, 525 S. Tryon St, DEP 14B, Charlotte, North Carolina 28202**.
    b. Employee acknowledges that if Employee has signed this Agreement it is because Employee freely and voluntarily chose to do so.
    c. Employee has **seven (7) calendar days** after he or she signs this Agreement within which to revoke it. To be effective, a revocation must be communicated in writing to the **Employee Relations Control Center, Attn: Lindsay Walles, 525 S. Tryon St., DEP 14B, Charlotte, North Carolina 28210**, and delivered no later than 5:00 p.m. Eastern Time on the final day of the seven (7) day period.

12. Governing Law. This Agreement shall be interpreted, enforced and governed under the laws of the State of North Carolina.

13. No Admission of Liability. This Agreement shall not in any way be construed as evidence or as an admission of any liability or wrongdoing by the Company.

14. Binding Effect of Agreement. This Agreement will be binding upon and shall operate for the benefit of the heirs, executors, administrators, assigns, and successors in interest of Employee and the Company.

15. Severability. If any portion of this Agreement should be unenforceable for any reason, the parties agree that the remaining portions will continue in effect.

16. Effective Date. This Agreement shall become effective and enforceable upon the expiration of the revocation period established in Paragraph 11 (the “Effective Date”).

AGREED TO BY:

_____ _____
Employee Date

THE COMPANY

By: _____ _____
Jay Alvaro Date
VP, Employee and Labor Relations

Management Toolkit

Duke Energy
Retirement Transition Program (RTP)

Nov. 2015, Rev. Feb. 2016, Oct. 2016, March 2017, March 2022

This document contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans nor your plan participation will be considered a contract for future employment.

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RETIREMENT TRANSITION PROGRAM (RTP)

Purpose and Overview

As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or knowledge who are eligible to retire (i.e., more than 55 years old with at least 10 years of service) to address the potential risk of losing their critical skills or knowledge. In many instances, knowledge transfer plan(s) are incomplete or clear successors may not be identified or known for those employees.

The Retirement Transition Program (RTP) is an optional retention program designed to retain, for a specified period of time, certain employees with critical skills to ensure knowledge transfer in an orderly manner before retirement. It also provides the Company with the ability to have clarity around an employee's retirement date for planning purposes. The RTP is not a severance program, but is designed to be management-initiated, although participation in the RTP is based on mutual agreement between management and the employee.

This Management Toolkit provides an overview of the process to help facilitate the identification and review of employees with critical skills or knowledge and also help managers with planning for the future. "Retirement-eligible" refers to an employee who is at least 55 years old with 10 years of service. "Critical skills" generally refers to those skills essential for continued operations and not replaceable without significant notice or transition time. Additional detail is provided on the "Definitions" page of this Toolkit.

Program Phases

Phase	Description	Objective
1	Identify risk of losing retirement-eligible employees with critical skills via manager script for a 1-on-1 meeting or through use of a survey.	Determine critical skilled employees' intent and timing for retirement. The same information is designed to be obtained regardless of whether the employee takes the survey or the manager meets with them one-on-one.
2	Gather additional information from employees identified in Phase 1 performing a critical role using a manager script.	Gather more specific information from employees performing critical roles who have shared an intent to retire, and begin discussing a knowledge transfer plan. Determine if knowledge transfer plan can be implemented through business-as-usual or if employee's retirement plans creates a business risk.
3	Obtain approvals and conduct a follow-up meeting with the employee to present options **if** knowledge transfer plan is not yet developed and/or no clear successor is identified (*e.g., cannot transition business-as-usual*).	Obtain approvals (*by the business unit Senior Management Committee member and HRBP Director*), and meet with employee to present options for retaining the employee.

It is important to note that although there are three potential phases in the RTP process, situations may vary and it may not be necessary to go through all three phases. For example, if the business decides not to do the survey in Phase 1, and they have already identified their retirement eligible employees performing critical roles, then they may go straight to Phase 2 to gather more detailed information before determining whether to utilize the RTP for certain employees.

Phase 1 and 2 are only for gathering information to help in management discussion with the HR Business Partner to determine next steps. This will ensure consistent administration of the RTP and allow time for necessary approvals prior to presenting any RTP options as described in Phase 3.

Prior to embarking on Phase 3 of the RTP process, managers should work with their HR Business Partner to determine if their employee would be eligible for possible transition benefits or reduced schedule with premium pay. Eligibility for the RTP must be approved by the business unit Senior Management Committee member and HRBP Director.

In situations where the RTP option is presented to a designated employee, the HRBP should provide the relevant information to the ER Control Center (Severance @duke-energy.com) for purposes of tracking and administration. Updated information should be provided to the ER Control Center once the employee declines or accepts the RTP option. This will permit us to track and report RTP letter agreements and signed waivers, and ensure timely administration of payments and other benefits.

Program Options

There are two options within the RTP. Eligible employees who meet all program requirements have the opportunity to either receive transition benefits upon retirement, or to participate in a reduced work schedule with premium pay and a separation bonus, as described below.

Option 1: Transition Benefits

1. Transition Payments. The Transition Payments will consist of the following:

    a. Transition Bonus. The amount of the Transition Bonus depends on the length of time the employee remains employed with the Company (called the “Transition Period”) under the terms of the RTP Program. The Transition Bonus will be (i) equal the sum of two weeks of regular base pay for each full month of the Transition Period, but never less than 6 weeks, or more than 48 weeks, of the employee’s final rate of regular base pay, and (ii) provided as a lump sum payment.

    b. Health Care Supplement. The Health Care Supplement will be (i) equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion, and (ii) provided as a lump sum payment.

2. Outplacement. The Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

3. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

Option 2: Reduced Work Schedule

1. Premium Pay: During the time an eligible employee remains employed in a reduced work schedule under the RTP, the employee will receive his or her regular base wages/ salary reduced proportionately based on their reduced hours, plus a "Salary Premium" equivalent to 50% of their newly calculated regular base wages/ salary.

   The work schedule will be determined by mutual agreement between the eligible employee and his or her manager. Hours worked on a weekly basis will be tracked by the employee and monitored by the manager to ensure the work schedule is consistent with the reduced schedule. For example, the employee and manager may agree that in certain weeks the employee may work more hours than the schedule provides, as long as the employee reduces hours worked in a subsequent week.

2. Separation Bonus. In addition, eligible employees on a reduced work schedule who meet all program requirements will receive a Separation Bonus, in the form of a lump cash payment equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion, provided as a lump sum payment

3. Outplacement. In addition to the opportunity to earn the Separation Bonus, the Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

4. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

General Provisions

1. Approvals Required. Eligibility must be approved by the Senior Management Committee member and business unit HRBP Director. The RTP is management initiated, but based on mutual agreement regarding the employee's participation in the program, the transition period and the retirement date.

2. Relationship to other Benefits. The benefits of RTP participants will be determined based on their compensation and work schedule as in effect from time to time under the terms of

the applicable plans. For example, employees participating in the reduced schedule option under the RTP will be treated as part-time employees. The annual base salary of an employee on a reduced work schedule will be his or her regular base wages/salary in effect immediately prior to the commencement of the reduced work schedule, reduced proportionately based on his or her reduced hours (i.e., if his or her hours are reduced by 50%, his or her regular base wages/salary will be reduced by 50%) for purposes of determining his or her benefits under the Company's benefit plans and programs, including, but not limited to, the Company's life, accidental death & dismemberment, business travel accident and long-term disability insurance plans. Any unused, accrued vacation provided to a RTP participant who participated in the reduced schedule option under the RTP upon separation in accordance with the RTP will be based on the RTP participant's annual base salary in effect immediately prior to the commencement of the Transition Period.

The 401(k) and pension benefits of RTP participants will be determined pursuant to the applicable plan documents based on the amount of compensation the RTP participants actually receive, and neither the Transition Payments nor Separation Bonus, as applicable, will be considered eligible or credited compensation, and, therefore, these items will not be taken into consideration when determining benefits under the 401(k) and pension plans. For purposes of the reduced work schedule option above, Salary Premium Pay will be considered eligible or credited compensation, and, therefore will be taken into consideration when determining the RTP participant's benefits under the 401(k) and pension plans, in accordance with applicable plan documents, which are subject to change. Solely for purposes determining their rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, RTP participants will be treated as having been separated without cause.

3. Changes in Employment.

   (i) If Employment Ends During the Transition Period. If the employment of an eligible employee with the Company ends before the end of the Transition Period due to voluntary resignation or involuntary termination by the Company with cause, RTP Program benefits will not be provided. If, however, the Company terminates the employee involuntarily without cause or due to changing business conditions, the employee will be eligible to receive severance benefits under the Company's applicable severance plan in lieu of any RTP benefits.

   (ii) If an Authorized Leave is Taken During the Transition Period. Eligible employees remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, the Company may determine that the Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

   (iii) If an RTP Participant Obtains Another Internal Position. If a RTP participant accepts another internal position with the Company before separating in accordance with the RTP , Program benefits will not be provided.

4. Timing of Payment; No Severance Benefits Available. If eligible employees meet the conditions for earning the Transition Payments or the Separation Bonus, as described above, the applicable payment(s) (less applicable taxes) will be provided in a cash

payment(s) as soon as administratively practicable (not more than 60 days) after termination of employment. Please note that if payment of the Transition Payments or Separation Bonus are/is received, the employee will not be considered eligible for any benefits under any applicable severance plan that otherwise covers the employee.

RTP FORMS

PHASE 1: Manager Script for 1-on-1 Meeting (In Lieu of Survey) to Identify Risk of Losing Retirement-Eligible Employees with Critical Skills

A survey can be conducted to determine the risk of losing employees with critical skills or knowledge who are eligible to retire (e.g., at least 55 years old with 10 years of service). In lieu of a survey, this script/ form can be used to gather information from retirement-eligible employees. The completed form should be returned to your HR Business Partner.

Employee ID: _____ **Employee Name:** _____

Date: _____ **Employee Job Title:** _____

Department: _____

Background

As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or knowledge who are eligible to retire. Some of these employees do not have clear successors, and also may not have plans in place to ensure knowledge transfer in an orderly manner before they leave.

A survey or in person meeting is being conducted for certain retirement-eligible employees in our group to assess their intent and timing on their departure.

Introduction

Use the information below as talking points during the meeting with your employee. Once you have the information, please return this document to your HR Business Partner.

- As part of our workforce planning, this survey is being conducted to help identify the unique knowledge and skills of employees eligible to retire that may be lost to the Company if not transitioned properly. Please be assured that the information provided will be used solely for knowledge transfer purposes, if and when needed.

- I value your contributions and would like your input in our workforce planning process. I have a few questions I would like to ask you, which will help in this process.

What do you believe are the top three areas of your role that require knowledge transfer?

1.
2.
3.

How long do you believe it would take to transfer this knowledge to others?

	Less than 6 months
	6 to 12 months
	12 to 18 months
	18 to 24 months
	Greater than 24 months

If you are anticipating retirement, how long do you plan to continue working for the company?

	Less than 6 year
	6–12 months
	12-18 months
	18-24 months
	> 24 months
	I'm thinking about retirement but not sure about the timeframe

If asked, would you consider staying at the Company for a longer time period to help with knowledge transfer? If yes, would you be willing to stay?

	Less than 1 year
	1 year
	2 years or more

I would like to thank you for being candid with me about your intentions over the next several years. This has been very helpful as we continue to work on our workforce planning.

RTP FORMS

PHASE 2: Management Script for Meeting to Gather Information from Retirement Eligible Employees with Critical Skills

This script is used to gather specific information from retirement-eligible employees who have been identified as having critical skills and knowledge for purposes of workforce planning and to evaluate potential eligibility for the RTP.

Background

As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or knowledge who are eligible to retire. Some of these employees do not have clear successors, and also may not have plans in place to ensure knowledge transfer in an orderly manner before they leave.

This script should be used to meet with retirement eligible employees who have been identified as having critical skills and knowledge (e.g., essential for continued operations and not replaceable without significant notice). The objectives of the meeting are to:

(1) Help facilitate discussion in order to allow efficient knowledge transfer and/or the advancement of highly engaged employees;
(2) Gain a better understanding of an employee's retirement intentions
(3) Assist in determining potential eligibility for the Retirement Transition Program (RTP)

Introduction

Use the information below as talking points during the meeting with your employee.

- As part of our workforce planning efforts, the Company is seeking to identify employees with critical skills or unique knowledge who are eligible to retire. Some of these employees don't have a clear successor and we're concerned about the impact of ineffective knowledge transfer if we have to endure a sudden retirement.

- You have been identified as having critical skills and being eligible to retire.

  (Manager can add more details here about the nature of those critical skills as appropriate.)

- I value your contributions and would like your input in our workforce planning process. The goal here is to identify options for effective knowledge transfer for certain employees like yourself that may be planning to leave the Company.

- I was hoping you could share with me what your current thinking is around your future here at Duke.

  - Let's talk about your critical skills and how you think we may need to approach knowledge transfer.

  - Can you provide me with additional details on your employment status within the next two years? *(If the employee has critical knowledge but not likely to retire within next 2*

years, no Retirement Transition Program (RTP) is offered, consider the development of a knowledge transfer plan)

- If you do not anticipate changes in your employment status at this time, would you be willing to provide us with notice if you do decide to make a change and, if so, how much?

Based on the answers to the questions above, consider whether there is time to capture knowledge and transfer skills with a business as usual approach, or whether eligibility might be appropriate for the Retirement Transition Program (e.g. transition payment, reduced work schedule, etc.). Refer to table below.

Potential additional talking points may include:

- If retirement likely in the next six months
  - Would you consider staying longer to complete knowledge transfer?
  - Would you want to consider a reduced work schedule to transition into retirement?
  - Let's discuss developing a knowledge transfer plan.
- Retirement likely in the next 12 months
  - Would you want to consider a reduced work schedule to transition into retirement?
  - Let's discuss developing a knowledge transfer plan.
- Retirement likely in the next 24 months
  - Would you want to consider a reduced work schedule to transition into retirement?
  - Let's discuss developing a knowledge transfer plan

Do you think there is anything else I need to know in planning for the future of this work that you perform?

I would like to thank you for being candid with me about your career intentions. This has been very helpful as we continue to work on our workforce planning.

RTP FORMS

PHASE 3: Management Script for Meeting with Employees Eligible for the RTP

Background

Prior to any offers or discussions with the Employee, approval of eligibility for the RTP should be obtained from the Senior Management Committee (SMC) member or designee and HRBP Director.

Use this script to discuss the Retirement Transition Program if you have an employee identified as having critical skills or knowledge who is planning to leave relatively shortly and needs to be retained for purposes of knowledge transfer, which cannot be handled in a business-as-usual manner.

During this conversation, be prepared to present the employee with the following documents:

1. *Retirement Transition Program (RTP) Overview*

2. *RTP Letter Agreement- for either a Transition Benefits or Reduced Schedule Option*

3. *Sample of the Waiver and Release Form*

*The employee **must** voluntarily agree to sign and return the Letter Agreement in order to enter the RTP Program. The Waiver and Release form should not be signed until after the employee's release date if the employee wants to participate.*

Introduction

Use the information below as talking points during the meeting with your employee.

- As you know from our prior discussions, you have been identified as having critical skills and knowledge and you have indicated an intent to retire in the relatively near future. *(Manager can add more details here about the nature of those critical skills as appropriate.)*

- I'd like for you to consider whether you are willing to work with me on an agreement to transfer your knowledge before you retire.

- Toward that end, I would like to discuss the Retirement Transition Program options with you and offer you the opportunity to participate in this program. This is a voluntary program that offers two options to choose from: (1) Transition Benefits at the end of employment; or (2) Reduced Work Schedule with Premium Pay and Separation Bonus. Under both options, we would agree on a firm retirement date so we will have certainty around the timing of your transition.

- I'm giving you an **RTP Letter Agreemen**t for you to review and consider. If you are interested in participating in the RTP, please sign and return the Letter Agreement to me. I'm sure you will need time to read and think about this, so let's plan to meet again in a few days to continue this discussion.

- Let me emphasize that participation in the RTP is voluntary, and based on mutual agreement.

- I appreciate your consideration of the RTP option, and I look forward to working through these issues with you.

- If you have any questions, please let me know or feel free to contact our HR Business Partner.

Definitions

Critical Role: The following chart is used during the knowledge risk phase to classify the level of knowledge loss risk associated with strategic/critical positions.

Value	Definition	Criteria
High	Very difficult to replace	1. Critical and unique knowledge and skills 2. Mission critical knowledge and skills with limited duplication and documentation 3. Duke Energy specific knowledge 4. Key contact for strategic relationships that are difficult to establish 5. Requires at least 2-4 years of core training and experience 6. Critical knowledge that is unique to one employee and generally requires 5+ years of core training or experience 7. No replacements readily available
Medium	Difficult to replace	1. Important knowledge and skills 2. Documentation exists or other employees possess similar knowledge and skills 3. Key contact for relationships that can be transferred orderly 4. Replacements generally available and can be trained within 1-2 years
Low	Easy to replace	1. Possess procedural or non-mission critical knowledge and skills or common knowledge and skills 2. Up to date documentation exists 3. Training programs are current and effective and can be completed in less than 1 year 4. External hires possessing the knowledge and skills are readily available and require minimal training

FORMS

Retirement Transition Program (RTP) Overview

The Retirement Transition Program (RTP) is a voluntary program designed to facilitate business continuity and work transition when employees designated by management as having critical skills plan to leave the Company without a clear successor or existing knowledge transfer plan.

Eligible employees who decide to voluntarily participate and meet all program requirements have the opportunity to either receive transition benefits, or to participate in a reduced work schedule with premium pay and a separation bonus, as described below.

Option 1: Transition Benefits

1. Transition Payments. The Transition Payments will include of the following:

    a. Transition Bonus. The amount of the Transition Bonus depends on the length of time the employee remains employed with the Company (called the "Transition Period") under the terms of the RTP Program. The Transition Bonus will be (i) equal the sum of two weeks of regular base pay for each full month of the Transition Period, but never less than 6 weeks, or more than 48 weeks, of the employee's final rate of regular base pay, and (ii) provided as a lump sum payment.

    b. Health Care Supplement. The Health Care Supplement will be (i) equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion, and (ii) provided as a lump sum payment.

2. Outplacement. The Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

3. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

Option 2: Reduced Work Schedule

1. Premium Pay. During the time an eligible employee remains employed in a reduced work schedule under the RTP, the employee will receive his or her regular base wages/ salary reduced proportionately based on their reduced hours, plus a "Salary Premium" equivalent to 50% of their newly calculated regular base wages/ salary.

    The work schedule will be determined by mutual agreement between the eligible employee and his or her manager. Hours worked on a weekly basis will be tracked and monitored to ensure the work schedule is consistent with the reduced schedule. For example, the employee and manager may agree that in certain weeks the employee may work more

hours than the schedule provides, as long as the employee reduces hours worked in a subsequent week.

2. Separation Bonus. In addition, eligible employees on a reduced work schedule who meet all program requirements will receive a Separation Bonus, in the form of a lump cash payment equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which the employee and his or her eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates, as determined by the Company, in its sole discretion.

3. Outplacement. In addition to the opportunity to earn the Separation Bonus, the Company will make outplacement services available to eligible employees for a period of up to six months through a vendor selected by the Company, in accordance with our policies as in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

4. Conditions to Payment. To earn the RTP Program benefits, eligible employees must remain employed and in good standing with us through the end of the Transition Period, and sign and not revoke a valid Waiver and Release of Claims as required by the Company.

General Provisions

1. Relationship to other Benefits. The benefits of RTP participants will be determined based on their compensation and work schedule as in effect from time to time under the terms of the Company's applicable plans. For example, employees participating in the reduced schedule option under the RTP will be treated as part-time employees. The annual base salary of an employee on a reduced work schedule will be his or her regular base wages/salary in effect immediately prior to the commencement of the reduced work schedule, reduced proportionately based on his or her reduced hours (i.e., if his or her hours are reduced by 50%, his or her regular base wages/salary will be reduced by 50%) for purposes of determining his or her benefits under the Company's benefit plans and programs, including, but not limited to, the Company's life, accidental death & dismemberment, business travel accident and long-term disability insurance plans. Any unused, accrued vacation provided to a RTP participant who participated in the reduced schedule option under the RTP upon separation in accordance with the RTP will be based on the RTP participant's annual base salary in effect immediately prior to the commencement of the Transition Period.

   The 401(k) and pension benefits of RTP participants will be determined pursuant to the applicable plan documents based on the amount of compensation the RTP participants actually receive, and neither the Transition Payments nor Separation Bonus, as applicable, will be considered eligible or credited compensation, and, therefore, these items will not be taken into consideration when determining benefits under the 401(k) and pension plans. For purposes of the reduced work schedule option above, Salary Premium Pay will be considered eligible or credited compensation, and, therefore will be taken into consideration when determining the RTP participant's benefits under the 401(k) and pension plans, in accordance with applicable plan documents, which are subject to change. Solely for purposes determining their rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, RTP participants will be treated as having been separated without cause.

2. Changes in Employment. If the employment of an eligible employee with the Company ends before the end of the Transition Period due to voluntary resignation or involuntary termination by the Company with cause, RTP Program benefits will not be provided. Similarly, if a RTP participant accepts another position with the Company before separating in accordance with the RTP, RTP Program benefits will not be provided. If, however, the Company terminates the employee involuntarily without cause or due to changing business conditions, the employee will be eligible to receive severance benefits under the Company's applicable severance plan in lieu of RTP benefits. Eligible employees remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, the Company may determine that the Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

3. Timing of Payment; No Severance Benefits. If eligible employees meet the conditions for earning the Transition Payments or Separation Bonus, as described above, the applicable payment(s) (less applicable taxes) will be provided in a cash payment(s) as soon as administratively practicable (not more than 60 days) after termination of employment. Please note that payment of the Transition Benefits or Separation Bonus will be in lieu of and, the employee will not be considered eligible for any benefits under any applicable severance plan that otherwise covers the employee.

[On Duke Energy Letterhead- **To be completed by the Severance Control Center**]

[Date]

Re: Retirement Transition Program -- Transition Benefits Opportunity

Dear Participant:

Duke Energy ("we" or "us") is offering you the opportunity to voluntarily participate in our Retirement Transition Program (the "Program"), in order to encourage business continuity, work transition and knowledge transfer as you near the end of your career with us.

If you agree to participate in the Program, you will have an opportunity to earn special compensation awards -- called "Transition Benefits" – provided you remain employed in good standing with us for a "Transition Period" described below and otherwise meet the conditions described in this letter. The following describes the Transition Benefits opportunity:

1. Transition Period. Your Transition Period will begin on [starting date] and end on [ending date]. We may in our sole discretion shorten the Transition Period or, subject to your agreement, extend it. Your employment with us will end on the last day of the Transition Period, unless we mutually agree otherwise.

2. Transition Payments.

    a. Transition Bonus. The amount of the Transition Bonus depends on the length of your Transition Period. The Transition Bonus will be (i) equal the sum of two weeks of regular base pay for each full month of the Transition Period, but never less than 6 weeks, or more than 48 weeks, of your final rate of regular base pay, and (ii) provided as a lump sum payment.

    b. Health Care Supplement. The Health Care Supplement will be (i) equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which you and your eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by Duke Energy in its sole discretion, and (ii) provided as a lump sum payment.

3. Other Transition Benefits. In addition to the opportunity to earn the Transition Payments, we will make outplacement services available to you for a period of up to six months through a vendor selected by us, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

4. Conditions to Payment. To earn the Transition Benefits described above, you must meet each of the following conditions:

    a. You must remain employed in your current position and in good standing with us through the end of the Transition Period.

    b. As of the date of your termination of employment with us at the end of the Transition Period, you must sign a waiver of claims within 45 days after your termination of employment and not revoke such waiver within 7 days after its execution. The form

of the waiver will be based on our standard form used at the time of your termination. The current form is attached to this letter as Exhibit A.

5. Relationship to other Benefits. Solely for purposes determining your rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, you will be treated as having been separated without cause.

6. Changes in Employment. If your employment with Duke Energy ends before the end of the Transition Period due to voluntary resignation or involuntary termination by Duke Energy with cause, RTP Program benefits will not be provided. Similarly, if you accept another position with Duke Energy before separating in accordance with the RTP, RTP Program benefits will not be provided. If, however, Duke Energy terminates your employment involuntarily without cause, you will be eligible to receive severance benefits under Duke Energy's generally applicable severance plan for involuntary severances of similarly-situated employees in lieu of RTP Program benefits. You will remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, Duke Energy may determine that your Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

7. Timing of Payment; No Severance Benefits. If you meet the conditions to earn the Transition Payments, as described above, you will be paid the Transition Payments (less applicable taxes) in a cash payment(s) as soon as administratively practicable (not more than 60 days) after your termination of employment. Please note that if you receive payment of the Transition Benefits, you will not be considered eligible for any benefits under any applicable severance plan that otherwise covers you.

To be eligible to receive the RTP Program benefits, please sign and date a copy of this letter and return it to our HR Business Partner, [insert name] by no later than [date]. Of course, you also are free to choose not to participate in the RTP.

This letter in all events will govern and control your rights with respect to the Transition Benefits and may be changed or modified only in writing signed by both parties. See Exhibit B for certain additional terms and conditions. If you have any questions, please contact our HR Business Partner.

Sincerely,

[Supervisor Name and Title]

Accepted and Agreed To:

By:_____

Print Name:_____

Date:_____

[On Duke Energy Letterhead **To be completed by the Severance Control Center**]

[Date]

Re: Retirement Transition Program -- Reduced Work Schedule and Separation Bonus Opportunity

Dear Participant:

Duke Energy ("we" or "us") is offering you the opportunity to voluntarily participate in our Retirement Transition Program (the "Program"), in order to encourage business continuity, work transition and knowledge transfer as you near the end of your career with us.

If you agree to participate in the Program, you will provide services to us on a reduced work schedule for a "Transition Period" with your base wage/ salary adjusted and increased by a 50% "premium" as described below. In addition, you will have an opportunity to earn a special compensation award -- called a "Separation Bonus" -- if you remain employed in good standing with us for the Transition Period and otherwise meet the conditions described in this letter. The following describes these Program benefits:

1. Transition Period. Your Transition Period will begin on [starting date] and end on [ending date]. We may in our sole discretion shorten the Transition Period or, subject to your agreement, extend it. Your employment with us will end on the last day of the Transition Period, unless we mutually agree otherwise.

2. Reduced Work Schedule and Salary Premium. During the Transition Period, your work schedule will be at [___%] of your regular work schedule, which equates to [___] hours per week or [____] hours per month.[1] We will track your hours worked on a weekly basis, and you and your manager will coordinate to ensure that your work schedule is consistent with this reduced schedule. For example, you and your manager may agree that in certain weeks you may work more hours than the schedule above provides, as long as you reduce your work schedule accordingly in a subsequent week or weeks.

   In exchange for your agreement to work on a reduced schedule, you will receive your regular base wages/ salary reduced proportionately based on your reduced hours, plus a "Salary Premium" equivalent to 50% of your newly calculated regular base wages/ salary.

3. Amount of Separation Bonus. Your Separation Bonus will be a lump cash payment equal to the premium cost of six months of COBRA continuation coverage under the Duke Energy sponsored medical, dental and/or vision coverage, if any, in which you and your eligible dependents are enrolled as of the last day of the Transition Period, plus a tax gross up based on applicable rates as determined by Duke Energy in its sole discretion, provided as a lump sum payment

4. Other Program Benefits. In addition, we will make outplacement services available to you for a period of up to six months through a vendor selected by us, in accordance with our policies in effect from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

[1] These blanks should be filled in by the Severance Control Center based depending on the employee's individual circumstances.

5. Conditions to Payment. To earn the RTP Program benefits described above, you must meet each of the following conditions:

    a. You must remain employed in your current position and in good standing with us through the end of the Transition Period.

    b. As of the date of your termination of employment with us at the end of the Transition Period, you must sign a waiver of claims within 45 days after you receive the waiver of claims and not revoke such waiver within 7 days after its execution. The form of the waiver will be based on our standard form, and will be provided no later than your date of separation. The current form is attached to this letter as Exhibit A.

6. Relationship to other Benefits. During the Transition Period, your benefits will be determined based on your compensation and work schedule as in effect from time to time under the terms of Duke Energy's applicable plans. For example, in light of your reduced work schedule, you will be treated as part-time employee. Your annual base salary will be your regular base wages/salary in effect immediately prior to the commencement of the reduced work schedule, reduced proportionately based on your reduced hours (i.e., if your hours are reduced by 50%, your regular base wages/salary will be reduced by 50%) for purposes of determining your benefits under Duke Energy's benefit plans and programs, including, but not limited to, Duke Energy's life, accidental death & dismemberment, business travel accident and long-term disability insurance plans. Any unused, accrued vacation provided to you upon separation in accordance with the RTP will be based on your annual base salary in effect immediately prior to the commencement of the Transition Period. Your 401(k) and pension benefits will be determined pursuant to the applicable plan documents based on the amount of compensation you actually receive, and the Separation Bonus will not be considered eligible or credited compensation and will not be taken into consideration when determining benefits under the 401(k) and pension plans. Solely for determining your rights under the annual incentive plan and/or any outstanding equity awards, upon separation in accordance with the RTP, you will be treated as having been separated without cause.

7. Changes in Employment. If your employment with Duke Energy ends before the end of the Transition Period due to voluntary resignation or involuntary termination by Duke Energy with cause, RTP Program benefits will not be provided. Similarly, if you accept another position with Duke Energy before separating in accordance with the RTP, RTP Program benefits will not be provided. If, however, Duke Energy terminates your employment involuntarily without cause, you will be eligible to receive severance benefits under Duke Energy's generally applicable severance plan for involuntary severances of similarly-situated employees in lieu of RTP benefits. You remain eligible to earn the RTP Program benefits in case of an authorized FMLA leave or authorized short term disability leave during the Transition Period. In case of a non-FMLA short-term disability leave, however, Duke Energy may determine that your Transition Period should either be ended early or extended upon return to work. In case of any other leave of absence, except as may otherwise be required by law, RTP Program benefits will not be provided.

8. Timing of Payment; No Severance Benefits. If you meet the conditions described above, you will be paid the Separation Bonus in a single cash payment as soon as administratively practicable (not more than 60 days) after your termination of employment. Please note that if you receive payment of the Separation Bonus, you will not be considered eligible for any benefits under any applicable severance plan that otherwise covers you.

To be eligible to receive reduced work schedule with RTP benefits, please sign and date a copy of this letter and return it to our HR Business Partner, [insert name] by no later than [date]. Of course,

you are free to decline to participate in the RTP. This letter in all events will govern and control your rights with respect to the reduced work schedule with RTP benefits and may be changed or modified only in writing signed by both parties. See Exhibit B for certain additional terms and conditions. If you have any questions, please contact our HR Business Partner.

Sincerely,

[Supervisor Name and Title]

Accepted and Agreed To:

By:_____

Print Name:_____

Date:_____

Exhibit A
SAMPLE WAIVER AND RELEASE OF CLAIMS
UNDER THE DUKE ENERGY RETIREMENT TRANSITION PROGRAM (OPTION 1)

This Waiver and Release of Claims (the "Agreement"), delivered on _____, is entered into by and between Duke Energy Corporation and its subsidiaries and affiliates and any predecessors and successors thereto (individually and collectively referred to as the "Company"), and _____ ("Employee") pursuant to the Retirement Transition Program (the "Program") with the mutual exchange of promises as consideration.

WHEREAS, Employee is eligible to separate from employment on _____ (the "Separation Date") and receive severance benefits described below provided Employee enters into and does not revoke this Agreement; and

WHEREAS, the Company is willing to provide the Employee the severance benefits described below, provided Employee enters into and does not revoke this Agreement.

THEREFORE, the Company and Employee agree as follows:

1. Program Benefits. In exchange for Employee remaining employed and in good standing with the Company and separating employment from the Company on his or her Separation Date in accordance with the Program and entering into and not revoking this Agreement, the Company agrees to provide the Employee the following:

   a. Transition Payments. Transition Payments consisting of the following:

      i. Transition Bonus. A lump sum cash payment equal to $_____ less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Agreement.

      ii. Health Care Supplement. A lump sum cash payment equal to $_____, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Agreement.

   b. Outplacement Services. Outplacement services for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy).

2. Basis for Entitlement. Employee acknowledges and agrees that Employee would not be entitled to the benefits described in Paragraph 1 absent Employee's separation from employment on his or her Separation Date and execution and non-revocation of this Agreement in accordance with the Program. Employee further acknowledges that he or she is not entitled to a pension enhancement under the Program.

3. Adequate Consideration. Employee acknowledges and agrees that this Agreement provides good, valuable and sufficient consideration for Employee's obligations under this Agreement.

4. Release by Employee. Employee, of the Employee's own free will, voluntarily waives and releases the Company, its employee benefit, pension, welfare, and other plans or programs

(including any and all fiduciaries thereof), and any of the Company's respective current or former officers, directors, agents, employees, attorneys, insurers, plan administrators, predecessors, successors or assigns from any and all rights or claims that Employee has, or may have, as of the date of the execution of this Agreement, based on or arising out of the employment relationship or the termination of the employment relationship, other than those rights or claims set forth below in Paragraph 5. The rights and claims so waived and released shall include, but not be limited to:

a. Those arising under any federal, state or local statute, ordinance, common law (including, but not limited to, claims of breach of promise, breach of contract, promissory estoppel, intentional or negligent infliction of emotional distress, defamation, tortious interference with a business relationship or contract and wrongful discharge), or claims in equity or public policy; and
b. Those arising under any law based on any protected status, including but not limited to, sex, age, race, color, religion, handicap or disability, national origin, pregnancy, discrimination, retaliation, or whistleblower (including, but not limited to, any rights or claims arising under Title VII of the Civil Rights Act of 1964, as amended, the Civil Rights Act of 1991, the Americans with Disabilities Act, the Rehabilitation Act, the Older Workers Benefits Protection Act of 1990, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Family and Medical Leave Act, the Genetic Information Nondiscrimination Act, the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Indiana Discrimination on Account of Age Act, the Indiana Civil Rights Statute, the Kentucky Civil Rights Statute, the Ohio Civil Rights Statute, the North Carolina Equal Employment Practices Act, the North Carolina Persons with Disabilities Protection Act, the North Carolina Retaliatory Employment Discrimination Act, the South Carolina Human Affairs Law, the Florida Civil Rights Act, the Florida Whistleblower Act, the Texas Labor Code Chapter 21, the Tennessee Human Rights Act and every other local, state, or federal law, regulation, or other legal authority concerning employment rights or claims); and
c. Those arising under the Employee Retirement Income Security Act of 1974; and
d. Those arising under the civil rights laws of any state or municipality; and
e. Any claim for compensatory damages, punitive damages, attorneys' fees, expenses and litigation costs; and
f. Any grievance, charge or other claim arising under the applicable collective bargaining agreement, National Labor Relations Act, or other similar labor laws, regulations, and authority.

Employee acknowledges that he or she has been paid for all hours worked during his or her employment with the Company and has received all other payments owed to him or her by the Company as of his or her Separation Date. In addition, Employee acknowledges that he or she has received all leave to which he or she may have been entitled to under the Family and Medical Leave Act or applicable state law during his or her employment with the Company.

5. Claims Not Waived. Notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release any workers' compensation or unemployment compensation claims filed prior to the date of execution of this Agreement, or claims against the Company arising out of possible exposure to asbestos during Employee's employment with the Company at a facility or facilities owned by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release Employee's rights or claims to accrued or vested benefits under an employee benefit plan or program maintained by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release claims that may arise after the date of execution

of this Agreement, including, but not limited to, claims that may arise under an employee benefit plan or program maintained by the Company.

6. Acknowledgement of No Interference with Reporting and Compliance Rights. Employee acknowledges and agrees that it is the policy of the Company to comply with all applicable federal, state and local laws and regulations. Employee affirms that he or she has reported all compliance issues and violations of federal, state and local law or regulation or Company policy of which he or she had knowledge during the term of his or her employment, if any. Employee represents and acknowledges that he or she has no further or additional knowledge or information regarding compliance issues or possible violations of federal, state or local law or regulations or Company policy other than what Employee may have previously reported, if any, including, but not limited to, any and all outstanding nuclear safety concerns Employee has involving any nuclear power plant owned or operated by the Company. Nothing in this Agreement shall be construed to prohibit, restrict or otherwise discourage Employee from participating in "protected activity" as defined in 10 CFR 50.7 and Section 211 of the Energy Reorganization Act of 1974, including, but not limited to reporting any suspected instance of illegal activity of any nature, any nuclear safety concern, any workplace safety concern, any public safety concern, or any other matter within the United States Nuclear Regulatory Commission's ("NRC") regulatory responsibilities to the NRC, the United States Department of Labor, or any other federal or state governmental agency. This Agreement further does not prohibit Employee from participating in any way in any state or federal administrative, judicial, or legislative proceeding or investigation. Further, nothing in this Agreement prevents Employee from filing a charge or complaint, with or from participating in an investigation or proceeding conducted by the Equal Opportunity Commission ("EEOC"), National Labor Relations Board ("NLRB"), Securities and Exchange Commission ("SEC"), or any other federal, state or local agency charged with the enforcement of any laws, or from exercising rights under Section 7 of the NLRA to engage in joint activity with other employees, although by signing this Agreement, Employee acknowledges that the Agreement waives Employee's right to individual relief based on claims asserted in a such a charge or complaint, regardless if such claim is brought individually or as part of a class or collective action, except where such waiver of individual relief is otherwise legally prohibited.

7. Promise Not to Sue. Employee agrees not to institute a lawsuit against the Company asserting any of the claims that are released in Paragraph 4 of this Agreement. **Employee acknowledges that signing this Agreement means that Employee has waived not only his or her right to recover in a lawsuit, claim or other action brought by him or her as described herein, but also in any claim, lawsuit or other action brought on his or her behalf (including any claim of age discrimination) against the Company based on or arising out of the employment relationship or the termination of the employment relationship up to the date this Agreement is signed. This does not mean that Employee is precluded from filing a charge of discrimination with the Equal Employment Opportunity Commission ("EEOC"), or other state commission or otherwise participating in proceedings before the EEOC or those commissions; however, if Employee does file such a charge, he or she shall be entitled to no monies, pay, compensation or relief of any type from the Company as a result of the charge.**

8. Confidentiality. Employee shall not, at any time, directly or indirectly, use any trade secrets or confidential information of the Company for Employee's benefit or the benefit of any other person or, directly or indirectly, disclose any such trade secrets or confidential information of the Company to any other person. Employee acknowledges that the Program Benefits described in Paragraph 1 of this Agreement are not subject to this confidentiality provision. The Company and Employee agree to keep the terms and conditions of this Agreement confidential except to the extent the terms and conditions are required to be disclosed by any judicial or administrative federal, state or local agency. Employee may also disclose the

terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Notwithstanding any provisions of this Agreement to the contrary the Employee may be entitled to immunity and protection from retaliation under the Defend Trade Secrets Act of 2016 for disclosing a trade secret under limited circumstances, as set forth in the Company's Innovations and Intellectual Properties Policy.

9. Cooperation with Litigation. Upon the Company's request, Employee agrees to render reasonable assistance to the Company in connection with any litigation or investigation relating to the Company's business. Such assistance shall include, but not be limited to, providing information, attending meetings, assisting with discovery, giving depositions and making court appearances. Employee agrees to promptly notify the Chief Legal Officer of the Company of any requests for information or testimony that Employee receives in connection with any litigation or investigation relating to the Company's business; provided however, that this reporting requirement will not apply in the context of "protected activity", as defined in Paragraph 6 of this Agreement.

10. Consultation with Attorney Advised. **Employee is advised to consult with an attorney prior to executing this Agreement.** Employee acknowledges being given that advice. Employee represents that he or she has read and fully understands all of the provisions of this Agreement. Employee represents that he or she is voluntarily signing this Agreement.

11. Due Care - Time Frame for Acceptance. **Employee acknowledges that he or she has received a copy of this Agreement and has been given a period of forty-five (45) days from receipt within which to freely and voluntarily consider and sign this Agreement.**

    a. To enter into this Agreement, Employee must execute it by signing, dating and returning it to the **Employee Relations Control Center, Attn: Lindsay Walles, 525 S. Tryon St, DEP 14-B, Charlotte, NC 28202**

    b. Employee acknowledges that if Employee has signed this Agreement it is because Employee freely chose to do so.

    Employee has **seven (7) calendar days** after he or she signs this Agreement within which to revoke it. To be effective, a revocation must be communicated in writing to the **Employee Relations Control Center, Attn: Lindsay Walles, 525 S. Tryon St, DEP 14-B, Charlotte, NC 28202**, and delivered no later than 5:00 p.m. Eastern Time on the final day of the seven (7) day period.

12. Governing Law. This Agreement shall be interpreted, enforced and governed under the laws of the State of North Carolina.

13. No Admission of Liability. This Agreement shall not in any way be construed as evidence or as an admission of any liability or wrongdoing by the Company.

14. Binding Effect of Agreement. This Agreement will be binding upon and shall operate for the benefit of the heirs, executors, administrators, assigns, and successors in interest of Employee and the Company.

15. Severability. If any portion of this Agreement should be unenforceable for any reason, the parties agree that the remaining portions will continue in effect.

16. Receipt of Required Disclosures. To the extent applicable, the job classifications and the birth dates of all individuals in Employee's decisional unit who are currently eligible and

ineligible to participate in the Plan are shown on the Attachment. Employee acknowledges receipt and possession of the Attachment.

17. Effective Date. This Agreement shall become effective and enforceable upon the expiration of the revocation period established in Paragraph 11 (the "Effective Date").

AGREED TO BY:

_____ _____
Employee Date

THE COMPANY

By: _____ _____
Jay Alvaro Date
VP, Employee and Labor Relations

EXHIBIT A
SAMPLE WAIVER AND RELEASE OF CLAIMS
UNDER THE DUKE ENERGY RETIREMENT TRANSITION PROGRAM (OPTION 2)

This Waiver and Release of Claims (the "Agreement"), delivered on _____, is entered into by and between Duke Energy Corporation and its subsidiaries and affiliates and any predecessors and successors thereto (individually and collectively referred to as the "Company"), and _____ ("Employee") pursuant to the Retirement Transition Program (the "Program") with the mutual exchange of promises as consideration.

WHEREAS, Employee is eligible to separate from employment on _____ (the "Separation Date") and receive severance benefits described below provided Employee enters into and does not revoke this Agreement; and

WHEREAS, the Company is willing to provide the Employee the severance benefits described below, provided Employee enters into and does not revoke this Agreement.

THEREFORE, the Company and Employee agree as follows:

1. Program Benefits. In exchange for Employee remaining employed and in good standing with the Company and separating employment from the Company on his or her Separation Date in accordance with the Program and entering into and not revoking this Agreement, the Company agrees to provide the Employee the following:

   a. Separation Bonus. A lump sum cash payment equal to $_____, which amount will be grossed up for taxes based on applicable rates as determined by the Company in its sole discretion, less applicable taxes and withholdings, with such amount being payable as soon as administratively practicable (not more than 60 days) following his or her Separation Date subject to Employee executing and not revoking this Agreement.

   b. Outplacement Services. Outplacement services for a period of up to six months through a vendor selected by the Company, in accordance with its policies in effect as from time to time (including the Duke Energy Corporation Section 409A Payment Policy.

2. Basis for Entitlement. Employee acknowledges and agrees that Employee would not be entitled to the benefits described in Paragraph 1 absent Employee's separation from employment on his or her Separation Date and execution and non-revocation of this Agreement in accordance with the Program. Employee further acknowledges that he or she is not entitled to a pension enhancement under the Program.

3. Adequate Consideration. Employee acknowledges and agrees that this Agreement provides good, valuable and sufficient consideration for Employee's obligations under this Agreement.

4. Release by Employee. Employee, of the Employee's own free will, voluntarily waives and releases the Company, its employee benefit, pension, welfare, and other plans or programs (including any and all fiduciaries thereof), and any of the Company's respective current or former officers, directors, agents, employees, attorneys, insurers, plan administrators, predecessors, successors or assigns from any and all rights or claims that Employee has, or may have, as of the date of the execution of this Agreement, based on or arising out of the employment relationship or the termination of the employment relationship, other than those rights or claims set forth below in Paragraph 5. The rights and claims so waived and released shall include, but not be limited to:

   a. Those arising under any federal, state or local statute, ordinance, common law (including, but not limited to, claims of breach of promise, breach of contract, promissory estoppel, intentional or negligent infliction of emotional distress, defamation, tortious interference with a business relationship or contract and wrongful discharge), or claims in equity or public policy; and
   b. Those arising under any law based on any protected status, including but not limited to, sex, age, race, color, religion, handicap or disability, national origin, pregnancy, discrimination, retaliation, or whistleblower (including, but not limited to, any rights or claims arising under Title VII of the Civil Rights Act of 1964, as amended, the Civil Rights Act of 1991, the Americans with Disabilities Act, the Rehabilitation Act, the Older Workers Benefits Protection Act of 1990, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Family and Medical Leave Act, the Genetic Information Nondiscrimination Act, the National Labor Relations Act, the Worker Adjustment and Retraining Notification Act, the Indiana Discrimination on Account of Age Act, the Indiana Civil Rights Statute, the Kentucky Civil Rights Statute, the Ohio Civil Rights Statute, the North Carolina Equal Employment Practices Act, the North Carolina Persons with Disabilities Protection Act, the North Carolina Retaliatory Employment Discrimination Act, the South Carolina Human Affairs Law, the Florida Civil Rights Act, the Florida Whistleblower Act, the Texas Labor Code Chapter 21, the Tennessee Human Rights Act and every other local, state, or federal law, regulation, or other legal authority concerning employment rights or claims); and
   c. Those arising under the Employee Retirement Income Act of 1974; and
   d. Those arising under the civil rights laws of any state or municipality; and
   e. Any claim for compensatory damages, punitive damages, attorneys' fees, expenses and litigation costs; and
   f. Any grievance, charge or other claim arising under the applicable collective bargaining agreement, National Labor Relations Act, or other similar labor laws, regulations, and authority.

   Employee acknowledges that he or she has been paid for all hours worked during his or her employment with the Company and has received all other payments owed to him or her by the Company as of his or her Separation Date. In addition, Employee acknowledges that he or she has received all leave to which he or she may have been entitled to under the Family

and Medical Leave Act or applicable state law during his or her employment with the Company.

5. Claims Not Waived. Notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release any workers' compensation or unemployment compensation claims filed prior to the date of execution of this Agreement, or claims against the Company arising out of possible exposure to asbestos during Employee's employment with the Company at a facility or facilities owned by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release Employee's rights or claims to accrued or vested benefits under an employee benefit plan or program maintained by the Company. Further notwithstanding the provisions of Paragraph 4 above, this Agreement does not waive and release claims that may arise after the date of execution of this Agreement, including, but not limited to, claims that may arise under an employee benefit plan or program maintained by the Company.

6. Acknowledgement of No Interference with Reporting and Compliance Rights. Employee acknowledges and agrees that it is the policy of the Company to comply with all applicable federal, state and local laws and regulations. Employee affirms that he or she has reported all compliance issues and violations of federal, state and local law or regulation or Company policy of which he or she had knowledge during the term of his or her employment, if any. Employee represents and acknowledges that he or she has no further or additional knowledge or information regarding compliance issues or possible violations of federal, state or local law or regulations or Company policy other than what Employee may have previously reported, if any, including, but not limited to, any and all outstanding nuclear safety concerns Employee has involving any nuclear power plant owned or operated by the Company. Nothing in this Agreement shall be construed to prohibit, restrict or otherwise discourage Employee from participating in "protected activity" as defined in 10 CFR 50.7 and Section 211 of the Energy Reorganization Act of 1974, including, but not limited to reporting any suspected instance of illegal activity of any nature, any nuclear safety concern, any workplace safety concern, any public safety concern, or any other matter within the United States Nuclear Regulatory Commission's ("NRC") regulatory responsibilities to the NRC, the United States Department of Labor, or any other federal or state governmental agency. This Agreement further does not prohibit Employee from participating in any way in any state or federal administrative, judicial, or legislative proceeding or investigation. Further, nothing in this Agreement prevents Employee from filing a charge or complaint, with or from participating in an investigation or proceeding conducted by the Equal Opportunity Commission ("EEOC"), National Labor Relations Board ("NLRB"), Securities and Exchange Commission ("SEC"), or any other federal, state or local agency charged with the enforcement of any laws, or from exercising rights under Section 7 of the NLRA to engage in joint activity with other employees, although by signing this Agreement, Employee acknowledges that the Agreement waives Employee's right to individual relief based on claims asserted in a such a charge or complaint, regardless if such claim is brought individually or as part of a class or collective action, except where such waiver of individual relief is otherwise legally prohibited.

7. Promise Not to Sue. Employee agrees not to institute a lawsuit against the Company asserting any of the claims that are released in Paragraph 4 of this Agreement. **Employee acknowledges that signing this Agreement means that Employee has waived not only his or her right to recover in a lawsuit, claim or other action brought by him or her as described herein, but also in any claim, lawsuit or other action brought on his or her behalf (including any claim of age discrimination) against the Company based on or arising out of the employment relationship or the termination of the employment relationship up to the date this Agreement is signed. This does not mean that Employee is precluded from filing a charge of discrimination with the Equal**

Employment Opportunity Commission ("EEOC"), or other state commission or otherwise participating in proceedings before the EEOC or those commissions; however, if Employee does file such a charge, he or she shall be entitled to no monies, pay, compensation or relief of any type from the Company as a result of the charge.

8. Confidentiality. Employee shall not, at any time, directly or indirectly, use any trade secrets or confidential information of the Company for Employee's benefit or the benefit of any other person or, directly or indirectly, disclose any such trade secrets or confidential information of the Company to any other person. Employee acknowledges that the Program Benefits described in Paragraph 1 of this Agreement are not subject to this confidentiality provision. The Company and Employee agree to keep the terms and conditions of this Agreement confidential except to the extent the terms and conditions are required to be disclosed by any judicial or administrative federal, state or local agency. Employee may also disclose the terms and conditions of this Agreement to Employee's spouse, attorney and financial advisor, provided they first agree to be bound by this same pledge of confidentiality. Notwithstanding any provisions of this Agreement to the contrary the Employee may be entitled to immunity and protection from retaliation under the Defend Trade Secrets Act of 2016 for disclosing a trade secret under limited circumstances, as set forth in the Company's Innovations and Intellectual Properties Policy.

9. Cooperation with Litigation. Upon the Company's request, Employee agrees to render reasonable assistance to the Company in connection with any litigation or investigation relating to the Company's business. Such assistance shall include, but not be limited to, providing information, attending meetings, assisting with discovery, giving depositions and making court appearances. Employee agrees to promptly notify the Chief Legal Officer of the Company of any requests for information or testimony that Employee receives in connection with any litigation or investigation relating to the Company's business; provided however, that this reporting requirement will not apply in the context of "protected activity", as defined in Paragraph 6 of this Agreement.

10. Consultation with Attorney Advised. **Employee is advised to consult with an attorney prior to executing this Agreement.** Employee acknowledges being given that advice. Employee represents that he or she has read and fully understands all of the provisions of this Agreement. Employee represents that he or she is voluntarily signing this Agreement.

11. Due Care - Time Frame for Acceptance. **Employee acknowledges that he or she has received a copy of this Agreement and has been given a period of forty-five (45) days from his or her Separation Date within which to freely and voluntarily consider and sign this Agreement.**

    a. To enter into this Agreement, Employee must execute it by signing, dating and returning it to the **Employee Relations Control Center, Attn: Lindsay Walles, 525 S. Tryon St, DEP 14-B, Charlotte, NC 28202**

    b. Employee acknowledges that if Employee has signed this Agreement it is because Employee freely chose to do so.

    c. Employee has **seven (7) calendar days** after he or she signs this Agreement within which to revoke it. To be effective, a revocation must be communicated in writing to the **Employee Relations Control Center, Attn: Lindsay Walles, 525 S. Tryon St, DEP 14-B, Charlotte, NC 28202**, and delivered no later than 5:00 p.m. Eastern Time on the final day of the seven (7) day period.

12. Governing Law. This Agreement shall be interpreted, enforced and governed under the laws of the State of North Carolina.

13. No Admission of Liability. This Agreement shall not in any way be construed as evidence or as an admission of any liability or wrongdoing by the Company.

14. Binding Effect of Agreement. This Agreement will be binding upon and shall operate for the benefit of the heirs, executors, administrators, assigns, and successors in interest of Employee and the Company.

15. Severability. If any portion of this Agreement should be unenforceable for any reason, the parties agree that the remaining portions will continue in effect.

16. Receipt of Required Disclosures. To the extent applicable, the job classifications and the birth dates of all individuals in Employee's decisional unit who are currently eligible and ineligible to participate in the Plan are shown on the Attachment. Employee acknowledges receipt and possession of the Attachment.

17. Effective Date. This Agreement shall become effective and enforceable upon the expiration of the revocation period established in Paragraph 11 (the "Effective Date").

AGREED TO BY:

_____ _____
Employee Date

THE COMPANY

By: _____ _____
Jay Alvaro
VP, Employee and Labor Relations

EXHIBIT B: OTHER TERMS AND CONDITIONS

1. General. The contingent rights set forth in this letter agreement (the "Agreement") are not transferable otherwise than by will or the laws of descent and distribution. Nothing in this Agreement shall restrict our right to terminate your employment at any time with or without cause. The terms of this Agreement shall be binding upon and inure to the benefit of us and our successors and assigns, and to you and your beneficiaries, executors, administrators, heirs and successors. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions of this Agreement.

2. Choice of Law. Except to the extent pre-empted by federal law, this Agreement and your rights under it shall be construed and determined in accordance with the laws of the State of North Carolina.

3. Entire Agreement. This Agreement contains the entire agreement and understanding of the parties with respect to the subject matter contained in this Agreement, and supersedes all prior

communications, representations and negotiations in respect thereto. This Agreement may be executed in counterparts. We shall have final authority to interpret and construe this Agreement and to make any and all determinations under it, and our decision shall be binding and conclusive upon you and your legal representative in respect of any questions arising under this Agreement. No change, modification or waiver of any provision of this Agreement shall be valid unless the same is in writing and signed by the parties.

4. Interaction with Other Rights. Any payments to you under this Agreement shall be paid from our general assets, and you shall have the status of a general unsecured creditor with respect to our obligations to make payments under this Agreement.

5. Internal Revenue Code Section 409A. The Agreement and any payments provided under it are intended to comply with, or be exempt from, Section 409A of the Internal Revenue Code of 1986, as amended ("Section 409A"). The Agreement shall in all respects be interpreted, operated, and administered in accordance with this intent. Payments provided under the Agreement may only be made upon an event and in a manner that complies with Section 409A or an applicable exemption, including to the maximum extent possible, exemptions for separation pay due to an involuntary separation from service and/or short-term deferrals. Any payments provided under the Agreement to be made upon a termination of employment that constitute deferred compensation subject to Section 409A shall only be made if such termination of employment constitutes a "separation from service" under Section 409A. If any payments or other benefits due to you under the Agreement would cause the application of an accelerated or additional tax under Section 409A, the payments or other benefits will be deferred if deferral will make such payment or other benefits compliant under Section 409A, or otherwise such payment or other benefits will be restructured, to the extent possible, in a manner that does not cause such an accelerated or additional tax and result in a material additional cost to us. Notwithstanding anything to the contrary in the Agreement, to the extent required to avoid accelerated taxation and additional taxes under Section 409A, amounts that would otherwise be payable and benefits that would otherwise be provided under this Agreement that (i) are subject to the requirements of Section 409A, (ii) are payable due to your "separation from service" with us within the meaning of Section 409A and (iii) are otherwise payable during the six (6) month period immediately following your separation from service shall instead be paid (without interest) on the first payroll date that is at least six months after your separation from service (or your death, if earlier). We make no representations or warranties that the payments provided under the Agreement comply with, or are exempt from, Section 409A, and in no event shall we be liable for any portion of any taxes, penalties, interest, or other expenses that may be incurred by you on account of non-compliance with Section 409A.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-035

REQUEST:

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

RESPONSE:

The most recent labor documents were provided in the Direct Testimony of Shannon A. Caldwell as Attachments SAC-2 (a) and (b):

- Attachment SAC-2(a): Agreement and Sidebar Letters between Utility Workers Union of America Local 600 and Duke Energy Ohio, Inc. and Duke Energy Kentucky, Inc.
- Attachment SAC-2(b): Contract between Duke Energy Ohio, Inc. Duke Energy Kentucky, Inc., and USW Local 12049 & 5541-06.

The prior labor documents are provided as the following attachments to this data request:

- STAFF-DR-01-035 Attachment 1: Utility Workers Union of America Local 600 most recent contract previously in effect for 4/1/2019 – 3/31/2023.
- STAFF-DR-01-035 Attachment 2: Contract between Duke Energy Ohio, Inc. Duke Energy Kentucky, Inc., and USW Local 12049 & 5541-06 most recent contract previously in effect for 5/15/2016 – 5/15/2021.

PERSON RESPONSIBLE: Shannon A. Caldwell

Agreement

between

Duke Energy Ohio, Inc

and

Duke Energy Kentucky, Inc

and

Utility Workers Union of America,

AFL-CIO, Local 600

2019-2023

AGREEMENT

Between the

Utility Workers Union of America, AFL-CIO, Local 600

and

Duke Energy Ohio, Inc.
Duke Energy Kentucky, Inc.

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AGREEMENT

Between the

Utility Workers Union of America, AFL-CIO, Local 600

and

Duke Energy Ohio, Inc.
Duke Energy Kentucky, Inc.

THIS AGREEMENT is entered into between the Utility Workers Union of America, AFL-CIO, Local 600, formerly the Independent Utilities Union, hereinafter referred to as the "Union," and Duke Energy Ohio, Inc., Duke Energy Kentucky, Inc., hereinafter referred to as the "Company," through and by their duly authorized representatives.

WITNESSETH: Whereas, the parties to the Agreement as are mentioned above are desirous of maintaining collective bargaining between the Employer and its Employees, as are represented by the Union as bargaining agent, and are desirous of stabilizing employment, eliminating strikes, lockouts, curtailment of employment, and the peaceful settlement of all employer and employee disputes, and of making an honest effort to improve the conditions of both the employer and the employees.

WHEREAS, it is deemed desirable and necessary that definite operations and practices between the Company and the employees of the Company represented by the Union be formally set forth and described, with a desire that uniformity of working conditions exist between the aforementioned Companies and such employees.

WHEREAS, the Company and the Union recognize that in order for the parties to meet the challenge of competition, the need for long term prosperity and growth, and establish employment security, each must be committed to a cooperative labor management relationship that extends from the bargaining unit members to the executive employees. The Company and the Union agree that employees at all levels of the Company must be involved in the decision making process and provide their input, commitment, and cooperation to improving productivity and helping the Company become the lowest cost producer and highest quality provider of energy service.

NOW, THEREFORE, the Company and the Union do hereby agree to the following terms and conditions, to-wit:

ARTICLE I

Section 1. (a) The Company hereby recognizes the Union during the term of this Agreement as the sole and exclusive representative of all regular full-time and part-time employees of the occupational classifications in the units defined as "The Office, Clerical and Technical Unit" and "The Residual Unit," as described in the Order issued by the National Labor Relations Board dated August 12, 1944 and amended by the National Labor Relations Board Order dated February 24, 1967. The units so defined shall retain jurisdiction over such work as was normally performed by them prior to this Agreement but such jurisdiction shall not be expanded except by mutual agreement of the parties hereto or through due processes under the National Labor Relations Act. A-14

(b) The Company recognizes the Union as the sole bargaining agent of the units contained in the preceding paragraph for the purpose of collective bargaining with respect to rates of pay, wages, hours of employment, or other conditions of employment, and the Company agrees to attempt to adjust any and all disputes, and any other matters, arising out of or pursuant to this Agreement, with the Union.

(c) This Agreement shall be final and binding upon the successors, assignees or transferees of the Union and the corporate entity of the Company.

Section 2. (a) The Company agrees not to interfere, restrain, coerce, or discriminate against any of the members of the Union, because of their membership in the Union, or because of their activity as a member or officer of the Union. Should reasonable proof of any such interference, restraining, coercion or discrimination by any person in a supervisory capacity against a member of the Union be shown to the Company by the Union, the Company agrees to take immediate corrective action in connection with such complaint. It is further agreed that no member shall be discharged because of his or her service, or lawful activity as a member of the Union, nor will the Company at any time attempt to discourage membership in the Union.

(b) There shall be no discrimination, interference, restraint or coercion by the Company or the Union or their agents against any employee because of race, color, religion, sex, disability, national origin or ancestry or for any other reason. References to the masculine gender are intended to be construed to also include the feminine gender wherever they appear throughout the Agreement.

(c) The Union recognizes that the management of the Company, the direction of the working forces, the determination of the number of people it will employ or retain in each classification, and the right to hire, suspend, discharge, discipline, promote, demote or transfer, and to release employees because of lack of work or for other proper and legitimate reasons are vested in and reserved to the Company. A-9

(d) The above rights of Management are not all-inclusive, but indicate the type of matters or rights which belong to and are inherent to Management. Any of the rights, powers, and authority the Company had prior to entering this Agreement are retained by the Company, except as expressly and specifically abridged, delegated, granted or modified by this Agreement.

(e) The foregoing two paragraphs do not alter the employee's right of adjusting grievances as provided for in Article VII, Section 1 of this Agreement.

Section 3. Respecting the subject of "Union Security," the parties mutually agree as follows:

(a) All regular employees in the bargaining unit represented by the Union shall be required as a condition of their continued employment to maintain their membership in the Union in good standing on and after the thirty-first (31st) day following the employee's date of hire. The Union shall notify the Company's Labor Relations Department of any members who are not in good standing as determined by the Union. For the purposes of this provision, "membership in good standing" shall mean being a full member or a core fee payer of the Union.

(b) The Union agrees that neither it nor any of its officers or members will intimidate or coerce any of the employees of the Company to join or become members of the Union, nor will said Union or any of its officers or members unfairly deprive any employee within the bargaining unit represented by the Union of union membership or of any opportunity to obtain union membership if said employee so desires. In this connection the Company agrees that it will not discriminate against any employee on account of activities or decisions in connection with the Union, except as the same may become necessary on the part of the Company to carry out its obligations to the Union under this Agreement.

(c) If a dispute arises as to the actual union status of any employee, at any time, as to whether or not the employee has been unfairly deprived of or denied union membership, the dispute shall be subject to arbitration, in accordance with the arbitration provisions of Article VII of this Agreement.

(d) The Company shall provide the Union with time to discuss with new employees the Union and the existence of the collective bargaining agreement. The Company will provide new employees with electronic and/or paper access to the collective bargaining agreement, along with the Union's "Membership Application" and the "Payroll Deduction Authorization" cards for Union dues or core fees, so that enrollment will be effective 31 days after being hired.

(e) Except for those employees mentioned in subsection (d) of this section and subject to all state and federal laws, all employees who are not members of the Union shall be required, as a condition of their continued employment, to pay to the Union the applicable core fees representing the percentage of the Union's expenses that are for representational and other legally chargeable activities.

(f) The Union agrees that any present or future employee who is now or may become a member of the Union may withdraw from membership in the Union by giving notice in writing to the Labor Relations Department of the Company and to the Union. However, the Union will not impose restrictions, which are prohibited by law, on employees who wish to withdraw from Union membership. After such withdrawal, an employee shall not be required to rejoin the Union as a condition of continued employment. Any such employee will remain obliged to pay the applicable core fees.

(g) The Company agrees to dismiss any employee represented by the Union, at the written request of the Union, for nonpayment of union dues or core fees or to discipline employees represented by the Union in the manner herein provided for violation of this Agreement, if requested to do so, in writing, by the Union. Nothing in this clause, however, shall be construed so as to require the Company to dismiss or discipline any employee in violation of any state or federal law.

(h) The Company agrees, after receiving proper individual authorizations by means of written individual assignments in a form mutually agreeable to both parties, to deduct Union dues or core fees and initiation fees from employees' pay. This deduction shall be made a mutually agreed upon number of times each year and shall be forwarded to the Treasurer of the Union.

(i) The Union agrees that in the event of any strike, work stoppage, slowdown, picketing or any other interference to the work or the operations of the Company by any individual employee or group of employees in the bargaining unit represented by the Union this section of the Agreement is then and there and by reason thereof automatically canceled and of no further force and effect; provided, however, that the Company shall upon the presentation of proof satisfactory to the Company, within ten days thereafter, that the Union did not directly or indirectly authorize, permit, endorse, aid or abet said strike, work stoppage, slowdown, picketing or interference referred to, reinstate this section of the Agreement, which section, if reinstated will, from and after the date of reinstatement, be of the same validity, force and effect as if it had not been canceled. In this connection, it is the expressed intention of the parties that for the purpose of making this cancellation provision effective without affecting the other sections of the Agreement, this Agreement is to be considered a severable agreement. Should the automatic cancellation of this section occur, it is the intention and agreement of the parties that all other sections and provisions of the Agreement remain in full force and effect as therein provided. The Company agrees that it will not deliberately arrange or incite such interference to the work or operations of the Company as are referred to in this section.

(j) The provisions of this Article I, Section 3(a) regarding Union Security, shall not be applied to bargaining unit members in any state in which such union-security provisions are prohibited by law. The parties agree that, if the current law changes to make such union security provisions applicable, or not applicable, to any employees covered by this Agreement, the Parties will deem the Agreement amended to comply with the then current law.

Section 4. The Company agrees that it will not attempt to hold the Union financially responsible or institute legal proceedings against the Union because of a strike, slowdown or work stoppage not authorized, abetted or condoned by the Union. The Union agrees that, in the event of an unauthorized work stoppage, it will in good faith and without delay exert itself to bring the work stoppage to a quick termination and insist that the employee(s) involved cease their unauthorized activities. To that end, the Union will promptly take whatever affirmative action is necessary. Furthermore, the Union agrees that any employee or employees who agitate, encourage, abet, lead or engage in such a strike, work stoppage, slowdown or other interference with the operations of the Company shall be subject to such disciplinary action as the Company may deem suitable, including discharge, without recourse to any other provision or provisions of the Agreement now in effect.

ARTICLE II

Section 1. The Company agrees to designate and authorize a representative or representatives to meet with The General Board of the Union. It is agreed that these meetings shall be held quarterly, at a time mutually agreed upon, and at any other time upon the written request of either party to this Agreement. These meetings will be held within seven days after such request is made. A-32

Section 2. The Company agrees to meet and confer with any special committee of the Union, duly appointed by the President to administer any activity relating to the welfare of the members of the Union.

ARTICLE III

Section 1. (a) This Agreement and the provisions thereof, shall become effective April 1, 2019 and shall continue in full force and effect until April 1, 2023, and from year-to-year thereafter unless changed by the parties.

(b) Either of the parties hereto desiring to change any section or sections of this Agreement and/or to terminate this Agreement shall notify the other party in writing of the desired changes at least 60 days prior to April 1, 2023 or any subsequent anniversary date. During this 60-day period, conferences shall be held by and between the parties hereto, with a view to arriving at a further Agreement, and in all events this Agreement shall remain in full force and effect during the period of negotiations. A-32

(c) In the event agreement is reached on or before April 1, the 2019 – 2023 Agreement will be extended for a mutually agreed number of calendar days. The Union shall have one-half of the mutually agreed number of calendar days immediately following the date an agreement is reached in which to submit the Agreement to its membership for ratification and in case of failure to ratify, in order that the Company shall have the remaining one-half of the mutually agreed number of calendar days as notice before a strike or work stoppage commences. Providing the mutually satisfactory Agreement is ratified by the

membership within the first one-half of the mutually agreed number of days following the date an agreement is reached, such Agreement will be made retroactive to the 1st day of April and any agreed upon wage adjustments will be made retroactive to the 1st day of April.

Section 2. It is agreed that this Agreement may be amended or added to at any time by the written consent of both parties hereto.

ARTICLE IV

Section 1. The Company agrees to do nothing to encourage an employee to bargain individually.

Section 2. The Company agrees that if a matter rightfully termed a Union activity is referred by an employee to his or her representative or delegate, and this is taken up with the supervisor or any one qualified or authorized to act for the Company, such Company representative shall not initiate, negotiate, or discuss this question with the employee without affording the representative or delegate of the division an opportunity to be present.

Section 3. Departmental supervisory personnel will notify the departmental union delegate when a significant change or condition affecting that department or a work group within that department is contemplated by the management of the particular department. A-83
Upon written request by the departmental union delegate or the President of the Union, a meeting shall be arranged between the Company and the Union to discuss such changes. When major organizational changes affecting personnel in various departments are contemplated, the Company agrees to notify the Union President, in writing, at least 14 calendar days in advance of the change, and, upon written request by the President of the Union, a meeting shall be arranged between the Company and the Union to discuss such changes.

Section 4. Copies of bulletins issued by the Company concerning working conditions for any division or department represented by the Union, shall be forwarded to the General Board of the Union.

ARTICLE V

Section 1. The principle of seniority is recognized by the Company. There shall be two types of seniority defined as follows:

1. System service shall be based upon the length of time an employee has been continuously employed by the Company, and shall be the governing factor in establishing vacation dates.

2. Classified seniority shall be the length of time worked by an employee on a specific classified job.

3. Bargaining unit seniority shall be the length of time an employee has been (continuously) employed in a job position within the bargaining unit represented by the Union, and shall be the governing factor in the selection of vacation. The bargaining unit seniority list will be maintained by the Union based on information provided to the Union by the Company. The bargaining unit seniority list will be provided to the Company and used for the purpose of vacation selection beginning January 1, 2020.

It shall be considered a break in system service and seniority when an employee has been off the Company payroll, except when an employee has:

(1) Been laid off because of lack of work and has not, at any time during the period of layoff or during a period not to exceed three years from the date of layoff, refused to return to work for the Company in a capacity formerly held or comparable to the capacity formerly held, by the employee. However, actual time away will be deducted from the employee's system service.

(2) Been granted a leave of absence for good cause by consent of the Company, without loss of system service and seniority rights, providing the employees are available whenever necessary for the Company's medical examinations during the leave of absence. However, the employees will receive vacation in accordance with the second paragraph of Article IX, Section 5. Requests for leave of absence and consent hereto shall be in writing.

(3) Entered the military service of the United States or has been conscripted by the United States Government. No deductions for time away shall be made from the employee's system service and seniority record.

(4) Resigned voluntarily and subsequently been re-hired. Actual time away will be deducted from the employee's system service and seniority record, and, while previous system service shall be maintained, no classified seniority shall be retained.

Existing system service and seniority records shall not be rearranged to meet the above requirements in exceptions (1), (2) and (3), but they shall be met in all cases beginning March 21, 1983.

Section 2. (a) Job available postings for job classifications covered by this Agreement shall be provided by the Company and posted for a period of seven calendar days on the appropriate bulletin boards and/or on the Duke Energy Job Opportunities Portal page. A-65 A-82

(b) If after the initial posting the job opening has not been filled by a qualified applicant from the department or division, the job available notice will then be reposted for a period of seven calendar days on all bulletin boards throughout the Company where there are employees covered by this Agreement. In certain cases where it is known that A-3

there are no qualified applicants within a division or a department, the initial posting may be waived and the job posting will then be initially posted throughout the Company where there are employees covered by this Agreement. However, if applications are received from employees within the department requesting the job opening, these applications will be given consideration before those received from employees in other departments. Furthermore, anytime employees are accepted for a job opening on a lateral or cross bid, they shall not be eligible to laterally or cross bid again for a period of six months from the date of acceptance. The only exception to this six month waiting period is that employees may cross bid to another headquarters within the same bidding area at any time.

(c) It is agreed that classified seniority will be considered within a department, district or departmental section concerning available advancements, although other qualifications for the particular position will of necessity be considered. All other factors being sufficient, the employee oldest in the point of classified seniority shall be given a reasonable opportunity to qualify for the position. A-20 A-21 A-44 A-65

(d) Should the classified seniority of any two or more employees be equal, the respective seniority position of such employees shall be determined by the Union randomly drawing the names of the affected employees. The Company will be notified of the results, in writing.

In the event no fully qualified individual has bid on a Union wide job opening, the previous experience requirement only will be waived, with the exception of positions within the General Clerical sequence, and an employee will not be disqualified for promotion on the basis of not having passed through a lower job in the promotional sequence if otherwise qualified. Employees who have at least one half of the required previous experience and are in the direct promotional sequence of a job opening, posted Union wide, where previous experience has been waived, will be considered for the job before all other non-qualified employees. Any claim of discrimination in this connection may be taken up by the Union as a grievance.

(e) An employee may waive his right to promotion, providing such waiver is presented to the Company in writing and does not prevent other employees from acquiring experience in the job held by the employee. When an employee waives his right to promotion, the employee next in seniority, other qualifications being sufficient, shall be entitled to such promotion. When it is necessary to fill an open position, and no employees are willing to promote, the Company may assign the junior qualified employee to promote to the job classification.

(f) If no qualified regular full-time employee has been accepted following the posting procedure and consideration of requests for demotion, second consideration for non-technical job openings shall be given to part-time employees within the bargaining unit based on qualifications as determined by the Company. For technical job openings, the Company will give second consideration to part-time employees with a technical degree and/or technical expertise based on qualifications as determined by the Company. As a result of these determinations, if the top two or more part-time applicants have equal assessments, then the non-technical or technical job opening will be offered to the

applicant with the greatest system seniority.

(g) Should the job opening not be filled after the posting procedure above, at the discretion of management, consideration may be given to requests for transfer which have been received from employees outside the bargaining unit or may be filled from outside the Company.

(h) If the particular job opening is not filled within 60 days from the expiration date of the bargaining unit-wide posting, the job opening will be reposted in accordance with the job posting procedure outlined above.

(i) The job posting procedure outlined above does not restrict the Company's right to cancel a job posting at any time.

(j) An employee shall not have seniority rights to bid on a demotion but may, in writing by letter or by submitting a bid for a posted job opening, request consideration for a demotion. However, if an employee's request for demotion is granted by the Company, any accumulated classified seniority will be forfeited in job classifications above the job to which he demotes.

(k) The Company and the Union agree that the job posting procedure will be waived for the employment of Co-ops, as probationary employees in job classifications represented by the bargaining unit, providing that the next opening in the same job classification and bidding area is posted and made available to employees within the bargaining unit. If such opening is not filled by a bargaining unit employee, openings in the same job classification and bidding areas will continue to be posted and made available to employees within the bargaining unit until such time that a bargaining unit employee fills one of the openings.

Section 3. (a) In the event of any layoffs or curtailments of employment, the Company will attempt to place the employee in a temporary assignment. Prior to making an assignment, the Company will discuss such assignment with the Union. If a temporary assignment is not available, rollbacks and layoffs shall be made in accordance with system seniority rights. When the Company reduces the number of employees in a job classification, the Company will use the following process to determine rollbacks and layoffs. Employees with the least amount of System Service seniority within the job classification that is targeted for a reduction will be assigned to vacant positions and/or replace full-time employees in the bidding area with the least amount of System Service seniority. Displaced employees must be qualified for the job classification to which they are assigned and the job classification must be within the same bidding area and below their former job classification. Displaced employees will be reclassified into the next lower job classification within their bidding area for which they are qualified, if there are employees in that job classification and they have less system seniority than the displaced employees. Displaced employees will have their wage rates red-circled for a period of 18 months. At the end of 18 months, their wage rates will be reduced to the maximum wage rate of the job classification to which they were reclassified. Displaced employees who are assigned to perform work in lower level job classifications, if qualified, will be

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reassigned to higher job classifications as they become available within the bidding area, until the displaced employees return to assignments within their former job classification; obtain a job within the bidding area at the same or higher wage level as their former job classification; or, obtain a job in another bidding area. Displaced employees will not be assigned to or be required to perform the duties of job classifications at levels higher than their former job classification. Any employees unable to be assigned to vacant positions and/or replace full-time employees in the bidding area will be subject to layoff.

Part-time Meter Readers will be laid off before any full-time Meter Readers are rolled back or laid off. The same holds true for part-time and full-time call-takers in the Call Center.

Where multiple part-time employees in a job classification at the same location are scheduled to work a total of 40 or more hours per week, a qualified displaced full-time employee in the same bidding area may replace the part-time employees by accepting a full-time job at that location, if the department can still schedule straight-time coverage for the required hours.

For those full-time displaced employees with at least 15 years of service and subject to layoff, including employees who have been placed in a temporary position in accordance with this subsection, an effort will be made by the Company to find another job at the same or lower wage level for which the employee is qualified. The Company will discuss the employee's reclassification with the Union prior to it going into effect. If there are multiple displaced employees, vacant positions will be offered by system seniority; an employee has the right to turn down one offered position. An employee who turns down a position and who is not currently in a temporary assignment, could be subject to immediate rollback or layoff in accordance with this Section or to rollback or layoff at the end of the temporary assignment if no job is available. If the Company identifies such a vacant position for which the employee is qualified, the Company may reassign and reclassify the employee without posting the position. If no positions are identified by the Company the displaced employee, if qualified, will be allowed to displace the employee with the least amount of system seniority outside of the displaced employee's bidding area.

An employee unable to be reassigned and subject to being rolled back to the Call Center or Meter Reading Departments, will have the option of accepting the assignment in the Call Center or Meter Reading, being laid off, or being offered a severance as outlined in Sidebar Letter A-70. A-70

Displaced employees unable to displace full-time employees and subject to layoff, if qualified, will be allowed to replace employees in part-time positions within their bidding area, by accepting the wage rate, benefits, work hours and other terms and conditions of employment of the part-time employee. The two exceptions are Meter Reading and Call Center, where these employees may retain their full-time status and accept the wage rate applicable to new full-time employees in these departments. Full-time employees within the Customer Relations bidding area, but outside the Call Center and Meter Reading Departments, may displace a maximum of four part-time employees in each department (i.e., Call Center and Meter Reading) within a 12-month period.

Employees who were rolled back prior to April 1, 2012 and whose wage rates are red-circled will continue to have their wage rates red-circled.

An employee will not have the right to recede to a position within his bidding area that he did not pass through before reaching his present position. For purposes of this section, if an employee is unable to exercise system seniority rights in lower job classifications within his department because he did not pass through those job classifications before reaching his present position, he will be credited with system seniority in all job classifications lower than his initial job within the bidding area which are in the same direct promotional sequence. Under no circumstances may an employee exercise seniority rights outside his own bidding area or in the selection of a specific job within a classification.

(b) In a department where there have been layoffs and a subsequent increase in employment exists within three years, the Company agrees to recall those employees in the department who have suffered a layoff because of lack of employment, in the reverse order of the dates of their layoffs. It is further agreed that the Company will notify the employee or employees, in writing by registered or certified mail, to report back to work. The Company agrees to send a copy of these letters to the Union at the time of the mailing of the original. If they do not report back to work within a 15-day period, the Company shall have the right to recall the next employee in line.

(c) It shall be the duty of all employees, including those on layoff status, to have their proper post office address and telephone number on file with their individual departments and the Human Resources Department of the Company.

(d) The Union may designate a witness to tests given in a departmental section, and shall have the right to review the results of these departmental tests upon request. This does not apply to standard tests given by the Staffing Services Division or by outside consultants. A-4

(e) The Company will make an effort to find another job classification for which an employee is qualified if his job is abolished. An employee who, because of this job abolishment, is assigned to a classification having a lower rate of pay, will maintain his existing level of pay until the maximum wage rate of the job classification to which he is assigned is equal to his existing wage rate. This provision does not affect the right of an employee to bid on a future posted job opening for which he may be qualified.

Section 4. (a) Temporary transfers from one department, district, or departmental section to another will not affect an employee's system service or seniority rank(s) and his record will remain posted in the department, district, or departmental section from which he was transferred.

(b) Permanent transfers from one department, district, or departmental section to another will not affect an employee's system service or classified seniority, which will be used to determine his system service and seniority rank in his new department, district, A-2

or departmental section.

(c) When an employee has successfully bid on a posted job and his move to the posted job is delayed, consideration shall be given to the proper adjustment of the employee's seniority rank so that the employee will not be penalized with respect to future promotions. The employee will receive a seniority date and the wage rate of the job on which he has been accepted no later than the beginning of the third week after the employee is notified that he has been accepted for the new job.

Section 5. All new employees shall be classed as probationary for a period of one year and shall have no system service or seniority rights. After one year's service as a probationary employee, they shall be reclassified and their system service and seniority record shall include their previous employment as a probationary employee.

The probationary period of any employee on an approved leave of absence lasting more than thirty days, will be extended by the duration of the leave of absence.

Section 6. Temporary employees shall be those hired for a specific job of a limited duration, not to exceed six months unless agreed upon by both parties, and shall not acquire system service or classified seniority rights. The Union shall be notified of the hiring of such employees. A-6

Section 7. (a) Part-time employees shall be those hired to perform a continuing specific work requirement that is temporary in nature or less than 40 hours per week. Part-time employees will only be used for part-time applications in order to supplement the regular full-time workforce, unless otherwise agreed. While the intention is for part-time employees, who are non-temporary in nature, to be regularly scheduled to work less than 32 hours per week, the actual hours worked may be greater due to temporary operational needs or trading of hours with other employees. The departments utilizing part-time employees will develop schedules to be worked by such personnel. However, schedules for part-time employees may at times vary according to work needs. These employees will work in bargaining unit positions and will be paid the minimum wage rate for the job classification or at a specially negotiated rate. They shall not acquire classified seniority rights. Part-time employees may be laid off for any reason without recall rights. Such layoffs shall not be subject to the grievance procedure. Benefits for part-time employees shall be on a prorated basis as agreed to by the parties. A-48 A-61

(b) Part-time employees may request consideration for other part-time openings and may submit applications for openings in regular full-time positions. When part-time employees become full-time employees, they shall be credited with system service for the length of time they were employed by the Company as a part-time employee on or after January 1, 1996. For part-time employees who become full-time employees after April 1, 2008 and who have been employed as part-time for at least 12 consecutive months prior to becoming full-time, the probationary period shall be reduced from one year to nine months.

(c) The overtime provisions of this Agreement, including meal compensation, will only apply to part-time employees when they work in excess of their regular scheduled hours per day or eight hours per day, whichever is greater. Part-time employees will not be called out for overtime assignments unless all full-time available employees have been called. The total number of part-time employees, excluding those in the Call Center and Meter Reading work groups and those hired to perform a continuing specific work requirement that is temporary in nature, will not exceed 5% of the total number of full-time employees performing work represented by the Union.

Section 8. Employees promoted to a job outside the bargaining unit and who return to the bargaining unit within six months, shall retain all classified and bargaining unit seniority accumulated up to the date of their promotion. If employees who were in a job outside the bargaining unit for more than six months return to the bargaining unit the will be placed in a starting job classification and receive a classified seniority date behind all employees but shall retain all bargaining unit seniority accumulated up to the date of their promotion out of the bargaining unit. No employee may return to a bargaining unit job classification if management does not approve, a position is not available or if as a result, an employee represented by the Union would be laid off.

ARTICLE VI

Section 1. The parties hereto recognizing the importance of safety projects and regulations for the protection of the health, life and limb of all employees, agree to make all reasonable efforts to maintain such rules and regulations conducive to the health and safety of all concerned. The Company will notify the Union leadership of any work related accident resulting in the hospital admission or death of any employee in the bargaining unit. A-83

ARTICLE VII

Section 1. Any dispute or disagreement arising between an employee and the Company or the Union and the Company involving wages, hours or work, conditions of employment, or otherwise of any nature arising out of this Agreement may become the subject of a grievance. However, with respect to any claim or dispute involving the application or interpretation of an employee welfare or pension (includes defined benefit and 401(k) plans) plan, the claim or dispute shall not be resolved under the grievance procedure outlined herein, but instead, shall be resolved in accordance with the terms and procedures set forth in the relevant plan document. Additionally, should the content of any communication relating to employee benefits conflict with the terms of the relevant plan document, the terms of the plan document shall govern. Recognizing the importance of resolving disputes or disagreements in a peaceful and timely manner and at the earliest stage possible, grievances shall be processed in accordance with the following procedure: A-18 A-32

1st Step

An employee must take up any grievance initially with the supervisor involved, within 20 days of its occurrence or 20 days from the time the employee or the Union became aware of the occurrence. The initial meeting shall be held between the supervisor(s), the employee involved and the elected union representative or delegate. Grievances in this step shall be answered verbally at the meeting or within 5 days of the conclusion of the meeting. The supervisor will also inform the Union of the appropriate management person to notify in the event that the Union wishes to pursue the grievance to the second step.

2nd Step

If the parties are unable to resolve the grievance following the first step, within 10 workdays of the first step response, the Union may submit a written grievance to the management of the department designated in the first step. Department management will schedule a meeting with a small committee representing the Union within 20 workdays after receipt of the written grievance. A written decision will be sent by email and/or US Mail to the President of the Local Union within 20 workdays of the Step 2 meeting.

3rd Step

If the parties are unable to resolve the grievance following the second step, within 20 workdays of the second step response, the Union may notify the Labor Relations Department in writing of its desire to advance the grievance to the third step of the grievance procedure. The Labor Relations Department will schedule a meeting with the appropriate management representatives and a small committee representing the Union within 20 workdays after receipt of the written request. The Labor Relations Department will render a written decision within 20 workdays of the date of the third-step meeting. The written response will be sent by email or US Mail to the President of the Local Union.

In the case of a discharge, the Union may bypass the first step of the grievance procedure and submit a written grievance requesting a second step grievance meeting, within 10 days following the date of discharge.

Arbitration

Section 2. (a) If the parties are unable to resolve the grievance following the third-step, the Union, within 30 workdays of receipt of the third step response, may notify the General Manager, Labor Relations in writing of its desire to advance the grievance to arbitration.

(b) Upon receipt of the Union's notification, the parties within ten workdays will petition the Federal Mediation and Conciliation Service (FMCS) for a panel of seven arbitrators and will cooperate to select promptly an arbitrator from that list. In the event that no acceptable arbitrator appears on the panel of arbitrators submitted by FMCS, either party may request an additional panel from FMCS.

(c) The arbitrator so selected shall hold a hearing as promptly as possible on a date satisfactory to the parties. If a stenographic record of the hearing is requested by either party, the initial copy of this record shall be made available for the sole use of the arbitrator. The cost of this initial copy and its own copy shall be borne by the requesting party, unless both parties desire a copy. If both parties desire a copy, they shall equally share the cost of the arbitrator's copy, and shall each bear the cost of any copies of the record they desire.

(d) After completion of the hearing and the submission of the post-hearing briefs, the arbitrator shall render a decision and submit to the parties written findings that will be binding on both parties to the Agreement.

(e) The arbitrators' and other joint expenses mutually agreed upon shall be borne equally by both parties.

(f) Any grievance that is not taken to the next step within the time limits specified will be deemed to have been withdrawn. If at any step in the grievance procedure, the Company does not answer within the designated time frame, the Union may notify the Company of its desire to advance the grievance to the next step of the grievance procedure. Any time limits may be extended by written agreement between the parties.

(g) The arbitrator shall have no authority to add to, detract from, alter, amend, or modify any provision of this Agreement. It is also mutually agreed that there shall be no work stoppage or lockouts pending the decision of the arbitrator or subsequent thereto.

ARTICLE VIII

Section 1. (a) The parties hereto agree that the wage rate schedules in effect immediately prior to the execution of this Agreement shall be amended as follows:

MAXIMUM HOURLY WAGE RATES

		Clerical				
		As Of	Effective	Effective	Effective	Effective
		April 1,	April 1,	April 1,	April 1,	April 1,
		2018	2019	2020	2021	2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
Wage level	1	$ 14.86	$15.23	$15.61	$16.00	$16.40
	2	$ 16.43	$16.84	$17.26	$17.69	$18.14
	3	$ 18.37	$18.83	$19.30	$19.78	$20.28
	4	$ 18.37	$18.83	$19.30	$19.78	$20.28
	5	$ 19.71	$20.20	$20.71	$21.23	$21.76
	6	$ 21.52	$22.06	$22.61	$23.17	$23.75
	7	$ 21.52	$22.06	$22.61	$23.17	$23.75
	8	$ 23.88	$24.48	$25.09	$25.72	$26.36
	9	$ 25.53	$26.17	$26.82	$27.49	$28.18
	10	$ 27.45	$28.14	$28.84	$29.56	$30.30

	Year	2018	2019	2020	2021	2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
	11	$ 27.45	$28.14	$28.84	$29.56	$30.30
	12	$ 28.61	$29.33	$30.06	$30.81	$31.58
	13	$ 29.88	$30.63	$31.39	$32.18	$32.98
	14	$ 30.97	$31.74	$32.54	$33.35	$34.19
	15*	$ 31.66	$32.45	$33.26	$34.09	$34.95
	16*	$ 32.33	$33.14	$33.97	$34.82	$35.69
	17*	$ 33.96	$34.81	$35.68	$36.57	$37.49

* Specially negotiated rates not subject to the Wage Evaluation Committee.

		Meter Reading				
		As Of	Effective	Effective	Effective	Effective
		April 1,	April 1,	April 1,	April 1,	April 1,
		2018	2019	2020	2021	2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
Wage level	MR1	$ 18.32	$18.78	$19.25	$19.73	$20.22
	MR2	$ 18.52	$18.98	$19.46	$19.94	$20.44
	MR3	$ 21.75	$22.29	$22.85	$23.42	$24.01
	MR4	$ 25.79	$26.43	$27.10	$27.77	$28.47
	MR5	$ 27.72	$28.41	$29.12	$29.85	$30.60
	MR6	$ 19.81	$20.31	$20.81	$21.33	$21.87

		Call Center and Revenue Services				
		As Of	Effective	Effective	Effective	Effective
		April 1,	April 1,	April 1,	April 1,	April 1,
		2018	2019	2020	2021	2022
	Base Increase	NA	Max Rate	Max Rate	Max Rate	Max Rate
Level	C2*	$ 16.00	$16.00	$16.40	$16.81	$17.23
	C3**	$ 15.08	$15.08	$15.08	$15.08	$15.08
	C4**	$ 13.00	$13.00	$13.00	$13.00	$13.00
	C5**	$ 18.50	$19.00	$19.00	$19.00	$19.00
	C7*	$ 19.00	$19.50	$19.50	$19.75	$19.75

*Eligible for the annual wage increase.

** Not eligible for the annual wage increase.

Employees at the maximum rate of pay will receive the annual wage increase applicable to Clerical employees in the form of a lump sum.

		Manual				
		As Of April 1, 2018	Effective April 1, 2019	Effective April 1, 2020	Effective April 1, 2021	Effective April 1, 2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
Wage Level	7	$ 29.36	$30.09	$30.84	$31.61	$32.40
	10	$ 27.80	$28.50	$29.21	$29.94	$30.69
	12	$ 31.69	$32.48	$33.29	$34.12	$34.98
	16	$ 31.69	$32.48	$33.29	$34.12	$34.98

		Technical				
		As Of April 1, 2018	Effective April 1, 2019	Effective April 1, 2020	Effective April 1, 2021	Effective April 1, 2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
Wage Level	1	$ 23.42	$24.01	$24.61	$25.22	$25.85
	2	$ 25.58	$26.22	$26.88	$27.55	$28.24
	3	$ 28.38	$29.09	$29.82	$30.56	$31.33
	4	$ 30.39	$31.15	$31.93	$32.73	$33.55
	5	$ 32.66	$33.48	$34.32	$35.17	$36.05
	6	$ 34.09	$34.94	$35.81	$36.71	$37.63
	7	$ 35.50	$36.39	$37.30	$38.23	$39.19
	8	$ 36.83	$37.75	$38.69	$39.66	$40.65
	9	$ 37.89	$38.84	$39.81	$40.81	$41.83
	10*	$ 39.68	$40.67	$41.69	$42.73	$43.80
	11*	$ 40.75	$41.77	$42.81	$43.88	$44.98
	12*	$ 41.81	$42.86	$43.93	$45.02	$46.15

* Specially negotiated rates not subject to the Wage Evaluation Committee.

		CPC				
		As Of April 1, 2018	Effective April 1, 2019	Effective April 1, 2020	Effective April 1, 2021	Effective April 1, 2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
Level	CP1	$ 29.09	$29.82	$30.56	$31.33	$32.11
	CP2	$ 34.30	$35.16	$36.04	$36.94	$37.86
	CP3	$ 41.81	$42.86	$43.93	$45.02	$46.15

		IT				
		As Of April 1, 2018	Effective April 1, 2019	Effective April 1, 2020	Effective April 1, 2021	Effective April 1, 2022
	Base Increase	NA	2.50%	2.50%	2.50%	2.50%
Level	IT1	$ 39.68	$40.67	$41.69	$42.73	$43.80
	IT2	$ 34.12	$34.97	$35.85	$36.74	$37.66
	IT3	$ 28.85	$29.57	$30.31	$31.07	$31.85

(b) These wage rate increases shall not apply to the minimum wage rates of starting job classifications. Any changes to wage rates, including merit or general wage increases, will be applied beginning the first day of the pay period that includes the effective date of the increase.

(c) The wage increases mentioned above shall not apply to any employee whose present wage rate is on or above the new maximum wage rate of his job classification, except employees who are on physical retrogressions, who shall receive the increase applicable to their individual wage rate as of the indicated dates of increase.

(d) Manual employees shall be provided the higher of a $10.00 promotional increase above the maximum wage rate of the job classification from which they promote, or the minimum wage rate of the job classification to which they promote. Clerical and Technical employees shall be provided the higher of a $10.00 promotional increase or the minimum wage rate of the job classification to which they promote. This provision will not apply when the maximum wage rate of a job classification is not at least $10.00 above the maximum wage rate of the job classification from which it promotes.

(e) Whenever the difference between the minimum and maximum wage rates of a job classification is not divisible by $0.25, the intermediate wage rates will be by $0.25 steps, with the exception of the last step to the maximum wage rate of the job. In such case the increase to the maximum wage rate will include the $0.25 increment plus the odd amount necessary to equal the maximum wage rate, provided, however, that the total amount of this increase is less than $0.50. A-40

(f) Any employee in the Union who was on or below the maximum wage rate of his job classification as of the indicated dates of increase shall receive the increase applicable to the maximum wage rate of his job classification.

(g) The shift differentials and Sunday premium paid to employees on scheduled shifts on classified jobs will be as follows:

Name of Shift	Definition of Shift	Shift Differential Cents Per Hour May 6, 2019 – March 31, 2023
Day Shift	Where the majority of the scheduled hours worked are between 8:00 a.m. and 4:00 p.m.	$0.00
Afternoon Shift	Where the majority of the scheduled hours worked are between 4:00 p.m. and 12:00 Midnight	$1.80

Night Shift	Where the majority of the scheduled hours worked are between 12:00 Midnight and 8:00 a.m.	$1.85

When the majority of the hours in a shift are on a Sunday, a Sunday premium will be paid to an employee for all scheduled straight time hours worked on that shift.

	As of May 6, 2019
Sunday Premium	$2.05

(h) The nature of the work involved under each payroll classification shall be defined, as nearly as possible, by the Company and occupational classifications and job descriptions shall be prepared by the Company and be subject to review by the Union. A-40

(i) The Job Evaluation Committee of the Company will be responsible for evaluating all new or revised job classifications. The evaluation established by this Committee will be used to determine the maximum wage rate for each new or revised job classification. Results of the evaluation will be communicated to the Union at least two weeks before the effective date of the new or revised job classification. A-21 A-38 A-40 A-41

(j) The Union shall appoint a Classification Committee consisting of not more than five members who may review the evaluation and wage rate of any new or revised classification. The Union's Committee may, by request, meet with the Company's Committee as soon as possible at a mutually agreeable time, but within 30 days after the Union has been notified by the Company of the proposed new or revised classification, for the purpose of presenting any information relative to the evaluation of a new or revised classification. The Union will be notified after the Company's Committee has reviewed the information presented by the Union. All wage rates so established shall be final and binding and not subject to the grievance and arbitration procedure. However, if any revised wage rates are reduced as a result of the evaluation(s), they will not be placed into effect until the Company and the Union have had an opportunity to negotiate them during full contract negotiations, even though the revised job classification will be in effect. Employees, presently in, or promoting to, such job classifications will continue to receive wage adjustments in accordance with the other provisions of the Agreement just as if the wage rate had remained at the same level until a new Agreement is reached.

(k) When the Union believes that a new or revised job description does not adequately describe the principal duties and minimum qualifications necessary to provide a sufficient basis for evaluating that job description, a letter outlining the Union's suggested changes may be sent to the management of the appropriate department for consideration. However, there will be no recourse to the grievance and arbitration procedure because of the language of a job description or the evaluation of a job classification.

(l) Where the Union deems an employee to be improperly classified, it will be considered as a grievance and shall be handled under the grievance procedure described elsewhere in this Agreement.

Section 2. (a) With the exception of shift differential premium, and a holiday occurring during an employee's vacation, it is agreed that under no circumstances shall any section of this Agreement be interpreted to provide the pyramiding of a benefit or premium payment to employees covered by this Agreement. For example, no employee may claim sick pay while receiving vacation pay or holiday pay while receiving sick pay.

(b) It is further agreed that there shall be no interruption in the payment of one benefit in order that employees may receive payment for another benefit. For example, employees may not interrupt vacation to begin sick leave or interrupt sick leave to include a holiday. The only exceptions to this provision are that an employee's sick pay may be interrupted to include vacation pay and that vacation pay may be interrupted to include death in family pay as set forth in the Agreement.

Section 3. Pay Checks will be directly deposited into one or more bank accounts employees shall designate and authorize. Direct Deposit advices will be mailed to the employee's home address if he/she has elected to receive a printed copy. For any employee who specifically declines to authorize direct deposit. a paper check will be mailed to the employee's home address.

ARTICLE IX

Section 1. ABSENCE DUE TO SICKNESS, FAMILY CARE AND PARENTAL LEAVE. (a) Effective January 1, 2020, employees will be eligible for paid time off due to qualifying sick or family care reasons and, effective upon ratification of this Agreement for paid parental leave, on the same basis as the Company's general, non-represented employee population.

(b) After a part-time employee with 12 months of service or a full-time employee has been continuously disabled, subject to medical determination, and unable to return to work for more than seven consecutive calendar days, the employee will receive Short-Term Disability pay consisting of up to 26 weeks of pay per incident with payment based on the schedule below or until the employee is able to return to work, whichever occurs first.

Years of Service	Maximum Weeks at 100% Pay	Weeks at 66 2/3% Pay
0-1	None	All
1-5	10	Balance
6-10	15	Balance
11-14	20	Balance
15-20	26	Balance
21 or more	ALL	N/A

(c) After an employee has been continuously disabled, subject to medical determination, and is unable to return to work for more than 27 consecutive weeks, and has exhausted Short-Term Disability benefits, the employee will receive Long-Term Disability benefits as described in the Company's Long-Term Disability Plan Description.

Section 2. Compensation will not be provided for illnesses resulting from such causes as: illegal use of drugs or alcohol, willful intention to injure oneself, the commission of a crime, elective or cosmetic procedures not covered by the medical plan, the employee's refusal to adopt such remedial measures as may be commensurate with the employee's disability or permit reasonable examinations by the Company. A-50

Section 3. It is also mutually understood and agreed that the Company shall have the right to investigate and determine for its own satisfaction the bona fide nature of any illness for which pay is requested as well as the duration thereof. In order to facilitate the scheduling of the work forces, employees who will be absent from work are expected to notify the Company as soon as possible, but not later than one hour after their regular starting times and in the case of shift workers, one hour before the start of their shifts. Unless an employee submits a legitimate excuse for not reporting the cause of absence before the end of the first hour of such absence, the employee's claim for sick leave pay shall not begin until such notice is received.

Section 4. When employees have received all of the disability pay to which they are entitled under this Agreement they shall be granted, upon written request on a form provided by the Company, a "leave of absence" and shall not be eligible for further disability pay benefits until they have returned to steady employment. A-5

Section 5. (a) An employee accrues entitlement of 1/12 of their current year's vacation for each full month the employee is employed during the current calendar year or is on STD, or leave of absence. Any employee leaving the Company's service during any calendar year shall receive payment for any unused portion of accrued vacation for that current year. However, in the event of an employee's death, the estate of the employee will be paid the unused portion of the employee's total vacation allotment for the current year. A-52

Employees returning from military service will receive vacations with pay in the calendar year in which they return as follows:

Month in which Employee Returns to Company's Employment	Amount of Vacation Based on System Service of Employee
Up to and including June	Full
July, August and September	One-Half
After September	None

(b) In order for an employee to qualify for a vacation, the employee must have been ready, willing and able to work as a full-time regular or probationary employee during the calendar year the vacation is taken.

(c) The anniversary of employment shall determine the employee's vacation status. Every effort will be made to grant vacations at a time suitable to the employee, but should the vacation of an employee handicap the operations of the Company in any way, the Company reserves the right to require the vacation be taken at another time. Normally, preference shall be granted in the selection of vacation dates on the basis of system service. A-1 A-8

(d) Employees with less than one year of service with the Company shall be entitled to one day of vacation for each month worked, with a maximum of 10 total days.

(e) Employees with one year of service with the Company shall be entitled to a vacation of two weeks.

(f) Employees with seven or more years of service with the Company shall be entitled to a vacation of three weeks. Should the amount of work or other working conditions be such that the operations of the Company would be handicapped by granting of the third week of an employee's vacation, the Company reserves the right to require an employee to take his third week of vacation at such time that does not interfere with the operations of the Company.

(g) Employees with 15 or more years of service with the Company shall be entitled to a fourth week of vacation or payment of one week's wages (40 hours) at straight time in lieu thereof. The Company may also require such employees to take the fourth week of their vacation at such time as does not interfere with the operations of the Company.

(h) Employees with 21 or more years of service with the Company shall be entitled to a fifth week of vacation or payment of one week's wages (40 hours) at straight time in lieu thereof. The Company may also require such employees to take the fifth week of their vacation at such time as does not interfere with the operations of the Company.

(i) Employees with 32 or more years of service with the Company shall be entitled to a sixth week of vacation or, if required to work by the Company, payment of one week's wages (40 hours) at straight time in lieu thereof. The Company may also require such employees to take the sixth week of their vacation at such time as does not interfere with the operations of the Company.

ARTICLE X

Section 1. Regular employees entering the armed services of the United States or employees who are conscripted by the United States Government during a period of national emergency shall continue to accumulate full system service and full seniority and may return to their former position or one of equal pay and rank, provided they report for work with a certificate of satisfactory completion of military or governmental service within 90 days after their release from active service.

Section 2. (a) All Company sponsored life and AD&D insurance coverage for employees starting an approved military leave of absence will be continued for a period of at least 90 days after the employee's leave of absence begins with the same cost sharing as before the leave began.

(b) Company Group Life Insurance of employees returning to Company service within 90 days after their release from active service will be reinstated without physical examination or waiting period.

Section 3. None of the foregoing provisions in this Article shall apply to those employees who are not eligible for statutory re-employment rights.

ARTICLE XI

Section 1. (a) The following days are observed as regular holidays which will be recognized on the indicated dates. The Company may change the date for recognizing a holiday if the date indicated is changed by a legislative enactment or if the prevailing community practice is not consistent with the indicated date.

HOLIDAY	DATE RECOGNIZED
New Year's Day	January 1
Memorial Day	Last Monday – May
Independence Day	July 4
Labor Day	First Monday – September
Thanksgiving Day	Fourth Thursday – November
Day after Thanksgiving	Friday after Thanksgiving
Christmas Eve	December 24
Christmas Day	December 25

(b) If the recognized date of a holiday occurs on a Saturday or Sunday, the Company will have the option of either celebrating that holiday on another date which is consistent with community practice or paying eight hours of regular straight time holiday pay in lieu thereof for the holiday.

(c) Regular employees whose duties do not require them to work on holidays will be paid straight time. Regular employees who are scheduled to work on a recognized holiday will be paid at time and one-half for the first eight hours worked in addition to their straight time holiday pay. However, those employees who work less than the eight hours scheduled will have their straight time holiday pay correspondingly reduced.

(d) Regular employees who are called out to work on a recognized holiday for a period of four hours or less not contiguous with hours worked into or out of the holiday will be paid for four hours at time and one-half in addition to their straight time holiday pay. Employees who are called out to work on a recognized holiday for more than four hours not contiguous with hours worked into or out of the holiday but less than eight hours will be A-11

paid for eight hours at time and one-half in addition to their regular straight time holiday pay. Employees who are required to work more than eight hours on a recognized holiday will be paid at the rate of double time for all such work in excess of eight hours. An employee must work either his full scheduled day before, or his full scheduled day after a holiday to be entitled to receive holiday pay. An employee will not be compensated for travel time on a call-out which occurs on a regular holiday.

(e) When a holiday falls within an employee's vacation, the employee shall, at the discretion of the Company, either be allowed an additional vacation day at such time in the same year as shall be mutually agreed upon between the employee and his supervisor or shall receive eight hours additional pay to compensate for the loss of such holiday pay.

(f) An employee beginning a leave of absence will not receive holiday pay for holidays occurring after the last day worked except when the employee works the full calendar day immediately before a recognized holiday which is in the same pay period.

Section 2. (a) An employee who has completed six months of service with the Company shall be entitled to four compensated Personal days off and one compensated Diversity day off each calendar year. Requests for Personal/Diversity days should be made at least five calendar days prior to the date requested and must be approved by management. However, because of extenuating circumstances, a day off with less than a five calendar-day notification may be approved by an employee's supervisor; such approval will not be unreasonably denied. The Company reserves the right to limit the number of employees who can be off on a specific day. Individual departments will attempt to accommodate as many requests as possible to take a Personal/Diversity day or vacation day on Martin Luther King, Jr. Day, Presidents' Day, and/or Good Friday.

(b) If a Personal/Diversity day is not used during a year, it shall be lost and no additional compensation shall be granted. Any employee who resigns, retires or is discharged from the Company for any reason shall not receive compensation for any remaining Personal/Diversity days.

(c) Personal/Diversity days must be taken in full day increments. Paid Personal/Diversity days will not be considered as absences for purposes of an individual's attendance record.

ARTICLE XII

Section 1. (a) It is agreed that the present establishment of 40 hours per week of the Company will remain in effect, except in those divisions where longer or shorter hours are now being worked, and the Company guarantees employment of not less than 40 hours per week for 52 weeks of each year to all employees represented by the Union as bargaining agent, who are available and ready to work, and who are regular full-time employees of the Company, except those on a less than 40 hour basis now. No such employees shall be required to work more than 40 hours in any one week, consisting of seven days, nor more than eight hours in any one day except as hereinafter provided.

(b) Nothing in this section will affect in any manner the right of the Company to make temporary or permanent reductions in forces when considered necessary by the Company.

(c) Nothing in this Agreement shall be deemed to require the Company or the Union to commit an unfair labor practice or other act which is forbidden by, or is an offense under, existing or future laws affecting the relations of the Company with the employees bargained for by the Union.

Section 2. (a) The work week of an employee for payroll purposes and for determining off-days shall consist of seven consecutive days with a minimum of two scheduled off days and be from midnight Sunday to midnight the following Sunday. Employees working on a shift beginning two hours or less before midnight will be considered as having worked their hours following midnight. A-12 A-17

(b) Regular scheduled hours of work per day will be at straight time for regular scheduled work days, time and one-half for the employee's first scheduled off-day in the work week, double time for the employee's second scheduled off-day in the work week and time and one-half for any additional scheduled off-days in the work week. Any time in excess of the employee's regular scheduled hours per day will be paid at the rate of time and one-half except the employee's second scheduled off-day worked which will be paid at double time. A-71 A-76

(c) Employees required to work more than 16 consecutive hours will be paid double time for all time worked in excess of, and contiguous with, the 16 consecutive hours.

(d) Schedules for all employees will be based on the time prevailing in the City of Cincinnati.

(e) In no case will an employee be forced to take time off in lieu of overtime pay. The Company shall be the sole judge as to the necessity for overtime work, and the employee shall be obligated to work overtime when requested to do so. When overtime occurs in a group or department, where more employees are qualified and available to work than are necessary at the moment, the Company agrees to establish a system of selecting the employees who are to work, in a sincere effort to equalize overtime work. The employees will be notified in advance, whenever possible, when they are required to work overtime.

Section 3. (a) The Union recognizes the need for shift work and weekend work in order to provide for continuous operation, and overtime rates will apply as set forth in Article XII, Section 2.

(b) An employee who is transferred from his regular shift to another shift shall be notified of said transfer at least 24 hours prior thereto. A-13

Section 4. (a) Employees called out for other than planned overtime shall be paid a minimum of four hours at the appropriate overtime rate. Travel time of one-half hour each way will be allowed on a call-out when such call-out exceeds four hours of continuous work that is not contiguous with a regular scheduled shift. Employees will not be compensated for any travel time for planned overtime; or on a call-out when the employee is not released from work before his regularly scheduled shift; nor will travel time be allowed when overtime is worked continuously at the end of a regularly scheduled shift. A-74 A-78

(b) Planned overtime shall be defined as time worked upon notice to an employee given before leaving his headquarters or place of reporting, or in case of an off-day, during or before what would have been his scheduled hours on that day, that he is to report outside of his regular schedule on any succeeding day. Such time worked shall be paid for at the appropriate overtime rate but not for less than four hours unless such planned overtime extends into or directly follows the employee's regularly scheduled work day, when it shall be paid for at the appropriate overtime rate for the actual hours worked.

Section 5. (a) Employees working two hours or more in excess of their normal work day, shall receive a meal, or compensation in lieu thereof, and an additional meal, or compensation in lieu thereof, after each additional five hours of continuous overtime work over and above the original two hours mentioned above.

(b) Employees called out on either their scheduled off day, or four or more hours before his regularly scheduled starting time, shall be furnished a meal, or compensation in lieu thereof, for each contiguous five hour interval worked even though he works into his regularly scheduled work day.

(c) The meal compensation allowance referred to above shall be as follows:

Effective May 6, 2019 – March 31, 2023
$11.50

Section 6. It is further agreed by the Company that any manual employee temporarily advanced to a higher classification shall receive the minimum rate of pay applicable to that classification if such work is for four hours or more. If such work is for more than four hours the employee shall receive the minimum rate of pay applicable to that classification for the remainder of the normal day worked. In the administration of this section of the Agreement, a temporary assignment shall be construed to mean any job assignment which is not expected to continue for more than 90 consecutive days. A-46

Section 7. (a) Employees in this bargaining unit temporarily assigned to a supervisory position outside the bargaining unit for four hours or more, shall receive $1.50 per hour above the maximum rate of pay of either their job classification, or the highest rated job classification they supervise, whichever is greater. It is expressly understood that employees temporarily assigned to a supervisory position shall direct the flow of work and oversee the assignment and completion of work in accordance with applicable policies and procedures in the department. However, they shall not have any responsibility for making hiring decisions, issuing evaluations or discipline, or moving work currently performed by

other bargaining unit members into or out of any department.

(b) Employees promoted to a job outside the bargaining unit and who return to the bargaining unit within six months, shall retain all classified seniority accumulated up to the date of their promotion. If employees who were in a job outside the bargaining unit for more than six months, return to the bargaining unit, they will be placed in a starting job classification and receive a classified seniority date behind all employees. No employee may return to a bargaining unit job classification if, as a result, an employee represented by the Union would be laid off.

ARTICLE XIII

Section 1. (a) The Company agrees that upon his or her return to work from illness or disability, consideration will be given to the employee's physical condition, and, if possible, a less vigorous type of work will be granted at no reduction in the employee's regular pay for a temporary period to be determined by the employee's and the Company's physicians.

(b) If an employee with 15 or more years of service becomes physically unable to satisfactorily and safely perform the regular duties of his classification, an effort will be made by the Company to find work of a less strenuous nature for which he is qualified and to which the employee will be retrogressed. The employee's wage rate will be reduced by an amount equal to the semi-annual merit increase for the employee's job classification at the time of the assignment to a job of a lower classification and at six months' periods will be reduced by an amount equal to the semi-annual merit increase for the employee's job classification until the employee's wage rate is equal to the maximum wage rate of the job classification to which he has been retrogressed.

(c) If an employee with 10 to 14 years of service becomes physically unable to satisfactorily and safely perform the regular duties of his job classification, he may request a demotion to a lower classification requiring work of a less strenuous nature for which he is qualified to perform. If such a demotion is granted by the Company, the employee will be assigned to a lower classification and will have his wage rate red-circled until it is equal to the maximum wage rate of the job classification to which he has been demoted. Employees whose wages have been red-circled and who subsequently achieve 15 years of service will become retrogressed in accordance with paragraph (b) above.

(d) If an employee with less than 10 years of service becomes physically unable to satisfactorily and safely perform the regular duties of his job classification, he may request a demotion to a lower classification requiring work of a less strenuous nature for which he is qualified to perform. If such a demotion is granted by the Company, the employee will be assigned to a lower classification and will have his wage rate established at the maximum wage rate of the job classification to which he has been demoted.

Section 2. Injured employees who are unable to work because of an industrial accident will be paid a supplement in an amount equal to one half of the difference between what he/she would have received at regular work and the amount received as compensation for such injury, for a period not to exceed 26 weeks. This supplemental industrial accident compensation will begin after the initial seven calendar day waiting period and will continue for not more than 26 weeks of continuous disability. If, however, an industrial accident disability continues for two or more weeks, the employee will receive this supplemental industrial accident compensation for the initial seven day waiting period.

Section 3. Upon the death of the designated relatives of an employee, the employee, upon request, may be entitled to the stipulated maximum number of calendar days off for which the employee is entitled to receive regular pay for not more than the indicated number of consecutive working days, including the day of the funeral. No pay will be granted for regular scheduled off days.

Relationship	Maximum Consecutive Calendar Days Off	Maximum Consecutive Working Days Off With Pay
Spouse or Domestic Partner	7	5
Child/Step/Foster	7	5
Mother/Step/Foster	7	5
Father/Step/Foster	7	5
Brother/Step/Foster	7	5
Sister/Step/Foster	7	5
In-Laws (father, mother, brother, sister, son or daughter)	5	3
Grandchild/Step	5	3
Grandparent/Spouse's Grandparent	5	3
Any relative who resides in the employee's household.	7	5
Aunt/Uncle	5	3
Nephew/Niece	5	3

If an employee has reported to work and is notified of a death in the family and leaves the job, the day will not be charged as one of the consecutive working days for which the employee is entitled to receive regular pay.

ARTICLE XIV

Section 1. The Company agrees to erect bulletin boards at locations to be selected by the Union and the Company. The use of these boards is restricted to the following: notices of Union meetings, notices of Union elections, notices of changes within the Union affecting its membership, and any other notices issued on the letterhead of the Union. There shall be no other general distribution or posting by the members of the Union of pamphlets, or political literature of any kind, except as herein provided.

ARTICLE XV

Section 1. Any member or members not to exceed three members elected or employed by the Union whose duties for the Union require their full time shall be granted a leave of absence by the Company for six months and additional six months' periods thereafter, provided that each member is from a different promotional sequence or that the Company has granted permission for two members to be from the same promotional sequence. On return to the employ of the Company, such employees shall be employed at their previous classification or other higher classification within this unit for which they may be qualified.

ARTICLE XVI

Section 1. (a) The Company agrees to notify the Union of the contemplated hiring of any outside contractors to do work normally performed by regular employees covered by this Agreement. Such notification will be given if it is contemplated that the work will be in excess of 2,000 man-hours.

(b) It is the sense of this provision that the Company will not contract/outsource any work which is ordinarily done by its regular employees if as a result thereof, it would become necessary to lay off any such employees.

Section 2. (a) Each employee shall have a specific headquarters for reporting for work. However, the right of the Company to effect transfers and reassignments to properly run its business is recognized.

(b) When it is necessary to temporarily assign employees to a headquarters other than their own or to a job site reporting location that is further from their home than their regular headquarters, these employees will be paid mileage at the prevailing rate based on the additional round-trip mileage employees are required to drive. No mileage compensation will be paid for the temporary assignment if the other reporting location is closer to the employee’s home. Employees reassigned (non-temporary assignment) to a different headquarters will be paid mileage compensation during the first fourteen calendar days of the reassignment. A-15

(c) When an entire work group is assigned to a new headquarters, paragraph (b) of this Article shall not apply.

(d) Job site reporting and other temporary assignments will be offered on a voluntary basis. If there is an insufficient number of volunteers, assignments will be made on a junior qualified basis. When assigning the junior qualified, unusual or extenuating circumstances will be taken into consideration.

(e) Employees may be assigned to drive Company vehicles from and to the job site from home or sites close to home. If Company vehicles are used in such a manner, the mileage provisions for job site reporting are not applicable. An option to the mileage provision is that employees may, during a job site reporting assignment, pick up and return a Company vehicle to their regular headquarters, provided travel is on their own time.

ARTICLE XVII

Section 1. Witness Fees. Regular pay and reasonable or required expenses will be allowed employees who may be summoned or requested to testify for the Company.

Section 2. (a) Employees required to serve on a jury shall be compensated on the basis of their regular salary. Employees must report to work during the working hours when they do not need to be present for jury duty.

(b) An employee working on either a night or afternoon shift at a time when he is scheduled for jury duty, who is unable to postpone the jury duty until a time when he will be working on a day shift, may request the Company to assign him to a day shift schedule. Such a request must be made at least seven working days before the jury duty service is scheduled to begin. When the term of jury duty for such an employee has ended, he shall return to his normal working schedule.

ARTICLE XVIII

Section 1. RETIREMENT INCOME PLAN: (a) Eligible Union employees hired or rehired before January 1, 2016 will participate, or continue to participate, in the existing Cinergy Corp. Union Employees' Retirement Income Plan (the "Retirement Income Plan"); provided, however, that effective January 1, 2009, the cash balance feature provided under the Retirement Income Plan shall be amended to provide that all future pay and interest credits provided thereunder to eligible Union employees will mirror the pay and interest credits provided as of the date of this Agreement under the Duke Energy Retirement Cash Balance Plan (i.e., 4% - 7% depending on age and years of service), and as further amended under the terms set forth in the April 15, 2015 Letter Agreement titled "Amendment to A58 Retirement Plan Agreement. Employees hired or rehired on or after January 1, 2016 will not be eligible to participate in the Retirement Income Plan.

(b) It is agreed that the Company will not reduce the benefits and the Union will not request any change in the Retirement Income Plan until the expiration of the Agreement on April 1, 2019.

ARTICLE XIX

Section 1. Any insurance benefit plans under the Duke Energy Health & Welfare Benefit Plans not specifically referenced elsewhere in this Contract (i.e. life insurance, supplemental, accidental death and dismemberment and dependent life insurance) that the Company maintains and/or implements for the general non-unionized employee population shall also be provided to the bargaining unit employees at the same benefit levels, costs and plan design structure as for the non-unionized employees. The Company has the right to add, eliminate, and alter or to make any other changes to these insurance benefit plans or the employee costs for the plans, consistent with any changes it makes for the general, non-unionized employee populations.

ARTICLE XX

Section 1. HOSPITAL AND MEDICAL PLANS: (a) Health care coverage shall consist of the specially negotiated EPO Plan and shall remain in effect for the term of the 2008 – 2012 Contract. All terms of the specially negotiated EPO Plan, regarding plan design, covered services, premiums and other employee costs, shall be in accordance with the 2008 negotiations letter of agreement entitled “Health Care Benefits.” A-42 A42b

(b) Any other health care plans (medical or dental) that the Company unilaterally implements at its sole discretion for the general non-represented employee population shall also be provided to the bargaining unit employees at the same costs and plan design structure as for the non-represented employees. It is expressly understood that the right to add, eliminate, and alter or to make any other changes to these health care plans or to employee costs for the plans, is reserved to the Company.

(c) The Company's part of the premium will continue to be paid while an employee is receiving illness or accident compensation provided the employee was covered by such a contract immediately prior to their sickness or industrial accident.

ARTICLE XXI

Section 1. The level of benefit coverage within the medical, dental, flexible spending accounts, basic and additional life, long-term disability, and pension plans will remain substantially equivalent to the coverages mutually agreed upon during negotiations.

ARTICLE XXII

Section 1. (a) Eligible Union employees will participate or continue to participate in the existing Duke Energy Retirement Savings Plan (the “RSP”); provided, however, that (i) for eligible Union employees in the Cinergy Traditional Formula under the Cinergy Corp. Union Employees’ Retirement Income Plan (Retirement Income Plan), the matching contribution formula (rate and definition of eligible compensation) under the RSP will continue to be the formula in effect prior to January 1, 2009 (i.e. 100% match on pre-tax and Roth 401(k) contributions up to 3% of the participant’s eligible pay, 50% match on the A-58 A-58a

pre-tax and Roth 401(k) on next 2% of the participant's eligible pay, and an incentive match based on the attainment of corporate goals established by Duke Energy), (ii) for all other eligible Union employees, the matching contribution formula rate (rate and definition of eligible compensation) under the RSP will mirror the matching contribution formula provided under the RSP for all eligible union employees other than "Cinergy Traditional Employees" as of the date of this Agreement (i.e. 100% match on pre-tax and Roth 401(k) contributions up to 6% of the participants eligible compensation, with no incentive matching contribution opportunity), and (iii) for eligible Union employees who are not eligible for the Retirement Income Plan on or after January 1, 2016, the RSP shall provide the employer retirement contribution formula (rate and definition of total pay under the RSP that mirrors the employer retirement contribution formula provided for all participants who are not eligible to participate in a defined benefit pension plan (i.e.4% of total pay) as of the date of this Agreement.

(b) The RSP is contained in the existing Duke Energy Retirement Savings Plan as amended and restated effective January 1, 2014 and as amended by an amendment dated December 19, 2014.

(c) The Company hopes and expects to continue the RSP indefinitely, but must reserve the right to alter it or discontinue Company contributions to it for a time. However, under no circumstances shall any part of the corpus or income held by the Trustee of the RSP be recoverable by the Company or be used for or diverted to any purposes other than for the exclusive benefit of the employee participants or their beneficiaries as provided in the RSP.

IN WITNESS WHEREOF, the Utility Workers Union of America, AFL-CIO, Local 600, formerly the Independent Utilities Union, Cincinnati, Ohio and Duke Energy Ohio, Inc., Duke Energy Kentucky, Inc., do hereby, by their duly authorized agents, execute and sign this Agreement in duplicate on this 29 day of March, 2019.

DUKE ENERGY OHIO, INC.
DUKE ENERGY KENTUCKY, INC.

Amy Spiller
State President-Ohio/Kentucky

Stan Sherrill
Vice President – Strategic HR Business Solutions, Employee & Labor Relations

Jay R. Alvaro
Director, Labor Relations

Lisa A. Gregory
Manager, Labor Relations

Michael A. Ciccarella
Sr. Human Resources Consultant

Terri Barnes
Sr. Human Resources Consultant

UTILITY WORKERS UNION OF AMERICA, AFL-CIO, LOCAL 600

Steve Kowolonek
President

Mike Hoffman
Vice President

D.L. Wallace
Secretary

Jueisha Boykin
Treasurer

Illyana Long
Delegate

Camille Waller
Delegate

Kelly Cooper
Sr. National Representative
UWUA Region III



HISTORICAL SIDEBAR LETTERS
2019 – 2023

Between

Duke Energy Ohio, Inc.
Duke Energy Kentucky, Inc.

and

Utility Workers Union of America,
AFL-CIO, Local 600

Appendix A

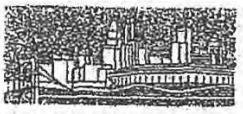
Historical Documents Preserved
And Made A Part Of This Agreement
For Interpretation And Application

The index and marginal references in the Labor Agreement to documents in Appendix A are intended only for convenience in administering the Labor Agreement. The index and marginal references and Appendix A are not intended to list every document that could be applicable to any factual situation arising under a given Article or Section of the Labor Agreement. It is also not intended that each document referenced in an Article or Section will be applicable to any or all factual situations covered by the referenced Article or Section. No inferences, presumptions, or conclusions shall be drawn by the Company, the Union, or any arbitrator from the indexing of, a marginal reference to, or failure to reference any document listed in Appendix A.

Document Number	Document Date	Article	Subject
A-1	12/22/71	IX, 5(c)	Vacation Selection
A-2	07/16/74	V, 4(b)	Inter-Department Transfers
A-3	03/28/77	V, 2(c)	Multiple Posting System in Property Department
A-4	03/28/77	V, 3(d)	Testing Procedures When Employees Promote
A-5	04/13/12	IX, 4	Leaves of Absence
A-6	04/18/89	V, 6	Hiring Co-ops – Union Notification
A-8	04/13/12	IX, 5(c)	Partial Day Vacation Administration
A-9	04/18/89	I, 2(c)	Falsification and Tampering with Company Records
A-11	04/16/92	XI, 1(d)	Holiday Call-Out
A-12	04/16/92	XII, 2(a)	Flextime
A-13	04/16/92	XII, 3(b)	24 Hour Notice – Change of Shift
A-14	04/16/92	I, 1(a)	Reorganization of Distribution Operations Division
A-15	04/16/92	XVI, 2(b)	Out-of-Town Work or Training
A-17	04/13/12	XII, 2(a)	Four 10-Hour Day Guidelines
A-18	04/16/92	VII, 1(a)	Personal Attorneys
A-20	07/19/94	V, 2(e)	Gas Operations Trainer
A-32	04/14/15	II, 1 III, 1(b) VII, 1(a)	Time Off for Union Duties/Business
A-38	09/02/98	VIII, 1(i)	BOGAR Job Evaluation System
A-40	12/29/00	VIII, 1(e) VIII, 1(h) VIII, 1(i)	Manual, Clerical and Technical Job Classifications
A-41	05/14/03	VIII, 1(i)	Disconnect Non-Pay, Succession and Special Reads
A-42	06/10/04	XX, 1	Post-Retirement Medical
A-42a	04/13/12	XX, 1	Amendment to Sidebar Letter A-42 Post- Retirement Medical Benefits
A42-b	04/01/19	XX, 1	Amendment to Sidebar Letter A-42 and A42a Post-Retirement Medical Benefits
A-46	04/01/19	XII, 6	Temporary Upgrading in Clerical and Technical Jobs
A-48	04/01/19	V, 7(a) VIII, 1(a)	East Meter Reading
A-49	04/21/05	V, 3(a)	Interplant Seniority Rights
A-50	04/21/05	IX, 2	Treatment for Substance Abuse
A-51	04/21/05	XI, 2(a)	Personal/Diversity Day Requests
A-52	04/01/19	IX, 5(a)	Vacation Carryover
A-55	04/21/05	V, 3(a)	Job Elimination Situations
A-58	06/02/08	XXII, 1	Retirement Plan Agreement
A-58a	04/14/15	XXII, 1	Amendment to Retirement Plan Agreement

Document Number	Document Date	Article	Subject
A-59	06/02/08	Misc.	Sabbatical Vacation Bank and Vacation Credit Programs
A-60	06/02/08	Misc.	Union Employee Annual Incentive Program (UEIP)
A-60a	04/14/15	Misc.	Amendment to Union Employee Annual Incentive Plan (UEIP)
A-60b	04/01/19	Misc.	Amendment to Union Employee Annual Incentive Plan (UEIP)
A-61	04/01/19	V, 7(a) VIII, 1(a)	Cincinnati Call Center
A-62	06/02/08	Misc.	Part-Time Employee Benefits
A-64	04/01/19	VIII, 1(a)	Revenue Services Representatives
A-65	04/01/19	V, 2	Competency Based Selection
A-70	04/01/19	V, 3(a)	UWUA Severance Program
A-71	04/13/12	XII, 2(b)	Overtime Provisions
A-72	04/13/12		Outsourcing Affecting Job Elimination
A-73	11/16/09	Misc.	LIT Job Progression
A-74	03/31/11	XII, 4(a)	On Call Rotation – Local IT Support
A-76	12/20/12	XII, 2(b)	Foreign Utility Assistance
A-77	05/08/14	Misc.	Senior Work Management Support Specialist
A-79	04/14/15	Misc.	Separation of Delivery Operations and Gas Operations
A-80	04/14/15	Misc.	Global Positioning Systems (GPS)
A-81	04/14/15	Misc.	Engineering Specialist Progression
A-82	04/14/15	V, 2	Customer Relations Representative/Clerk C Positions
A-83	04/01/19	VI	Inclement Weather
A-84	04/01/19	XII, 2(a)	Alternate Work Schedule
A-85	04/01/19	Misc.	Gas Marketing Progression
A-86	04/01/19	Misc.	Lighting Specialist

THE CINCINNATI GAS & ELECTRIC COMPANY



CINCINNATI, OHIO 45201

December 22, 1971

Mr. Charles J. Neuhaus
Chairman
Independent Utilities Union
P.O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Neuhaus:

Reference is made to our discussion at a meeting on November 30, 1971 and to your letter of December 1, 1971, concerning a uniform vacation selection procedure for employees represented by the Independent Utilities Union.

In accordance with our conversation, the Company will adopt the following vacation selection procedures effective January 1, 1972:

> Preference for the first two weeks of vacation to which an employee is entitled will be considered within a job classification at each particular work location on a system service basis. Employees entitled to more than a two week vacation may select that additional vacation on a system service basis after all eligible employees within the job classification at each particular work location have had an opportunity to select the dates for at least two weeks of their vacation.

It is emphasized that this procedure will in no way affect the Company's right to determine the number of employees who may take a vacation at any one time.

Please confirm that the procedure stated in this letter is satisfactory to the Union so that the various affected Company departments may be notified prior to January 1, 1972.

Very truly yours,

Robert E. Byrnes

Robert E. Byrnes
Manager
Industrial Relations

A-1

(Due to the deteriorating condition of the original, this letter has been retyped.)

July 16, 1974

Mr. Charles J. Neuhaus
Chairman
Independent Utilities Union
P.O. Box 1757
Cincinnati, Ohio 45202

Dear Mr. Neuhaus:

During the 1974-1977 negotiation meetings, the committees of the Company and the Independent Utilities Union discussed interdepartment transfers to different job classification and lateral bids and their effect on classified seniority. The following procedure has been implemented as a result of the negotiations and subsequent discussions with representatives of the Union.

Individuals who laterally bid or transfer from one bidding are to another will receive classified seniority dates based on the dates they enter the new job classifications in the new bidding area. However, when an employee's move is delayed, consideration will be given to the proper adjustment of the employee's classified seniority rank so that the employee will not be penalized with respect to future opening within the new department. When such employees bid on future openings in the new department, they will be ranked on the basis of their classified seniority date in that bidding area. Should these employees bid on an opening posted outside their immediate bidding area, their wage level seniority will be used in determining their ranking for consideration on the posting. In accordance with past practice, departmental personnel will be given first consideration on an initial I.U.U. wide posting.

The only exceptions to the above procedures are for the following employees in the Customer Services Division of the Customer and Public Relations Department: Douglas Ray Deaton, Patricia L. Lindsay, and Ronald Eugene May. These employees, as was agreed during the negotiations, will be ranked according to wage level date on all promotional bids after they acquire the minimum work experience required for a promotion.

The procedure described in this letter applies only to transfers and lateral bids across bidding areas. Wage level seniority will continue to govern on lateral bids within a bidding area where specific procedures have previously been established.

The Company believes that the described procedures will conform with the agreement reached during the discussions at the 1974 negotiation meetings and will eliminate the potential for employees who transfer or laterally bid into another bidding area from subsequently acquiring more seniority than incumbent employees within the same classification. If the Union concurs with these arrangements, please initial and return the attached copy of this letter.

Very truly yours,

Robert L. Byrnes
Manager
Industrial Relations

cc: L. M. Dagenbach
R. G. Graham

A-2

(Due to the deteriorating condition of the original, this letter has been retyped.)

March 28, 1977

Mr. E. Edward Divine
Chairman
Independent Utilities Union
P.O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Devine:

During the 1977 negotiation meetings, the Company and the Union agreed to the introduction of a multiple posting system into the Property Department. This system is designed to speed up the process of filling job openings in the clerical and manual groups of the Department. For the purpose of posing job openings, accepting bids and selecting qualified applicants for job classifications bargained for by the Independent Utilities Union the existing northern, southern, eastern and western divisions of the Department will remain unchanged. Through multiple posting any known original job openings that the Company decides to fill will be listed on the posting. Any equal or lower level job that opens as a result of the original postings may be filled as a resultant available opening. In addition, any original job opening that becomes available during the posting period may also be filled as a resultant available opening. However, the Company must maintain the right to discontinue the filling of openings at any level of the procedure.

To clarify the procedures, the meaning of certain terms used herein are defined at follows:

A "posting" is the announcement of a job opening on the proper forms which are displayed on the bulletin boards of headquarters within the four divisions of the Property Department.

A "bid" is a written request of an employee on the proper form for consideration for an opening.

A "cross-bid" is a bid for an opening in the same job classification in another Division.

A "lateral bid" is a bid for an opening in a different job classification having the same maximum rate of pay.

A "promotional bid" is a bid for an opening in a job classification having a higher maximum rate of pay.

Any Property Department employee may submit a bid at any time. It is not necessary that a job opening be posted before a bid can be submitted. Only one promotional bid, one cross-bid or one lateral bid can be made on a single bid sheet. The bidder may also indicate on the bid sheet his preference for geographical division in numerical sequence. The bid sheet on file with the latest date as of the closing date of a particular posting will be used in processing that posting. It is imperative that the employee be continually aware of the bids he has on file, as well as his promotional opportunities. An employee accepted on a valid bid must accept the new job classification or new location.

To be valid, a bid must be made out in duplicate and signed by the bidder's supervisor on or prior to the closing date of a posting. One copy of the bid will be returned to the bidder and the other copy will be forwarded to the general office of the Property Department. All bids submitted in the beginning of a calendar year will be retained and used for processing all postings for the calendar year unless changed by the employee.

The acceptance of a bidder on a posting will invalidate all bids of that employee and the employee must submit new bids for consideration on future openings. Any individual bid can be invalidated (withdrawn) by submission of a similar bid with a later date or by the bidder submitting a bid sheet requesting cancellation of all previous bids. In addition, all bids become invalid on December 31 of any year. This will require new bids to be submitted on the first working day of each year or as soon thereafter as practical.

After a job posting has closed the ranking of applicants will be determined on the basis of qualifications, promotional sequences, and classified seniority. Bids will be considered in the following order:

1. Cross-bids
2. Lateral bids
3. Promotional bids

The successful applicant on lateral and promotional bids may be required to qualify by means of an examination if specified by the applicable job descriptions.

Requests for specific job assignments, locations, or shifts within a division may be made in writing to the supervisor in charge of that division. The supervisor will forward a copy of such request to the general office of the Property Department for filing. These requests will be considered by the division supervisor when an opening occurs and prior to the posting of such an opening. However, employees may not exercise their seniority to assure a particular job assignment, location or shift within a division. Requests for assignments will be retained in file until December 31 of any particular year and will be given consideration when job openings occur in the division in which the applicant presently works.

A "results of job opening" will be posted after all bids have been processed. This form will indicate the successful applicants, the headquarters, shift schedule, type of change and effective date. Any applicable payroll changes will be effective on the date which is designated on the multiple posting results sheet.

If, as the result of a job posting, an original opening or any resultant opening cannot be filled by an employee within the Property Department, that job may be posted Company wide.

In addition to permitting more than one cross-bid per posted opening, it is believed that this procedure will materially reduce the time required for the filling of job openings thereby expediting the promotion of employees. It is contemplated that this change in procedure in the Property Department will become effective on or about May 1, 1977.

Very truly yours,

Arthur R. Ehrnschwender

(Due to the deteriorating condition of the original, this letter has been retyped.)

March 28, 1977

Mr. E. Edward Divine
Chairman
Independent Utilities Union
P.O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Divine:

During the 1977 negotiations, the committees for the Company and the Union discussed the testing procedures which are utilized in many promotional sequences when employees promote.

In certain areas of the Company, an employee is tested on the basis of the job from which he promotes. In other instances, testing is based on the job into which an employee will progress and is given within a certain time interval before or after the employee is accepted. Further, the re-testing time interval for employees who do not successfully complete a promotional test varies in different departments. In certain areas of the Company, employees may be pre-tested for future promotional openings. The Union has requested that such advance testing be made available to employees for the next job in their promotional sequence even though an opening may not exist.

The Company is not opposed to advance testing in those situations where a supervisor agrees that such advance testing is in the best interest of all concerned. It must be realized, however, that in some areas of the Company, methods or technology often change so that advance testing is not practical, in such instances the material upon which an employee is tested may be altered substantially at the time an employee may ultimately be promoted. An employee who wishes to be considered for this advance testing should consult with his supervisor. The supervisor will appraise the employee if such testing is permissible and, if not, the supervisor will explain to the employee why his request may not be granted.

It is thought that this letter will clarify any misunderstanding that may have existed concerning advance testing.

Very truly yours,

Arthur R. Ehrnschwender

A-4

Duke Energy®

April 13, 2012

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Leaves of Absence

Dear Mr. Anderson:

During 2012 contract negotiations, the parties discussed Sidebar Letter A-5 dated April 10, 1986 regarding good cause for granting leaves of absence. The parties recognized that there have been significant legal developments since 1986, including but not limited to passage of the Family Medical Leave Act (FMLA) and the Uniformed Service Employment and Reemployment Rights Act (USERRA). Given these and other similar developments, the parties agreed to replace the April 10, 1086 Sidebar Letter as set forth herein.

The Company understands that employees may need to be away from the workplace at times for legitimate reasons. The Company further recognizes that time away from work is important to maintaining a healthy work-life balance. At the same time, the Company depends on a responsible and dependable workforce to serve its customers and meet its business goals.

To balance these interests, the Company provides leaves of absence for qualifying reasons, such as for new parents, medical issues (experienced by the employee or eligible family members), military service, caregivers, education, and other personal reasons deemed by the Company or its third party administrators to justify a leave of absence. Leaves of absence may be granted for up to a maximum of six (6) months, or as otherwise set forth in the applicable summary plan description.

All leaves of absence are provided in a manner consistent with applicable laws. To the extent that a leave of absence provided by the Company is over and above the employee's legal entitlement, it is recognized to be a privilege and not a right of the employee. Such leaves are granted at the discretion of the Company. While never desirable, an employee's absence in most situations can be tolerated more so during certain times of the year than other times.

It is difficult to enumerate the variable circumstances under which employees may be granted personal leaves of absence. The Company evaluates each request on an individual basis in light of the surrounding circumstances specific to such request. For

example, leaves of absence will not be granted for individuals who are absent due to incarceration or for individuals who want to try full-time employment elsewhere.

Employees are expected to cooperate with providing supporting documentation in a timely and truthful manner as needed by the Company and/or its third party administrators to manage the leave process consistently. Employees also are expected to keep their management apprised of their return-to-work status and any work-related restrictions prior to returning to work. Advance notice of the employee's return-to-work date and of any work-related restrictions is necessary for business planning and to ensure compliance with applicable laws.

It is believed that this letter accurately describes the parties' agreement.

Very truly yours,

Jay R. Alvaro
Vice President, Labor Relations

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

Robert E. Byrnes
Senior Vice President

April 18, 1989

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1989 negotiations, the parties discussed the possibility of the Company notifying the Union of the initial employment of co-ops in two year Associate Degree programs.

As agreed during these negotiations, Department Managers will attempt to inform the Union delegates whenever a two year co-op is hired within their areas of responsibility.

It is thought that by proceeding in this manner, the concerns expressed by the Union during the negotiating meetings will be alleviated.

Very truly yours,

Robert E. Byrnes

Robert E. Byrnes

A-6

Duke Energy®

April 13, 2012

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Partial Day Vacation Administration

Dear Mr. Anderson:

During 2012 contract negotiations, the parties discussed the granting of vacations in less than one day increments.

As was agreed, 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 but not less than four hours. It was further agreed that requests for these partial days must be made at least seven 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 seven (7) calendar day notification may be approved by an employee's supervisor.

Currently there are some departments that allow, business needs permitting, employees to take partial vacation days in less than half day increments. It is agreed that individual departments will have the ability to grant vacation requests for less than half day increments at their discretion.

It is believed that this letter accurately describes the parties' agreement.

Very truly yours,

Jay R. Alvaro
Vice President, Labor Relations

A-8

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

Robert E. Byrnes
Senior Vice President

April 18, 1989

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1989 negotiation meetings, the committees for the Company and the Union discussed the degree of discipline to be administered to employees who falsify or tamper with Company records.

Many employees represented by the Union are in positions of trust concerning Company records and accounts. The management depends upon the integrity of each employee in the performance of his or her various job duties and responsibilities. The importance of this reliance upon complete employee veracity cannot be overemphasized.

In many disciplinary situations, the Company adheres to a policy of progressive and constructive discipline in order to impress upon employees the nature of Company expectations. However, as mutually agreed upon during the negotiations, employees whose dishonest acts adversely affect the Company will be summarily discharged. For example, it has been a long established Company policy that all meter reading personnel will be terminated who curb readings, falsify records, or are guilty of defalcation; immediate discharge for these activities will continue.

Employees in various departments have access to Company and other accounting and business records and are confronted with situations where circumstances could allow indiscretions for their personal gain or the benefit of others without proper remuneration to the Company. Many positions of trustworthiness could be misdirected to a manipulation or falsification of Company records in a fraudulent, larcenous, or otherwise dishonest manner. As agreed, such activities will result in immediate termination of employment.

If the types of activities occur as described above, the Company will react in good faith upon a full, fair, and impartial investigation. The Company will take every precaution to evaluate particular incidents in full light of all circumstances in order to make certain that any summary termination is not undertaken in an arbitrary, capricious, or disparate manner.

Very truly yours,

Robert E. Byrnes

Robert E. Byrnes

A-9

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

April 16, 1992

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1992 negotiation meetings, representatives of the Company and the Union discussed the negotiated intent and the current administration of holiday call out provisions contained in Article XI, Section 1 (d) of the Agreement.

There was no dispute between the parties as to how an employee is compensated for any call out assignment where all the hours worked by the individual were entirely within the holiday (midnight to midnight). When such call out assignments are for four hours or less the employee receives four hours pay at the appropriate overtime rate and no travel pay. When such call outs are more than four hours but less than eight, the employee receives eight hours of pay at the appropriate overtime rate and no travel pay. When an employee works entirely within the holiday for more than eight hours, all hours worked after eight hours are compensated at the double time rate of pay with no travel pay. The area of dispute between the parties concerns those call out assignments which are worked contiguous to hours on the day before or the day after a holiday.

In order to completely resolve this matter, the Company is willing to compensate the employee for one hour of travel time at the appropriate rate of pay for call outs of four hours or more contiguous with hours worked into or out of a Company recognized holiday. However, the guarantee of eight hours pay for a call out that is more than four hours but less than eight that is contained in Article XI, Section 1 (d) will not apply to call outs that are contiguous with hours into or out of the holiday.

By proceeding in this manner, it is thought that a consistent and equitable manner of administering the holiday pay provisions of the Agreement can be attained.

Very truly yours,

Edward R. Schuette

A-11

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

April 16, 1992

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1992 negotiation meetings between the Company and the Union, the committees discussed the use of flextime.

As was discussed during these meetings, it is the policy of the Company to use flextime programs in those work groups where such scheduling is deemed appropriate by the Department Manager. Although the Company reserves the right to discontinue the use of flextime where appropriate, it will meet with the Union before proceeding.

It is thought that this will adequately describe the discussion concerning this matter.

Very truly yours,

Edward R. Schuette

A-12

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

April 16, 1992

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1992 negotiation meetings, the committees for the Company and the Union discussed the change of schedule provision in Article XII, Section 3 (b).

Although the language in the current Agreement states that an employee will receive at least a 24-hour notice of a change in shift, the Company will attempt to give at least a five calendar day notice of such changes.

It is thought that this is a fair and equitable policy which will satisfy the interests of all concerned.

Very truly yours,

Edward R. Schuette

A-13

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

April 16, 1992

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1992 negotiations, the committees for the Company and the Union discussed the reorganization of the Distribution Operations Division of the Electric Systems Operations Department.

As was agreed during these negotiations, the supervisory positions within this section will have the flexibility to perform bargaining unit work when an Operations Technician is unavailable to readily respond to a customer inquiry that needs immediate attention. On those occasions supervision will be able to investigate, resolve and recommend solutions to customers about their inquiries. They may also be setting test equipment and or preparing written recommendations for customers. It is anticipated that the performance of this bargaining unit work will be minimal. As stated during the negotiations, it is thought that supervisory employees will only perform these types of operations on an average of one per week. In the event that the Operations Technician, assigned to a specific area, is on vacation, that average may increase to approximately two to three per week. This agreement does not restrict supervisory employees from doing work they previously performed.

It is thought that this agreement will enable us to better serve our customers.

Very truly yours,

Edward R. Schuette

A-14

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

April 16, 1992

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1992 negotiation meetings, representatives for the Company and the Union discussed the policies and procedures to be utilized when employees are required to work or train at out-of-town locations.

The mode of transportation to be utilized for all out-of-town trips will be determined by the Company. Commercial airlines will be used whenever possible. The Company will normally furnish roundtrip airline tickets (tourist or coach class) between the Greater Cincinnati Airport and the point of destination. If prior arrangements are made and the Company agrees, employees may drive to and from their destination and be reimbursed at the appropriate mileage rate but not exceeding the cost of the roundtrip airline ticket. Each individual request will be evaluated by the Company before determining if alternate transportation will be permitted. Employees utilizing the personal car option will not be granted additional time off from their regular scheduled work week in order to meet travel schedules not arranged by the Company. Nor will any other expenses such as personal auto repairs and insurance, extra meals or lodging be reimbursed by the Company.

Normally the Company will arrange for, and pay any living accommodation expenses. Occasionally, there will be times when employees will be responsible for direct payment prior to leaving the hotel/motel. In this case, the employees will receive advance payment for the applicable room rates and must reconcile their accounts personally. During most other out-of-town trips, prior arrangements may permit invoicing of applicable hotel/motel room costs directly to the Company. In this situation, involved employees will not receive any direct payments for room costs. Other types of accommodations will be handled on a case-by-case basis with methods of payment appropriate to the situation.

For extended trips, employees will be informed prior to leaving for the out-of-town assignment as to the number of return trips to Cincinnati they will be allotted. For these return trips, the Company will normally furnish transportation. In the event that visits home are granted and taken, the Company will reimburse each employee for roundtrip transportation costs only.

A-15

The Company may establish and pay an applicable per diem rate in advance for each out-of-town day and each travel day. This rate, which may vary between individual out-of-town locations, will include all other expenses, such as meals, laundry, telephone calls, tips, etc. Transportation and lodging will not be included in the daily per diem amount that each employee will receive. Any expenses incurred over and above the stipulated per diem amount for any given trip will be the responsibility of the employee. Alternately, the Company may elect to reimburse employees for the direct reasonable expenses for such items as meals, laundry, telephone calls, tips, etc. The Company will determine on a case-by-case basis whether a per diem arrangement or reimbursement for reasonable expenses is used for out-of-town assignments.

It is thought that this letter will clarify the Union's concerns about the policies and procedures to be utilized when employees are required to work or train at out-of-town locations.

Very truly yours,

Edward R. Schuette

Duke Energy®

April 13, 2012

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Four 10-Hour Day Guidelines

Dear Mr. Anderson:

During the 2012 negotiations, the parties discussed Side bar Letters A-17 and A-47 regarding four 10-hour day workweeks. As a result of those discussions, the parties agreed to the following revised Guidelines for employees who are assigned to work four 10-hour days.

1. **Off Days.** Management will attempt to provide employees working a four 10-hour day workweek with three consecutive off days. However, employees in a particular work group may request or may be required to have two consecutive off days and another off day within the scheduled workweek. Supervision will give due consideration to such requests.

2. **Overtime.** Time and one-half will be paid for all overtime hours worked in any single workweek, with the exception of Sunday. All overtime hours worked on a Sunday will be paid at double time.

3. **Vacation.** One day vacations are for 10 hours. Weekly vacations are for 40 hours. Employees who are transitioning to or from a four 10-hour day workweek shall be entitled to all accrued vacation (i.e., if an employee returns to an five 8-hour day schedule with 10 hours remaining vacation, the employee will have one day and two hours of vacation to take in accordance with the contract).

4. **Personal Days.** Personal days must be taken in full days regardless of the employee's schedule, and cannot be taken in smaller increments. For employees on 10-hour shifts, personal days are paid for 10 hours. For employees on 8-hour shifts, personal days are paid for 8 hours.

5. **Holidays.** Employees working four 10-hour shifts convert to a five 8-hour day schedule during all workweeks that contain a holiday recognized by the Company in an effort to maintain consistency throughout the bargaining unit for employees to receive 40 hours of pay.

A-17

For any other alternate work hour schedule that may be developed, it is agreed that at least two off days will be consecutive. The two consecutive off day agreement does not apply to any currently established workweek or when changing from one schedule to another. Furthermore, the two consecutive off day requirement can be waived, but both supervision and the employee must mutually agree to such a schedule.

It is thought that this letter accurately describes the parties' agreement.

Very truly yours,

Jay R. Alvaro

Jay R. Alvaro
Vice President, Labor Relations

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

April 16, 1992

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

Dear Mr. Bradford:

During the 1992 negotiation meetings the committees of the Company and the Union discussed the representation of employees by personal attorneys or outside agencies during the grievance and arbitration procedures.

As a result of these discussions, the parties agreed that the Union is the sole bargaining representative for its members and therefore no outside representation will be permitted during such meetings. This in no way restricts the Union's ability to have an attorney represent its own interests during the grievance and arbitration procedures.

It is believed that by proceeding in this manner the concerns expressed during these meetings have been alleviated.

Very truly yours,

Edward R. Schuette

A-18

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 · Cincinnati, Ohio 45201-0960

July 19, 1994

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P. O. Box 1757
Cincinnati, Ohio 45201

This letter cancels and supercedes my previous letter to you, dated July 13, 1994.

Reference is made to our meeting on Tuesday, June 28, 1994 regarding the new job classification, Gas Operations Trainer, Job Code #827. In addition to you and I, Messrs. E. Schuette and D. Zanitsch representing the Company and Mr. D. Rosing representing the IUU were also in attendance.

As agreed, the new job classification of Gas Operations Trainer, Job Code #827 will be established at wage level 12. This new job classification was evaluated by the Company's Non-Manual Job Evaluation Committee as a wage level 11.

In return for the Company's willingness to establish this new job classification at wage level 12, the Union agreed that the Management of Gas Operations will select the individual they deem to be most qualified for this position in lieu of accepting the most senior qualified individual. The Union further agreed not to process any grievances related to the selection process for this position.

If future re-evaluations of this job classification increase the total number of points sufficient to increase the wage level to 12, this job classification will remain a wage level 12 and the selection process will revert to being conducted in accordance with the Union contract in effect at that time.

If you concur with this agreement, please sign and date a copy of this letter and return it to my office.

Very truly yours,

Patrick P. Gibson

Chairman IUU
7/21/94

cc: E.R. Schuette
D.E. Zanitsch

\jobeval\trainer

A-20

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

April 15, 2015

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Time Off For Union Duties/Business

Dear Mr. Anderson:

During the 2015 - 2019 negotiations, the representatives of the Company and the Union clarified the administration of time off work and compensation for performing Union duties/business. Subject to legitimate business needs, the Company will grant compensated or non-compensated time off work in accordance with the following guidelines.

NEGOTIATIONS	Members of the Union negotiating committee and any other employee required to attend or prepare for negotiating meetings will be able to attend during working hours. These employees will not be compensated by the Company for time spent in and preparing for negotiations, unless previously agreed to by the parties.
GRIEVANCES & ARBITRATIONS	A reasonable number of employees will be able to prepare for and attend grievance and arbitration meetings. Union employees will not lose their straight-time wages while attending grievance meetings. The time spent by Union members in preparing for and attending all arbitration meetings is not compensable by the Company.
JOINT MEETINGS	A reasonable number of employees will be able to attend joint meetings between Union members and Company representatives. These employees will not lose their straight-time wages while attending or preparing for joint meetings.
UNION DUTIES/MEETINGS	A reasonable number of employees may be excused but not compensated by the Company for attending, preparing for or performing union duties/meetings. This includes items such as counting votes, regular Union meetings, General Board meetings, working on Union accounting records, or other union duties or meetings.

Sidebar Letter A32
Page 1

MILEAGE EXPENSES

The Company will agree to reimburse the Union mileage expenses for up to two union representatives to attend Company scheduled meetings. This does not include grievance meetings, arbitrations, negotiations or meetings held at the request of the Union. The Company will agree to reimburse the Union mileage expense for one union representative to attend fact finding meetings. The Union will provide an itemized statement each month for this expense and the Company will reimburse the Union.

There may be occasions when exceptions to these guidelines may be granted. The parties will make every effort to accommodate each other in these matters. The Union agreed to give as much advance notice as possible to supervisors of employees who need to be off work for Union business.

The advancing of wages for non-compensable union business will continue, absent abuse of this process. If problems arise, management will meet with the Union in an attempt to correct the abuse. However, management must maintain the right to discontinue this arrangement, if a satisfactory resolution cannot be reached.

Sincerely,

Jay R. Alvaro
Director, Labor Relations
Duke Energy

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

September 2, 1998

Mr. Patrick G. Bradford
Chairman
Independent Utilities Union
P O Box 1757
Cincinnati, Ohio 45202

CINERGY.
CG&E

Dear Mr. Bradford,

As you are aware, a new job evaluation system, the BOGAR Job Evaluation System is being implemented for all job classifications represented by the IBEW, Local 1347, IUU and the USWA, Locals #12049 and #5541-06. The new system was designed by the ERT Sub-Committee II (Joint Union/Management Team) and approved for implementation by the ERT at its June 29, 1998 meeting. The BOGAR Job Evaluation System completely replaces the McIntyre system.

The McIntyre Evaluation break points for each grade level have been mathematically converted to new break points under the BOGAR System, therefore it is not necessary for job classifications to be reevaluated at this time. Only new job classifications or revised job classifications with significant changes since their last evaluation will be evaluated using the new system. Job classifications will retain their current wage rates/grade levels, but will be subject to change if they are revised and reevaluated as was the practice in the past.

Under the current agreement, a company job evaluation committee is responsible for evaluating all new or revised job classifications. (Article VIII, Section 1(I)). A key component of the new job evaluation system is the establishment of a new joint Union/Management job evaluation committee. The committee will consist of two management representatives from each business unit, two representatives from the IUU, IBEW and each USWA local and two representatives from the Corporate Center. Accordingly, there will be 16 total members with a maximum of 10 active during an evaluation. Operating guidelines for the committee are as follows:

- Unions will appoint their representatives and they will only participate in the evaluation of job classifications represented by their Union.
- Unaffected union representatives may be present, but will not participate at this time.
- No more than two of the four USWA representatives will participate in the evaluation of USWA job classifications.

- The participating union must have at least one representative available during the evaluation process.
- Consensus should be reached on each factor during the evaluation; absent consensus, majority rules.
- The participating Business Unit must have at least one representative available during the evaluation process.
- All job evaluation members should be informed it is a long term commitment.
- A quorum to have a meeting is six members.

A job evaluation coordinator from the Human Resources Department will also facilitate in the evaluation process and will not be a voting member. The ERT Sub-Committee II also established the pre-evaluation process, presentation guidelines, post evaluation process, training, a creditability check and employee communication and these will be implemented as presented to the ERT at the June 29 meeting.

This letter and accord modifies the terms of the 1996-2001 contract with respect to the job evaluation system and it is believed that this letter accurately describes the agreement the Company and Union have reached.

Sincerely,

Kenneth E. Williams

Kenneth E. Williams
Manager
Employee Relations and Safety

INTERNAL CORRESPONDENCE

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:

INTERNAL CORRESPONDENCE

Knowledge

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

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.

INTERNAL CORRESPONDENCE

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

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

May 14, 2003

Ms. Mary Harthun
President
Local Union 600, IUU
Utility Workers Union of America
810 Brighton Street
Newport, Kentucky 41071

CINERGY.
CG&E

Re: Disconnect Non-pay, Succession
And Special Meter Reads Agreement

Dear Ms. Harthun:

This letter documents our discussions and agreements related to disconnect non-pay (DNP) field credit activity and succession and special meter reading work.

In August 2002, the Company met with the leadership of each of the CG&E affiliated local unions to discuss the need to significantly increase the number of completed DNP's and to complete all succession/special meter reads at a competitive cost. As a result of those discussions, a team was formed, which included the leadership from each union and management representatives, to evaluate the business case for implementing necessary flexibilities and cost control measures to perform the identified work at a competitive cost. The team was charged with reaching a consensus on a plan to achieve the desired results.

It was recognized that residual union jurisdictional issues around the DNP work and the succession and special meter reading work had resulted in restrictive work practices across the multiple unions connected with these job functions. Since August of 2002, the joint union and management team has worked together on a regular basis to achieve compromise for the implementation of the following competitive alternatives to outsourcing these job functions. Pending agreement with the leadership of the four local unions involved in the discussions, the Company will implement the changes described below.

The Company will form a new centrally managed work group for the specific purpose of performing the DNP fieldwork. The Company will initially staff the new work group with 10 existing employees (Senior Representatives) represented by the UWUA currently performing DNP work. Additionally, 8 employees will be added in each of two entry-level job classifications, one represented by the USWA and the other by the IBEW, Local 1347. It is understood that if any of the aforementioned 10 employees represented by the UWUA vacate their position and the Company decides to backfill the position(s), it will be filled as an entry-level DNP worker represented by the USWA or IBEW. The Company assured the Union that the two clerical positions that provide support to the DNP work process would not be eliminated as a result of this reorganization.

The 16 new entry-level DNP worker job openings will be made available to other employees represented by their respective unions (i.e., USWA and IBEW). If all 16 openings are not filled by employees in their respective unions or by displaced employees in redeployment represented by the IBEW, the remaining openings will be made available to full-time meter readers and then part-time meter readers, in that order. If any full-time or part-time meter

readers vacate their positions as a result of accepting any of the initial 16 DNP worker job openings represented by the IBEW and USWA, the Company will backfill those vacancies accordingly (i.e., part-time with part-time and full-time with full-time). These agreements only apply to the initial 16 DNP worker job openings.

If any of the 10 Senior Representatives in Revenue Collections are bumped by Senior Representatives with more seniority as a result of Company initiatives, it will not impact the number of positions being eliminated through attrition.

The succession and special meter reading duties will be primarily, but not exclusively, assigned to UWUA represented employees. As a result, 10 new full-time meter reader job openings will be filled. Management intends to assign work other than succession/special reads to DNP workers represented by the USWA and IBEW, whenever there is other productive work available for them to perform within their job classifications. However, this does not restrict management's right to assign those employees to perform such meter reads. The Company agreed to backfill part-time meter reader positions that are vacated as a result of part-time meter readers accepting any of the initial 10 new full-time meter reader positions.

This agreement is made between the parties without prejudice to the position of either party regarding the jurisdiction, assignment and contracting of work. However, the Union agrees that no grievances will be filed or pursued relating to the assignment of work as described above, for the duration of this agreement. To the extent that the Company has retained its rights with regard to making future changes to this, or any other work processes in the future, the Union retains its right to grieve in the event that management implements changes to the above-described terms for achieving the DNP, succession and special meter reading work. In this context, however, it is also understood that slight modifications to this overall business plan may be made, as long as the plan's basic design remains in effect.

The team of management and union leaders is commended for their commitment to meeting the present day business needs in a competitive manner. It is expected that all parties will benefit by this plan for achieving this work with company employees. Please sign where indicated below to indicate the Union's agreement to the above terms.

For the Company:

Todd Arnold 5/14/03
Todd Arnold Date
V.P., Customer
Contact Services

Patricia K. Walker 5/14/03
Patricia K. Walker Date
V.P., Billing &
Metering Services

For the Union:

Mary Hathun 5-15-03
Mary Hathun Date
President
Local Union 600, IUU
Utility Workers Union
Of America

Cc: J. O'Conner
J. Polley

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

June 10, 2004

Ms. Mary Harthun
President
Local Union 600, IUU
Utility Workers Union of America
810 Brighton Street
Newport, Kentucky 41071

CINERGY. CG&E

Re: Post-Retirement Medical Benefits

Dear Ms. Harthun:

On April 27, 2004, the Company met with union representatives from UWUA Local 600, USWA 5541-06 and 12049 and IBEW 1347 to continue the negotiations for providing a post-retirement health reimbursement account ("HRA") option (the "HRA Option") to our active employees. Prior to that meeting, in a letter dated March 2, 2004, the Company provided the unions (I) a written overview of the Company's proposed design for the HRA Option, and (II) written responses to certain related questions. This letter updates the Company's proposed design for the HRA Option.

I. OVERVIEW OF HRA OPTION

All current, full-time employees represented by UWUA, Local 600 will be able to make a one-time choice between continuing in the current traditional post-retirement medical option (the "Traditional Option") or electing to participate in the new HRA Option described below. Employees will be required to make this election by a specified election date in 2004. (Notwithstanding the foregoing, employees currently receiving long-term disability benefits or on a military leave of absence, will make this election when they return to active, full-time status. If they do not return to active, full-time status, they will default to the Traditional Option.) All employees hired or rehired on or after January 1, 2005 will participate in the HRA Option. Each employee who elects to participate in the HRA Option, and each employee hired on or after January 1, 2005, will be referred to as a "HRA Participant" herein.

Under the Traditional Option, eligible retirees (those who retire after attaining age 50 with five (5) years of Service, as defined in the applicable Pension Plan) are provided access to group medical coverage and a premium subsidy that varies based upon the retirees' service and classification (see detail regarding the various classifications and subsidy levels attached hereto).

Subject to any collective bargaining obligation, the Company reserves the right to amend, modify or terminate the Traditional Option and/or the HRA Option at any time. However, amounts already credited to a HRA Participant's account will not be reduced by amendment, except to the extent necessary or appropriate to comply with changes in the law.

The benefit under the HRA Option is based on a bookkeeping account that can grow like a savings account with service and interest credits as described below. An employee who elects the HRA Option will start with an opening balance that is equal to 1/12th of $1,000 for each prior calendar month in which the HRA Participant worked at least one day for the Company. In the future, the Company will credit eligible HRA Participants with an additional 1/12th of $1,000 for each calendar month in which the HRA Participant works at least one day for the Company. The Company will also credit each eligible HRA Participant's bookkeeping account with an annual interest credit. Interest will be credited at the same interest rate as the cash balance updates as determined in August of each year, except that for the term of the current labor agreement, the interest rate will not be less than 3.5%; for 2004, the rate is 5.31%. Except as discussed below, only HRA Participants who are active, full-time employees and work at least one day in the month are eligible for the monthly service credit. Like retirees in the Traditional Option, HRA Participants will have access to group medical coverage only if they retire after attaining age 50 with five (5) years of Service (as defined in the applicable Pension Plan), however, there will be no subsidy. Please note the following regarding the HRA Option:

a. If a HRA Participant retires after attaining age 50 with five (5) years of Service (as defined in the applicable Pension Plan), the amounts credited to the HRAs generally can be used for the qualified medical expenses, as defined in Section 213(d) of the Internal Revenue Code, of the retiree and the retiree's spouse and eligible dependents (see IRS publication 502 for examples of qualified medical expenses). To the extent permitted by applicable law and as is otherwise practicable, the HRA option is intended to provide a tax-free benefit. Due to future law changes, however, there can be no assurance of favorable tax treatment.

b. Except as provided below, if the employment of a HRA Participant terminates prior to attaining age 50 with five (5) years of Service (as defined under the applicable Pension Plan), the HRA Participant forfeits all amounts credited to the HRA Account.

c. If a HRA Participant dies while actively employed prior to attaining age 50 with five (5) years of service (as defined in the applicable Pension Plan), the HRA Participant forfeits all amounts credited to the HRA Account.

d. If a HRA Participant dies while actively employed after attaining age 50 with five (5) years of Service, his/her spouse and eligible dependents will be entitled to use amounts credited to the HRA to pay qualified medical expenses immediately.

e. In the event of disability or leave, the Company will continue monthly service credits for the first 12 months. The Company will continue interest credits while the HRA Participant is disabled or on leave (and prior to recovery or retirement). For HRA Participants on a military leave, service credits and interest credits will continue for the full qualified leave period.

f. If the employment of a HRA Participant is involuntarily terminated in connection with an involuntary reduction in force and such termination is in no way related to performance deficiencies, the HRA Participant will be eligible to maintain his/her HRA balance as of termination. The HRA Participant will be able to use amounts held in his/her HRA Account immediately following the termination.

g. For the term of the current Collective Bargaining Agreement, the Company will agree not to amend, modify or terminate retiree health care benefits for any active employees covered by the CBA. Amounts credited to a HRA Participant's account will not be reduced by amendment, except to the extent necessary or appropriate to comply with changes in the law.

II. QUESTIONS

Set forth below are responses to some of the questions regarding the HRA Option raised in previous meetings.

1. **Will the Company offer choice to all employees?**

   A: Yes. Presently, the Company plans to allow all current, full-time employees to elect to stay in the Traditional Option or switch to the HRA Option. After January 1, 2005, new hires and rehires will automatically participate in the HRA Option.

2. **Will an employee be able to elect the HRA Option upon retirement?**

   A: No. A one-time election will take place in 2004.

3. **Can a HRA Participant withdraw amounts credited to his/her HRA account in cash upon retirement? Can the Company pay the amount out in a lump sum?**

   A: Money may be withdrawn from the HRA account only for paying qualified medical expenses. The account will not be paid out in cash. Favorable tax treatment is available for a HRA only if the HRA reimburses medical expenses as defined in Section 213(d) of the Internal Revenue Code. As stated below from IRS Notice 2002-45, any right to receive cash will disqualify the HRA from receiving favorable tax treatment.

   "An HRA does not qualify for the exclusion under § 105(b) if any person has the right to receive cash or any other taxable or non-taxable benefit under the arrangement other than the reimbursement of medical care expenses. If any person has such a right under an arrangement currently or for any future year, all distributions to all

persons made from the arrangement in the current tax year are included in gross income, even amounts paid to reimburse medical care expenses. For example, if an arrangement pays a death benefit without regard to medical care expenses, no amounts paid under the arrangement to any person are reimbursements for medical care expenses excluded under § 105(b)... Arrangements formally outside the HRA that provide for the adjustment of an employee's compensation or an employee's receipt of any other benefit will be considered in determining whether the arrangement is an HRA and whether the benefits are eligible for the exclusions under §§ 106 and 105(b). If, for example, in the year an employee retires, the employee receives a bonus and the amount of the bonus is related to that employee's maximum reimbursement amount remaining in an HRA at the time of retirement, no amounts paid under the arrangement are reimbursements for medical care expenses for purposes of § 105(b)..."

4. **What happens to the HRA balance upon disability or extended leave from the Company?**

   A: See Section I(e).

5. **What happens to the HRA balance in the event of a termination of employment?**

   A: See Section I.

6. **What happens to the HRA balance if I die while actively employed?**

   A: See Sections I(c) and I(d). Currently, the spouse and eligible dependents of an employee who dies while actively employed with Cinergy can elect to become covered under the non-union medical plan and receive subsidized coverage at the active employee rate until death or a disqualifying event (for the spouse, this would include, but not be limited to, remarrying or becoming Medicare eligible; for an eligible dependent, it would include, but not be limited to, ceasing to qualify as an eligible dependent due to age).

7. **Will the Company contributions be indexed in future years (e.g., indexed to the trend line for health care costs)?**

   A: No. At this time, we do not plan to align our service credit or interest credit to any index. However, the Company will continue to evaluate its crediting levels. Subject to any collective bargaining obligations, the Company reserves the right to make adjustments, including increasing, decreasing or discontinuing credits unilaterally.

8. **Will the opening HRA balances be calculated with retroactive interest crediting?**

   A: No. Making retroactive interest credits would be cost prohibitive from the Company's perspective.

9. **What are other companies doing with regards to post-retirement healthcare?**

   A: See Hewitt survey previously provided (51% of survey respondents have a unionized workforce).

10. **How can HRA Participants use amounts credited to the HRA?**

    A: Money credited to a HRA can be used to reimburse the HRA Participant for medical expenses as defined in Section 213(d) of the Internal Revenue Code. See IRS publication 502 for examples of qualified medical expenses.

11. **Who will administer the HRA account balances?**

    A: Hewitt Associates will track the HRA credits while HRA Participants are actively employed. The Company is reviewing proposals from third party administrators for post-retirement administration, but this will likely be Hewitt Associates.

12. **Will the HRAs be protected/guaranteed?**

    A: The benefit under the HRA option is based on a bookkeeping account and is not funded like a 401(k) plan. See Section I regarding the Company's ability to amend.

13. **If the Company decides to eliminate the Traditional Option at a later date, would employees be allowed to get in the HRA?**

    A: The Company periodically evaluates its benefit programs and would determine the appropriate course of action at that time.

14. **Would interest on the HRA account continue to accrue after an employee retires?**

    A: See Section I.

15. **If two Cinergy employees are married, can they make different elections with respect to the HRA Option?**

A: Yes, one could elect to remain in the Traditional Option, and the other could elect the HRA Option; if they remain married during retirement and so elect, they would receive subsidized coverage under the Traditional Option and have access to amounts credited to the HRA on behalf of the other spouse. Regardless, the elections are independent of each other.

Please note that the explanation set forth above merely summarizes the basic elements of our currently proposed design for the HRA Option. The Company is in the process of working out the details of the HRA proposal and necessarily reserves the right to work out those details. The Company also reserves the right to more fully document the HRA Option, which option will be governed and construed in accordance with the terms of the Plan as adopted by the Company.

Very truly yours,

John E. Polley
General Manager
Labor Relations

cc: T. Verhagen
P. Gibson
K. Feld

bcc: L. Gregory

What are other companies doing with regards to post-retirement healthcare? Hewitt Associates conducted a survey for the Henry J Kaiser Family Foundation between June and September 2003 to understand how large private-sector employers are handling retiree health benefits. The survey included responses from 45% of all Fortune 100 companies and 30% of all Fortune 500 companies. Among the companies surveyed this is what they had to say:

- 10% have terminated all subsidized health benefits for *future* retirees
- 20% say they are very likely to terminate all subsidized health benefits for future retirees
- 35% of the firms terminated benefits for future retirees and now provide access-only to health benefits with the retiree paying 100% of the cost
- 6% of employers shifted to a defined contribution approach
- 71% report having increased retiree contributions to premiums in the past year 53% report increases to plan design cost sharing
- 57% increased prescription drug co-payments
- 12% now require mandatory mail-order refills for maintenance drugs

Summary of Post-Retirement Health Care Options

Current Post-Retirement Health Care Option

Employees hired before January 1, 2005, who elect the subsidy option and who retire from the company on or after age 50 with at least five years of service, may be entitled to a post-retirement health care subsidy from the company dependent on their years of service at retirement.

Subsidy Schedule:

Service at Retirement	(Pre-65 only)
30+	50%
29	45%
28	40%
27	35%
26	30%
25	25%
24	20%
23	15%
22	10%
21	5%
20	0%
19	0%
18	0%
17	0%
16	0%
15	0%
14	0%
13	0%
12	0%
11	0%
10	0%
9	0%
8	0%
7	0%
6	0%
5	0%

Duke Energy®

April 13, 2012

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Amendment to Sidebar Letter A-42 Post-Retirement Medical Benefits

Dear Mr. Anderson:

During 2012 contract negotiations, the parties discussed Sidebar Letter A-42 dated June 10, 2004 regarding post-retirement medical benefits. As a result of those discussions, the parties agreed that Sidebar Letter A-42 will (i) continue to apply without modification for employees hired prior to January 1, 2013, and (ii) be amended to reflect that any employee hired or rehired on or after January 1, 2013 will not participate in the HRA Option or the Traditional Option (both as defined in Sidebar Letter A-42). It follows that Sidebar Letter A-42 is hereby amended as set forth below:

In the second full paragraph on page one of Sidebar Letter A-42, the fifth and sixth sentences are hereby deleted and replaced with the following:

- All employees hired or rehired on or after January 1, 2005 and before January 1, 2013 will participate in the HRA Option. No employee hired on or after January 1, 2013 will participate in the HRA Option or the Traditional Option.

- No employee rehired on or after January 1, 2013 will continue to participate in the HRA Option or the Traditional Option following such rehire date. Any such rehired employee who was participating in the HRA Option or the Traditional Option at the time of such employee's prior termination of employment:
  (i) shall be eligible for access to the HRA or premium subsidies, as applicable, only if he or she was eligible for such HRA access or premium subsidies at the time of such prior termination of employment, and
  (ii) shall not accrue additional benefits under either the HRA Option or the Traditional Option.

- Employees hired or rehired on or after January 1, 2013 who retire after attaining age 50 with at least five (5) years of service under the applicable Pension Plan are provided unsubsidized access to post-retirement medical coverage.

- Each employee who elected to participate in the HRA Option, and each employee hired on or after January 1, 2005 and before January 1, 2013 will be referred to as an 'HRA Participant' herein.

A-42a

Any provision of Sidebar Letter A-42 that is inconsistent with the above shall be deemed no longer in effect. Except as provided herein, the remaining provisions of Sidebar Letter A-42 continue in full force and effect.

It is believed that this letter accurately reflects the parties' agreement.

Very truly yours,

Jay R. Alvaro
Vice President, Labor Relations

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Post-Retirement Healthcare

Dear Mr. Kowolonek:

During the 2019 negotiations, the parties discussed post-retirement healthcare benefits. This letter amends the Post-Retirement Medical Benefits Sidebar Letter A-42 dated June 10, 2004 and A-42a dated April 13, 2012, and confirms these discussions and the resulting agreement.

Access to Post-Retirement Health Benefits

Employees who terminate on or after October 1, 2015 after attaining at least age 50 with at least 5 years of service will have unsubsidized access (i.e., no Company contributions) to post-retirement medical, dental, and vision coverage; provided, however, that beginning as soon as January 1. 2021. employees who do not enroll in Duke Energy-sponsored pre-65 retiree medical. dental and vision coverage at the time of retirement or following the expiration of any COBRA continuation will not be permitted to enroll themselves or their eligible dependents at a future date. Coverage for retirees age 65 and older will be provided on an unsubsidized basis through a Medicare Coordinator. The Company shall provide a subsidy/contribution towards the cost of post-retirement health coverage only as provided below in this letter.

Subsidies/Company Contributions - Traditional Option

For employees who terminate on or after October 1, 2015, the "Traditional Option" is hereby amended to provide contributions towards the cost of post-retirement healthcare coverage, in the form of credits to a newly established Subsidy Health Reimbursement Account ("Subsidy HRA"), only for individuals who are under age 65 and who are:

- In a group eligible for a medical subsidy under the rules in effect prior to October 1, 2015, which is limited to those hired prior January 1, 2013; and
- At least age 55 with at least 1 O years of service at termination of employment.

The amount of the contributions will vary as follows:

- Eligible employees age 50 or older by October 1, 2015 will receive (during retirement) a pre- 65 contribution of $350 per month, plus $175 per month for their spouse/domestic partner, if any; and
- Eligible employees younger than age 50 as of October 1, 2015 will receive (during retirement) a pre-65 contribution of $250 per month, plus $125 per month for their spouse/domestic partner, if any.

Subsidies/Company Contributions - HRA Option

Effective October 1, 2015, the "HRA Option" is hereby amended such that:

- The Company will discontinue crediting 1 /12 of $1,000 each month to the health reimbursement accounts for those employees who have a health reimbursement account under the HRA Option, with interest credits continuing; and

- The Company will offer a choice window in 2015 to employees who have a health reimbursement account under the HRA Option to elect whether to continue In the HRA Option (modified as described in the above bullet) or to forego their rights to their modified health reimbursement accounts under the HRA Option in exchange for participation in the Traditional Option (modified to provide credits to a Subsidy HRA as described above).

Miscellaneous

The post-retirement health benefits described above will replace the post-retirement medical coverage options in effect prior to October 1, 2015, for employees who terminate on or after October 1, 2015, Including those described in Sidebar Letters A-42 and A-42a. These benefits will be governed by and construed in accordance with the applicable plan documents.

In all other respects, Sidebar Letters A-42 and 42a shall continue in accordance with their terms.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Temporary Upgrading

Dear Mr. Kowolonek:

During the 2019 contract negotiations, representatives of the Company and the Union discussed temporarily upgrading employees in clerical and technical job classifications.

The Agreement provides that temporary upgrading shall only be available for manual employees. However, as a result of these discussions, the Company will agree, during the term of the 2019 – 2023 Agreement, to permit clerical and technical employees to be temporarily advanced to higher classifications. Employees will only be given consideration for temporary advancement when they actually replace another employee in a higher job classification for a full day or more; or supervision deems there is a need for an employee to fulfill the duties of a higher classified job for a full day or more. When employees are temporarily upgraded they will receive the minimum rate of the higher job classification or $10.00 per week more than their current wage rate, whichever is greater. When selecting the individual to be temporarily advanced, the management will give consideration to seniority and rotation among qualified employees. Such upgrading will not take place when the work duties of another employee are distributed among several other employees, or when employees perform duties of higher classified jobs for training purposes.

The Company voiced a serious concern about the potential for voluminous grievances if temporary upgrading is permitted for non-manual employees as described. As agreed, no grievances will be processed by the Union as a result of this limited exception to Article XII, Section 6 of the Agreement.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

DUKE ENERGY.

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Meter Reading

Dear Mr. Kowolonek:

During the 2019 contract negotiations, representatives of the Company and the Union discussed Meter Reading operations.

Job Classification, Meter Reader - New: As discussed, the Meter Reader - Full Time job classification will be retitled Meter Reader - New and the wage rate adjusted to the MR 3 wage level upon ratification of the new Agreement. Incumbent employees in this classification will have their hourly rate adjusted to the minimum rate of the MR 3 wage level and will be eligible for merit and general wage increases as outlined in the Agreement.

Part-time Meter Readers: Should part time employees be utilized in the future, they will be hired into the Meter Reader - New classification at the minimum rate of pay as outlined in the Agreement. All provisions of the Agreement regarding part-time employment would apply to these employees. Part-time Meter Readers will receive the appropriate compensation for overtime when they work in excess of 8-hours in a day or any other regularly scheduled shift that is longer than 8 hours.

Hours of Work: Core meter reading hours will be from 7:30 AM to 4:00 PM, subject to changes based on business needs and to any schedule arrangements approved by an employee's supervisor or manager. The normal work day will consist of 8.5 hours including a 30 minute unpaid meal break; however, based on business needs, employees may be assigned a straight eight hour shift with a paid fifteen minute break. The Company reserves the right to change these hours based on business needs in accordance with the Agreement. Employees working in excess of their scheduled work day will receive premium pay and meal compensation as provided for in the Agreement.

Transfers: Any future full-time openings in divisions offices will first be offered to voluntary transfers of current qualified full-time Meter Readers.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

April 21, 2005

Mr. Jim Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky
Cincinnati, Ohio 45202

CINERGY.
CG&E

Re: Interplant Seniority Rights

Dear Mr. Anderson:

During the 2005 negotiations, representatives of the Company and the Union discussed the interplant seniority rights for employees at the electric generating stations, in the event of a surplus situation.

As agreed, during the term of the 2005 - 2008 Agreement, should the Company declare a surplus at one of its electric generating stations and affected employees cannot be absorbed into the work force at the plant, all of the electric generating stations within the CG&E service territory will be considered one department for purposes of administering roll-backs. The intent is to provide the more senior employees at the station with a surplus situation, the ability to bump the less senior employees at the other stations. The wage rates of surplus employees will be red circled.

By proceeding in this manner, the Union's concern in this matter is alleviated.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

April 21, 2005

Mr. Jim Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

CINERGY.
CG&E

Re: Treatment for Substance Abuse

Dear Mr. Anderson:

During the 2005 negotiations, representatives of the Company and the Union discussed the compensation policy for employees who undertake treatment for substance abuse.

While the treatment of these conditions is specifically excepted from coverage under the sick leave provisions of the Agreement, the Company will, for the term of the 2005 – 2008 Agreement, continue the arrangement of providing short-term disability benefits (STD) to employees who obtain treatment at an appropriate detoxification facility under the direction of the Company or in coordination with the Company and the employee's personal physician. Available STD may only be used for the first continuous absence when an employee undertakes to correct a substance abuse problem through an approved program. If the initial rehabilitation effort at a treatment center is not successful, the employee will not be granted additional STD.

The Company is willing to extend this extra effort to help afflicted employees and their families, to eliminate the burden imposed upon fellow employees, and to minimize lost productivity and absenteeism caused by substance abuse. Employees who are unwilling to accept the responsibility for their own behavior or who refuse to participate in a necessary program will, as in the past, jeopardize their continued employment with the Company.

The Union is encouraged to make the Company aware of individuals thought to have substance abuse problems. With such assistance, fellow employees may be given a chance for which they may be forever grateful.

Very truly yours,

John E. Polley
General Manager
Labor Relations

A-50

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

April 21, 2005

Mr. Jim Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

CINERGY.
CG&E

Re: Personal/Diversity Day Requests

Dear Mr. Anderson:

It was agreed that the individual departments would attempt to accommodate as many requests as possible to take a personal/Diversity or vacation day on Martin Luther King, Jr. Day, Presidents' Day and/or Good Friday during the term of the 2005 - 2008 Agreement. All requests for a personal/Diversity or vacation day must be made by employees at least 7 days in advance. Days requested with the 7 day advance notice will not be considered as an absence for determining an individual attendance record.

It is thought that this agreement will be mutually beneficial for all involved.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations

A-51

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Vacation Carryover

Dear Mr. Kowolonek:

During the 2019 negotiations, representatives of the Company and the Union discussed carryover vacations.

It was 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,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

April 21, 2004 2005

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Job Elimination Situations

CINERGY.
CG&E

Dear Mr. Anderson:

During the 2005 contract negotiations, representatives of the Company and the Union discussed the possibility of employees bumping other employees with less system service seniority at the same wage level in other job classifications in the event of a job elimination situation.

During the discussions the Union wanted the Company to agree to allow senior employees at a given wage level within a bidding area, the right to bump junior employees in other job classifications at the same wage level within the same bidding area, even though the senior employees had never been in the job classification(s) occupied by the junior employees. Due to the potential for a significant loss in productivity, the Company could not agree to that arrangement. However, during the term of the 2005 – 2008 agreement, it was agreed that if such a situation should arise, the Company would work with the Union on a case-by-case basis, in an attempt to place such employees in other available job classifications at the same wage level within the same bidding area. It was further agreed that if the Company is unable to place such employees in job classifications at the same wage level within the bidding area and they have 25 or more years of system service, they will maintain their job titles and wage levels and be eligible for negotiated increases and bonuses. This only applies when such employees with more system service seniority are qualified, but cannot bump into a same wage level job within the bidding area, held by a junior system service seniority individual because they have not passed through the other job.

It was also agreed that should a job elimination situation occur during the term of this Agreement, at the request of the Union, the parties would meet to discuss the rollback procedure described in Article V, Section 3, which may be revised by mutual agreement of the parties.

This accurately reflects the agreements reached between the parties.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations

A-55

Duke Energy®

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

June 2, 2008

Mr. James W. Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Retirement Plan Agreement

Dear Mr. Anderson:

During the 2008 contract negotiations, representatives of the Company and the UWUA, Local 600 (the "Union") discussed the Company's desire to migrate all employees to a common benefits program. The following outlines the agreement between the Company and the Union for providing the employees with options and protections for Retirement Plan participation that will remain in effect during the 2008 – 2012 Contract.

Traditional Retirement Program Frozen:

Participation in the Cinergy Traditional Retirement Program will be frozen as of January 1, 2013 for certain employees. Active employees on January 1, 2013 who are younger than age 50 (as of December 31, 2012) and anyone who is older than 50 but has fewer than 25 years of service (as of December 31, 2012), will automatically begin participating in the New Duke Retirement Program.

Voluntary Conversion Opportunities:

Active employees in the Traditional Retirement Program will be offered a voluntary window in 2008 to elect to remain in the Traditional Pension Program or elect the New Retirement Program. In 2012, a second voluntary window will be offered only to those active employees who remain in the Traditional Program and who are age 50 with 25 years or more of service as of December 31, 2012.

Voluntary Conversion to the New Retirement Program:

Part A Benefit (Part A): The pension plan benefit 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 at retirement (not the date of conversion).

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 Duke Energy Retirement Cash Balance Plan.

The Company matching contributions for the 401(k) plan will be enhanced to mirror 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).

Employees will also begin participating in an annual incentive plan with greater award opportunities (up to 5%).

With Mandatory Conversion to the New Retirement Program:

1. Mandatory conversion will be effective January 1, 2013 for employees who have elected to remain in the Cinergy Traditional Retirement Program. Other terms applicable to the mandatory conversion are as follows:

   a. The final average monthly pay for retirement will be frozen at the time of conversion (no pay run up).

   b. Employees will have no choice between annuity and lump sum on Part A; only the current traditional program annuitant options will be available for Part A.

   c. Can still grow in to the 85 points.

   d. Employees will receive the enhanced 401(k) and enhanced incentive pay as described above once they mandatorily convert.

Employees Currently in the Cash Balance Plans:

Employees who previously selected one of the Cinergy cash balance plans (Balance or Investor) will automatically transition to the New Retirement Program as soon as administratively possible, but no later than January 1, 2009, to include participation in a cash balance pension plan that mirrors the Duke Energy Retirement Cash Balance Plan and an enhanced 401(k) plan to mirror the Duke Energy Retirement Savings Plan and an enhanced annual incentive plan as described below:

Annual Incentive Plan Summary Changes for those who elect or automatically move to the New Retirement Program:

In conjunction with the New Retirement Program, all participants who volunteer or upon mandatory conversion to the New Retirement Program will be eligible for up to a 5% maximum annual incentive pay (payable in 2010) based on the achievement of goals as set forth below:

NEW RETIREMENT PROGRAM – UEIP

Goal	Level 1	Level 2	Level 3
Company Financial Result	.75%	1.5%	3%
Safety	.5%	.75%	1%
Customer Satisfaction	.5%	.75%	1%
	1.75%	**3.0%**	**5.0%**

Annual Incentive Plan Summary Changes for those who do not elect the New Retirement Program:

Employees who elect to remain in the Cinergy Traditional Program, which provides benefits under the current final average pay formula, will not be eligible for the higher incentive payout, but will continue their eligibility for the current Cinergy 401(k) Plan formula and will begin participating in an annual incentive plan, with a maximum award of 2% based on the achievement of goals as set forth below:

TRADITIONAL RETIREMENT PLAN – UEIP

Goal	Level 1	Level 2	Level 3
Company Financial Result	.5%	.75%	1%
Safety	.25%	.375%	.5%
Customer Satisfaction	.25%	.375%	.5%
	1.0%	**1.5%**	**2.0%**

The Retirement Conversion Agreement Survives the 2008 – 2012 Contract:

The Company and the Union expressly understand and agreed that the Retirement Program conversion agreement shall continue in full force through January 1, 2013, surviving the termination of the 2008 – 2012 Contract, and shall continue in full force through succeeding contracts, or in the absence of succeeding contracts, unless changed by mutual agreement of the parties.

Very truly yours,

Jay R. Alvaro
Vice President

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

April 15, 2015

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Amendment to A-58 Retirement Plan Agreement

Dear Mr. Anderson:

During the 2015 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, 2016, 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 compensation in accordance with the RSP plan documents on the same basis as employees hired or rehired prior to January 1, 2016. Employees hired or rehired on or after January 1, 2016 will not be eligible to participate in the Cinergy Corp. Union Employees' Retirement Income Plan (the "Retirement Income Plan").

Cash Balance Interest Credit

The cash balance interest credit rate under the Retirement Income Plan for pay credits made on and after January 1, 2016 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.

Retirement Income Benefit for Long-Term Disability

A participant who starts receiving long-term disability benefits on or after July 1, 2016 will receive interest credits under the Retirement Income Plan's cash balance formula while disabled, but will not receive pay credits while long-term disabled, in accordance with the Retirement Income Plan documents. This change will not apply for any individual who starts receiving long-term disability benefits before July 1, 2016, or participants 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.

For purposes of clarity, as previously agreed, the Company may in its discretion merge the Retirement Income Plan into the Duke Energy Retirement Cash Balance Plan or other defined benefit plan maintained by the Company. In accordance with applicable law, any such merger will not reduce participants' accrued benefits.

The complete provisions of the Company's retirement plans are set forth in the plan documents, as amended to make administrative changes, legally-required changes and/or technical changes that do not reduce the benefits formula. 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-58 relating to retirement plan agreements.

Sincerely,

Jay R. Alvaro
Director, Labor Relations
Duke Energy

Duke Energy®

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

June 2, 2008

Mr. James W. Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Sabbatical Vacation Bank and Vacation Credit Programs

Dear Mr. Anderson:

During the 2008 contract negotiations, representatives of the Company and the UWUA, Local 600 (the "Union") discussed the phasing out of the Sabbatical Vacation Bank and the Vacation Credit Programs.

As agreed, these programs shall be phased out in accordance with the attached document, Attachment A, which outlines the specific revisions to the Sabbatical Vacation Bank and Vacation Credit Programs that will remain in effect through December 31, 2012.

The Company and the Union expressly understand and agreed that the phasing out of the Sabbatical Vacation Bank and the Vacation Credit Programs, as stated in the attached document, shall continue in full force until December 31, 2012, surviving the termination of the 2008 – 2012 Contract, and shall continue in force through succeeding contracts, or in the absence of succeeding contracts, unless changed by mutual agreement of the parties.

Very truly yours,

Jay R. Alvaro
Vice President

Attachment

ATTACHMENT A

REVISIONS TO THE SABBATICAL VACATION BANK AND VACATION CREDIT PROGRAMS FOR UWUA, LOCAL 600

Effective January 1, 2009, the Vacation Bank and Vacation Credit Programs will be phased out over a four year period and will be ending on December 31, 2012.

THE CHANGES:

Sabbatical Vacation Program:

- The sabbatical banking program will be eliminated for employees who are younger than 47 years old as of December 31, 2008.
- Employees who are 47 years old or older as of December 31, 2008 will be eligible to continue banking vacation until December 31, 2012, 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 credits) cannot bank more after January 1, 2009 but will be grandfathered with the amount they have banked.
- No additional banking will be permitted after January 1, 2013. Therefore, the last opportunity to bank vacation will be in December 31, 2012 because banking is done at the end of the year.
- Banked vacation will be paid out at the final rate of pay at retirement.

Vacation Credit Program:

- Vacation Credits: Up to six weeks credit, starting at age 51, cannot exceed the employee's vacation entitlement.
- Employees who are at least 51 years old as of December 31, 2012 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, 2012. For 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, 2006.
- Vacation credits will be paid out at the final rate of pay of retirement.

Service Credit Program:

- Service Credits: Up to two weeks for years 32 and 33 years of employment in lieu of a 6th week of vacation time off.
- 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, 2012. Effective January 1, 2013, employees will be granted a 6th week of vacation time off during their 32nd year of employment in lieu of a week of service credit.
- An employee who has already reached their maximum or more of vacation bank before January 1, 2013 will receive their 6th week of vacation as "time off" in lieu of a service credit.

THE SCHEDULE:

Age as of: 12/31/2008	Maximum Banked Vacation (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

Duke Energy®

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

June 2, 2008

Mr. James W. Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Union Employee Annual Incentive Program (UEIP)

Dear Mr. Anderson:

During the 2008 contract negotiations, representatives of the Company and the UWUA, Local 600 (the "Union") discussed that the payout for the incentive bonuses for employees will vary based on their participation in the offered retirement program.

Beginning with the 2009 goals and during the term of the 2008 – 2012 Agreement, the UEIP payout (payable in 2010) will be administered as follows:

Annual Incentive Plan Summary Changes for those who elect or automatically move to the New Retirement Program:

In conjunction with the New Retirement Program, all participants who volunteer, or upon mandatory conversion, will be eligible for up to a 5% maximum annual incentive pay, as specified below:

NEW RETIREMENT PROGRAM – UEIP

Goal	Level 1	Level 2	Level 3
Company Financial Result	.75%	1.5%	3%
Safety	.5%	.75%	1%
Customer Satisfaction	.5%	.75%	1%
	1.75%	**3.0%**	**5.0%**

Annual Incentive Plan Summary Changes for those who remain in the Traditional Retirement Program:

Employees who elect to remain in the Cinergy Traditional Program, which provides benefits under the current final average pay formula, will not be eligible for the higher incentive payout, but will participate in an annual incentive plan, with a maximum award of 2%, as specified below:

TRADITIONAL RETIREMENT PLAN – UEIP

Goal	Level 1	Level 2	Level 3
Company Financial Result	.5%	.75%	1%
Safety	.25%	.375%	.5%
Customer Satisfaction	.25%	.375%	.5%
	1.0%	**1.5%**	**2.0%**

Very truly yours,

Jay R. Alvaro
Vice President

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

April 15, 2015

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Amendment to A-60 Letter Regarding the Union Employee Annual Incentive Plan (UEIP)

Dear Mr. Anderson:

During the 2015 contract negotiations, representatives of the Company and the UWUA, Local 600 ("Union") discussed eligibility for the Union Employee Annual Incentive Plan ("UEIP"). As a result of those discussions, the parties agreed to amend Letter A-60 dated June 2, 2008 as set forth below.

Beginning with the 2015 calendar year performance period under the UEIP, the Company will provide a prorated UEIP payment (calculated as set forth below) to any eligible Union employee who meets the following criteria during a performance period: (i) works for at least six complete calendar months, and (ii) retires (as defined below).

Such prorated UEIP payments shall be paid in the first quarter of the calendar year immediately following the applicable performance period at the same time and on the same basis as other UEIP payments are made to other eligible Union employees, and any such prorated UEIP payment shall be calculated based on the eligible earnings of the retired Union employee during the applicable performance period and actual achievement relative to the pre-established goals set forth in Letter A-60.

For purposes of clarity, in no event will a Union employee who does not meet the criteria set forth in this letter be eligible for a prorated UEIP payment for a performance period if he or she isn't employed on December 31st of the performance period. For purposes of this Letter, "retire" means separate from employment with the Company after having attained at least age 55 and 10 years of service (as determined for purposes of access to Company sponsored retiree medical coverage).

In other respects, Sidebar Letter A-60 shall continue in full force and effect herein for the duration of the 2015 - 2019 Agreement, unless changed by mutual agreement of the parties.

Sincerely,

Jay R. Alvaro
Director, Labor Relations
Duke Energy

Sidebar Letter A60a

DUKE ENERGY.

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Union Employee Annual Incentive Program (UEIP)

Dear Mr. Kowolonek:

During the 2019 negotiations, the parties discussed the UWUA Union Employee Annual Incentive Program (UEIP). This letter amends the UEIP Sidebar Letter A-60 dated June 2, 2008 and confirms these discussions and the resulting agreement.

As discussed during negations, beginning with the 2020 incentive year UWUA represented employees are eligible for an incentive lump sum bonus up to a maximum of 2% or 5% of straight time and overtime wages per year in accordance with Sidebar Letter A60 Union Employee Incentive Plan (UEIP), based on the achievement of goals during the previous year, as determined by the Company.

In all other respects, Sidebar Letters A60 shall continue in accordance with the terms as outlined.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Cincinnati Customer Care Center

Dear Mr. Kowolonek:

During the 2019 contract negotiations, representatives of the Company and the UWUA, Local 600 (the "Union") discussed the Duke Energy Cincinnati Customer Care Center.

As agreed, the Cincinnati Customer Care Center organization will consist of Customer Service Representatives (CSR) and Service Installation (SI). The CSR group will consist of employees in the Cust Svc Rep-FT Regular, Customer Service Rep-Full Time New, and Cust Service Rep-Part Time New job classifications. The Service Installation group will consist of employees in the Order Processing and Customer Service Representative – Service Installation classifications.

The Cincinnati Customer Care Center wages and merit increases will be administered per the attached (Attachment A). The minimum wage rate for the Cust Svc Rep-FT Regular and Customer Service Rep-Full Time New classifications will be $14.50 per hour and the maximum hourly rate will be $16.00 per hour. Effective April 1, 2020 and for the remaining term of the 2019 – 2023 Agreement, the General Wage Increase (GWI) applicable to UWUA represented Clerical employees will be applied to the maximum hourly wage rate of $16.00 for the Cust Svc Rep-FT Regular and Customer Service Rep-Full Time New classifications. In addition, this increase will be applied to the individual hourly wage rates for employees in these classifications not to exceed the maximum rate of pay. The minimum rate of pay will not increase over the term of the Agreement.

Incentives in the Cincinnati Customer Care Center will be based on the achievement of established performance measures as determined by the Company. The Company will notify the Union of any changes and will meet to discuss if requested by the Union. Any request by the Union to meet for discussion will not delay the implementation of incentive measures. Any employee, who is serving in a non-call-taking role, will receive a bonus equal to the average bonus payout for call-takers, unless an alternative method is mutually agreed upon by management and union representatives. There will be a quarterly review by management and union representatives to ensure that bonus calculations are accurate. Assuming the union representatives involved in this review are in agreement with the calculations, the Union agrees not to support or process grievances related to the bonus calculations.

An incentive eligible employee, who leaves the Cincinnati Call Center, prior to the end of a quarter, will receive a prorated bonus for the time worked in the Cincinnati Call Center organization.

It is expected that representatives working evening, night, holiday or weekend shifts provide at least three hours' notice if they are going to be unable to report to work, whether due to illness or other factors. It is understood that there will be times when an emergency occurs within three hours of the start of an employee's shift.

Employees (including SI), who are called out for other than planned overtime, will be paid a minimum of four hours at the appropriate overtime rate except when they come in, relative to storms, less than four hours before their scheduled shift. In this case, they will only be paid at the applicable overtime rate for a minimum of two hours.

Employees (including SI), who are called out for other than planned overtime, will be paid a minimum of four hours at the appropriate overtime rate except when they come in, relative to storms, less than four hours before their scheduled shift. In this case, they will only be paid at the applicable overtime rate for a minimum of two hours.

The Call Center may elect to observe the actual holiday or the Company designated holiday based on business needs. Prior to December 31 of each year the Company will notify employees of the holiday schedule for the following year. Employees scheduled to work the holiday designated by the Call Center that are excused from work by the Company will receive holiday pay for the regularly scheduled hours they would have worked on the holiday. All other employees will receive eight hours of holiday pay. Twelve hour and nine hour employees working on the holiday designated by the Call Center will receive time and one-half pay for their scheduled hours. If the employee exceeds their scheduled hours, double time will be paid for those hours worked in excess of their schedule. In order to be eligible to receive holiday pay, full time Customer Service Representatives must work the last regularly scheduled workday prior to the holiday and the first regularly scheduled workday after the holiday.

The Union agrees to support the following:

Virtual Routing (Base Customer Care)

- The Union agrees to not grieve the routing of Duke Energy customer calls and other types of Call Center non-call work to available representatives within the Duke Energy Call Centers or outsourced center(s). The outsourced portion of this work is not subject to any related side-letter agreements.

Premium for Specialties

- Employees in developmental roles will receive $1.75 per hour in addition to the employee's normal hourly wage rate. These roles currently include the training of new employees and performing the duties of On Job Trainer. This premium may be applied to other roles as determined by the Company. Prior to applying this premium to other duties, the Union and Company will meet at least thirty days in advance to discuss.

- Full-time new and part-time representatives, within the Cincinnati Call Center, who demonstrate, through assessment, that they are fluent in Spanish, will be paid a premium of $1.00 per hour.

Applicable to Customer Care Operations (Base and SI)

- *Virtual Agents.* The use of Virtual Agents was discussed and it was agreed that the Company will have the ability to implement a Virtual Agent program based on business needs. The advantages to such a program include faster response for emergency/outage situations, a more efficient use of resources, and increased customer satisfaction. Eligibility will be based on an employee's performance including but not limited to:

  - Achieving or exceeding all performance metrics.
  - No corrective action within the past twelve months.
  - Minimal escalations or Resource Support Line (RSL) calls.
  - Participating employees who subsequently develop performance related issues may have their Virtual Agent privileges revoked.

The number of employees participating in the program is at the sole discretion of the Company. In the event that two or more employees' performance is equal as determined by the Company, seniority will be the deciding factor. Order Processing Representative and Customer Service Representative – Service Installation (CSR-SI) classifications will be combined when determining eligibility for the Service Installation work group. In addition, the program may be suspended or discontinued based on business needs by the Company in its sole discretion. Prior to making such a decision, the Company will meet with the Union for discussion.

- *Emergency or Abnormal Operations.* In order to ensure that our customers' needs are met during outage, abnormal, or emergency situations, it was agreed that a 33% response rate over a rolling twelve month period would apply to all Cincinnati Customer Care employees. Response is defined as reporting to work a call out associated with these types of situations. Any employee who has pre-approved vacation/personal time scheduled immediately prior to or after scheduled off days, or is beginning or ending a bereavement leave, will not have a non-response credited to them for the purposes of calculating the response rate. However, if an employee does respond in this situation a credit will be applied. Employees failing to meet the required rate are subject to corrective action.

- *Vacation Availability.* In the event that Workforce Management determines that additional vacation slots are available during the workday, employees will have the ability to make a request to take advantage of these slots.

Applicable to Base Customer Care Operations

Employees may be hired either as full time or part time based on business needs. In accordance with the Collective Bargaining Agreement new employees will be classified as probationary for a period of one year. Probationary CSRs will not be eligible to apply for other positions for a period of twelve months from the date of hire. Employees meeting the educational requirements for technical positions represented by the UWUA will be eligible to apply within the twelve month period.

Based on business needs there may be a requirement for part time CSRs. All part-time CSRs will receive part-time employee benefits, regardless of the number of hours they work. While the intention is for part-time CSRs to be scheduled for less than 32 hours per week, they may exceed this number of hours due to actual or expected peak call volumes, trading of hours between employees, etc.

In 2012 two new schedules were agreed to;

A) 3 twelve hour days and 1 four hour day.

B) 4 nine hour days and 1 four hour day.

The Company reserves the right to implement these and other schedules based on business needs. At least 30 days prior to implementation, the Union and Company will meet to discuss the schedule. The Company will make every attempt to notify effected employees within a reasonable amount of time when planned overtime is being cancelled.

The meal provision for twelve hour workers will be triggered when the employee works thirteen consecutive hours and fifteen consecutive hours with the employee receiving a meal, or compensation in lieu thereof. For employees on a nine hour schedule, a meal or compensation in lieu thereof, will be provided at eleven and fifteen consecutive hours respectively.

Personal days must be taken in full day increments regardless of the employee's schedule. Twelve hour shift workers will be entitled to three personal day and one diversity day and nine hour shift workers will be entitled to four personal days and one diversity day.

Applicable to Service Installation

Customer Service Representative – Service Installation (CSR-SI) within the Customer Relations bid area will have a minimum wage rate of $16.50 and a maximum wage rate of $19.00 per hour. Only full time employees will be considered for this position. The minimum and maximum wage rates are not subject to the negotiated annual wage increases. For the first 12 months after entry into the classification, and in accordance with the Patrick P. Gibson Letter, employees failing to meet performance standards may be demoted to the Full Time New job classification. Such demotion may take place prior to corrective action being taken. This does not preclude action being taken on more serious offenses such as but not limited to attendance, zero tolerance calls, or any dischargeable offense. Any demotion will not be subject to the grievance procedure. If such a demotion occurs, the employee's rate of pay will be reduced to the rate of pay at the time the employee promoted to the CSR-SI position plus any merit increase that the employee had received since their promotion, not to exceed the maximum wage rate for the CSR classification. If the employee is demoted, they will not be considered for promotion for an additional nine months, from the date of demotion or last corrective action. During the first six months, an employee can request to demote from CSR-SI. Employees who demote within six months will retain their classified seniority. Employees demoted after six months will receive an adjusted seniority date.

Employees in the CSR-SI classification will receive a $0.50 merit increase every six months in accordance with the December 29, 2000 Patrick P. Gibson Letter in lieu of the annual general wage increase until reaching the maximum rate of pay. Once an employee reaches the maximum rate of pay, they will receive an annual lump sum equal to the negotiated general wage increase for clerical employees.

Employees accepting a Customer Service Representative – Service Installation position will not be eligible to cross or laterally bid for a period of nine months from the date they enter the classification.

This letter will be in effect during the term of the 2019 – 2023 Agreement.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

Sidebar Letter A61
Attachment A

Attachments

	Cust Svc Rep-FT Regular and Customer Service Rep-Ftn			
	Current Max	April 1, 2020	April 1, 2021	April 1, 2022
General Wage Increase	NA	2.5%	2.5%	2.5%
Max Wage	$16.00	TBD	TBD	TBD

1. Merit increases for Customer Service Rep-Ftn remain at $0.25 every six months in accordance with the Letter of Agreement dated February 23, 2018.

2. Merit increases for Cust Svc Rep-FT Regular remain at $0.50 until April 1, 2020 at which time the amount will be reduced to $0.25 due to the GWI being applicable.

3. Customer Care Incentive Bonus of up to $500 per quarter based on performance.

4. Employees are eligible to participate in the UEIP.

Title	Wage Range	Negotiated Base Wage Increases	Merit Increases	UEIP	Call Center Incentive Bonus
CSR – PTN	$12.00 - $13.00[1]	Same as Clerical[2]	$0.25	Yes	Up to $375 per Quarter
CSR-SI	$16.50 - $19.00[1]	See #3	$0.50[4]	Yes	See #5
Order Processing Rep	N9	Same as Clerical	$0.25 every six months.	Yes	See #5

1. The minimum and maximum wage rates for the CSR-PTN and CSR -SI will not increase with annual base wage increases.

2. Any CSR-PTN with a wage rate at or above the maximum will receive their annual increase in the form of a lump sum rather than a base increase.

3. Semi-annual merit increases are in lieu of General Wage Increase.

4. $0.50 every six months is in lieu of General Wage Increase. After maximum is reached employee will receive a lump sum increase equal to the negotiated annual wage increase for clerical employees.

5. Service Installation representatives assigned to take base calls at least 35% of the quarter will receive the quarterly Call Center Incentive based on their performance.

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

June 2, 2008

Mr. James W. Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Part-Time Employee Benefits

Dear Mr. Anderson:

During the 2008 contract negotiations, representatives of the Company and the UWUA, Local 600 (the "Union") discussed benefits that would be extended to part-time employees represented by the Union. Accordingly, the following table outlines the benefits that these employees will receive during the term of the 2008 – 2012 Collective Bargaining Agreement.

Benefit	Comment
Pension	Only if work greater than 999 hours in a 365 day period
401(k)	Same as full time employees
Medical	Same as full time employees
Dental	Same as full time employees
Vision	Same as full time employees
Flex Spending Accounts	Same as full time employees
Short-Term Disability (STD)	After 12 consecutive months of employment
Bereavement	Day of funeral only
Holidays	Only if holiday falls on a regular scheduled work day
Personal Day	One personal day after 12 consecutive months of employment
Vacation	Number of hours regularly scheduled per week times # of vacation weeks based on years of service
Supplemental Workers' Compensation	Same as full time employees
Jury Duty & Witness Pay	Only if it falls on a regular scheduled work day
Shift/Sunday Premiums	Same as full time employees
Life and AD&D Insurance	Same as full time employees
Dependent Life Insurance	Same as full time employees

Very truly yours,

Jay R. Alvaro
Vice President

A-62

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Revenue Services Representative

Dear Mr. Kowolonek:

During the 2012 negotiations, the parties discussed consolidating the current three work groups within the Revenue Services Department into one newly created job classification titled "Revenue Services Representative" (RSR). Based on these discussions, the parties agreed to create the RSR position in accordance with this letter.

Specifically, Revenue Services currently is comprised of three work groups: (1) Billing, (2) Accounts Receivables, and (3) Payments. These three work groups' functions will be combined and performed by the newly created RSR position. The job description for the RSR position is Attachment A to this letter.

Wage Rate: The minimum rate of pay for the RSR position is established at $17.00 per hour and will not increase during the term of the contract. The maximum rate of pay is $19.50 per hour with the maximum increasing to $19.75 on April 1, 2021. The GWI will not increase the minimum or maximum rate of pay for this position. Any employee below the new minimum rate of pay will be increased to new minimum with next payroll following contract ratification.

Merit Increases: Employees in the RSR position may progress to the maximum wage rate through merit increases of $0.25 at six-month intervals. Employees will be eligible for $0.25 merit increases in accordance with the December 29, 2000 Patrick P. Gibson Letter. Employees at the maximum rate of pay will receive an annual merit increase in a lump sum amount equal to the negotiated general wage increase for clerical employees, which may be in the form of a percentage pay increase and/or lump sum amount.

Selection: The Company will give first consideration to full-time employees over part-time employees in the competency-based selection process for the RSR position when all other things are equal.

Incumbent Employees. Incumbent employees will perform all functions of the newly created job description but will be considered grandfathered in their existing classifications. Incumbent employees will continue to receive the negotiated general wage increases applicable to their current job classifications in accordance with the Collective Bargaining Agreement. In addition, these employees will retain all bid and rollback rights in the Customer Relations Bidding Area.

Tamper Theft and Switched Meter Work -The Company and the Union agree to establish a $1.75 per hour premium to be paid to employees in the RSR position when management assigns them to perform tamper theft and switched meter work. Management will assign full-time employees to perform specialty-type work as needed. Any employee who has received a verbal warning in the past six months, or a disciplinary letter or higher-level discipline in the past year will not be considered. Such employees are eligible for consideration once his or her record is free from a verbal warning for six months, and/or free from any disciplinary letter or higher-level discipline for one year. It is anticipated the number of employees performing this work will vary based on work load.

Should additional specialty type work be brought into these teams the company will meet with the Union, at their request, to determine whether the premium is applicable to the work. The Company reserves the right in its sole discretion to determine whether the premium is applicable.

Management will consider seniority as a tiebreaker to determine which equally qualified employees will be assigned to perform this work. No premium will be paid to employees while training or on paid time off. This letter shall not be construed as limiting management's rights under the terms of the applicable collective bargaining agreement.

Title	Wage Range	Merit Increase
Revenue Services Rep April 1, 2019 - March 31, 2020	$17.00 - $19. 50	$0.25 every 6 months
Revenue Services Rep April 1, 2021 - March 31, 2023	$17.00 - $19.75	$0.25 every 6 months

This letter will be in effect during the term of the 2019 - 2023 Agreement.

Sincerely,

Michael Ciccarella

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Competency Based Selection

Dear Mr. Kowolonek:

During the 2019 negotiations, the Company and Union discussed the ongoing implementation of a Competency Based Selection (CBS) Process for certain job classifications. Specifically, this process will be utilized when filling certain clerical jobs designated as Level NB and above and certain technical jobs designated as level T4 and above. This will ensure that the most qualified candidate is selected for the position and is more likely to succeed.

Job openings will be filled using the following Competency Based Selection process:

- Job applications/resumes will be screened to determine that the basic qualifications, as set forth in the job description are met. An employee's corrective action which is below Suspension will not affect consideration of the employee for any jobs that are posted externally.

- To supplement their application, Company employees may print copies of their training records, job history, or other similar documents relating to their employment from the Employee Center on the Company's portal, and provide such documents to interviewers during the interview process or as attachments to their electronic application. All such documents provided by employees will be considered by the Company.

- Candidates meeting the minimum qualifications will be evaluated based on the following factors: skills and qualifications, prior job performance and/or experience and, in certain positions, a Basic Skills Assessment.

- Absent unusual circumstances, candidates will be interviewed by a team of at least three qualified, interviewers as determined by the Company. When determined by the Company to be feasible, one of the interviewers will be from a department outside of the department posting the position. Human Resources and/or Labor Relations will continue to provide guidance as appropriate.

- Company employees will be provided with advantage points in the process that will not be provided to external applicants. Specifically, the advantage points will be calculated as follows:

- One point will be provided for existing UWUA members; and

- One point will be provided for existing UWUA members who are full-time employees.

  Accordingly, a part-time UWUA member would be provided with one advantage point and full- time UWUA members would be provided with two advantage points.

- Seniority will be the deciding factor if there are two full-time, internal candidates who are equally qualified as determined by the Company. (
- Unsuccessful candidates under this process will be provided with additional interview training and/or assistance with resume preparation upon their written request to their HR Business Partner.

The process, as outlined above, will be used for the following job classifications:

CLERICAL	TECHNICAL
Gas Operations Administrator	System Integrity Technician Associate
Administrative Office Clerk	System Integrity Technician
Electric Operations Clerk	Sr System Integrity Technician
Order Processing Representative	Gas Technician
Sourcing/Purchasing Associate	Control Technician III
Customer Relations Representative B	Technician
Gas Document Specialist	Control Technician II
Customer Relations Clerk B	Gas Layout Technician
Office Coordinator	T&D Support Technician
Revenue Services Representative	Control Technician I
Service Installation Representative	Sr Gas Layout Technician
Customer Experience Support	GIS Technologist II
Senior Work Management Specialist	GIS Technologist I
Land Analyst	GIS Technologist III
Gas Office Coordinator	LIT Support Agent II
Gas Operations Support Specialist	LIT Support Agent I
Customer Relations Representative C	T&D Design Technician
Customer Relations Clerk C	Design Technician
Engineering Office Clerk	Operations Technician
Administrative Office Clerk - IT	Sr Substation Design Technician
	Sr T&D Design Technician
	Distribution Technician
	Substation Design Technician
	Surveying Technician
	Sr Transmission and Distribution Technician
	Sr T&D Support Technician
	Gas Marketing Specialist
	Configuration Management Specialist
	Engineering Specialist I
	Engineering Specialist Assistant
	Event Tech Services Specialist I
	Gas Controls System Tech
	P&C Design Document Specialist
	Lighting Specialist I
	Lighting Specialist II

Additionally, the Company would use this process to fill any newly created job classifications that are at or above the NB or T4 wage level (or its equivalent). The selection process for Customer Projects Resource Specialist, Customer Project Coordinator and the Gas Operations Trainer, will remain as outlined in the applicable side bar letters.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Severance Program

Dear Mr. Kowolonek:

To the extent the Company and the union agree that a severance opportunity will be provided to UWUA represented employees during the term of the CBA, the Company will provide employees who are designated as eligible by management a one-time lump-sum severance payment and other benefits if they meet basic plan requirements, as set forth below;

Severance Payment Formula

The Severance Payment will be calculated as follows based on the Eligible Employee's release date;

- Two weeks of Annual Base Pay for each Year of Service (including partial Years of Service).
- For employees hired on or after April 1, 1989, the Severance Payment will not be less than 12 weeks and not more than 52 weeks of the eligible employee's Annual Base Pay.
- For employees hired before April 1, 1989, the Severance Payment will not be more than two times the eligible employees Annual Base Pay. The maximum severance payment will not exceed two times an employee's annual compensation calculated as two times the compensation listed in Box 5 of the employee's most current W-2.

Additional Benefits

- Six months of Company-paid medical/dental coverage under COBRA following separation for all participating employees who have such coverage in effect as active employees upon separation.
- Access to outplacement services under the Company's program.

Design Features

- Employees are required to remain employed in good standing until their release date, which will be established by management in its sole discretion.
- Employees must sign and not revoke a Waiver and Release of All Claims in order to receive any benefits under this Program.
- Employees who separate under this Program will not be eligible for rehire or for staff-augmentation contingent worker (contractor) assignments for 12 months after their release date.

The Company shall designate who will be eligible for the severance program by department, job classification, age and/or years of service. or other legitimate, objective criteria, as determined by the Company, in its sole discretion.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

Duke Energy®

April 13, 2012

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Overtime Provisions

Dear Mr. Anderson:

During 2012 contract negotiations, the parties discussed providing employees' flexibility in certain situations to work overtime assignments at a time mutually agreeable to the individual employee and his or her management, when consistent with business needs.

Per our discussion regarding overtime scheduling, the parties have agreed to the following in order to provide flexibility to employees. If an employee volunteers or is required to work overtime and the employee requests to work the overtime on their second scheduled off-day in lieu of working the overtime on a different scheduled off-day, management may approve the employee's request if it meets business needs as determined by the Company. When such employee requests are granted by the Company, the overtime worked will be paid at the rate of time and one-half, instead of double time.

Similarly, if an employee requests to work overtime at a date and/or time of his or her choice and the supervisor approves the request as consistent with business needs as determined by the Company, the Company will pay the overtime at the time and one-half rate.

This in no manner restricts the right of the Company to schedule overtime based on business and operational needs. Such assignments may be mandatory and employees are expected to work such mandatory assignments, and the applicable overtime and meal provisions would apply as stated in the Agreement.

It is believed that this letter accurately describes the parties' agreement.

Very truly yours,

Jay R. Alvaro
Vice President, Labor Relations

A-71

Duke Energy®

April 13, 2012

Mr. James Anderson
President
Utility Workers Union of America
IUU Local 600
810 Brighton Street
Newport, Kentucky 41071

Re: Outsourcing Affecting Job Elimination

Dear Mr. Anderson:

During the 2012 negotiations, the parties discussed the issue of outsourcing and its impact on bargaining unit members. The parties agreed that the 2005 Labor Management Executive Committee (LMEC) process was outdated, and should be replaced as set forth herein.

The parties will continue to engage in a collaborative process where Labor Relations professionals, management, and union representatives exchange data, perspectives, and ideas so that outsourcing decisions affecting job elimination can be made in an open and candid environment.

As a first step, once the Company has determined that outsourcing is feasible based on proposals received from a potential vendor(s) and that outsourcing will likely result in job elimination, the Company will notify the Utility Workers Union of America, IUU Local 600 ("Union"). Upon receiving this notice, the Union can request information from the Company and/or propose how it would be more advantageous for unionized employees to retain the work at issue.

If requested by the Union, a meeting will be held to discuss the most competitive bid. During the meeting, the Company will provide the Union the key criteria used to evaluate the bid. The meeting should include the following representatives:

- Management representative of the outsourcing department;
- Union leadership;
- A representative from Labor Relations

The Company is fully aware of any legal responsibilities it may have, including the legal duty to share information and bargain in good faith, and will comply with those responsibilities. The Union understands that information shared between the parties while utilizing the process described in this letter is subject to legal protections, and the information shall remain confidential to this process and to the Company.

A-72

The parties recognize that each outsourcing proposal should be evaluated on a case-by-case basis, with consideration of factors including but not limited to the overall operating costs, relative labor costs (including the applicable loading rates such as benefits, pension, payroll taxes, etc.), any applicable regulatory requirements, equipment, technological developments, job process improvements, special expertise, efficiency, safety, availability of skilled labor and supervision, scalability, and any other factors that may impact the merits of outsourcing.

The parties further recognize and agree that neither party shall cause unreasonable delay during the process. It is the intent of the parties that this process will occur during approximately two months following the notice provided to the Union referred to in Paragraph 3 hereinabove and/or the parties' first meeting on the issue, if later than the notice. No provision of this letter shall be construed to eliminate or otherwise modify any applicable provision of the parties' collective bargaining agreement relating to outsourcing.

It is agreed that this letter accurately reflects the parties' agreement.

Very truly yours,

Jay R. Alvaro
Vice President, Labor Relations

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

Michael A. Ciccarella
Labor Relations Consultant
513.287.5022 (Tel)
513.287.1760 (Fax)

November 16, 2009

Mr. Jim Anderson
President, UWUA Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: *LIT Support Agent Job Progression*

Dear Mr. Anderson:

The Company is establishing a new job progression in order to provide information technology support to various business units. The classifications are as follows;

- LIT Support Agent I
- LIT Support Agent II
- LIT Support Agent III

Initially three positions will be filled with one employee classified as a Support Agent I and two classified as Support Agent II. Based on the skill set required to perform this work, the Company will select the individuals for these positions. In regard to educational requirements, employees initially placed in these positions will be grandfathered and will be considered as meeting the requirements for promotional opportunities within this progression. Going forward, the LIT Support Agent III will be the entry level position for this progression and posted as stated in the Collective Bargaining Agreement.

Wage Rates

The wage rates for this classification will be as follows;

Job Classification	Minimum Hourly Rate	Maximum Hourly Wage	Merit Increase
LIT Support Agent I	$30.71	$33.71	$0.25
LIT Support Agent II	$25.97	$28.97	$0.25
LIT Support Agent III	$21.88	$24.50	$0.25

Individuals placed initially in these positions will be placed at their current wage level not to exceed the maximum wage rate established for the classification. Employees making less than the minimum will be placed at the minimum wage rate for that classification.

Merit Increases

Merit increases will be given every six months is accordance with the *"Patrick P. Gibson"* letter dated December 29, 2000. These increases will be $0.25 per hour.

Out of Town Work Assignments

It is anticipated that all employees in this progression will be given out of town assignments to support Duke Energy facilities. Based on skill level, the majority of these assignments will fall within the LIT Support Agent I classification. When such assignments are made Sidebar Letter A-15 will prevail.

Emergency Overtime Callouts

There may be occasions when employees are called out to respond to information technology issues that require an immediate response to ensure continuity of operations. In such cases, employees will be permitted to respond from locations other than a Duke Energy facility. In such case, the minimum call out of four hours will apply. If a second call out is required within four hours of the first call out it will be considered a continuation of that call out. If an employee does not travel in order to respond then no travel time will be paid.

Employees are expected to respond to and work a reasonable number of emergency overtime assignments. Employees who are consistently unavailable for such assignments are subject to disciplinary action, up to and including discharge.

Progression

Employees will perform satisfactory will automatically promote from the Support Agent III classification to the Support Agent II classification once all qualifications are met. Employees on a disciplinary track or those that have been denied a merit increase will not be eligible to promote until they have received two consecutive merit increases or have been discipline free for one year. Promotions to the Support Agent I classification will be based on business need only.

This letter describes the establishment of the above mentioned classifications, wage rates, and initial staffing. Except where specifically abridged by this letter, all provisions of the 2008 – 2012 Collective Bargaining Agreement apply. In addition, the rights retained by the Company under Article I, Section 2 (c) of the Agreement remain unchanged. This letter in no manner represents a commitment on behalf of the Company in regard to staffing levels. The Company reserves the right to change or modify these job descriptions in accordance with the Agreement. I believe that this letter adequately describes our discussion regarding this matter. If the Union is in agreement with this proposal please return a signed copy of this letter to me at your earliest convenience.

Sincerely,

Michael Ciccarella

Michael A. Ciccarella
Labor Relations Consultant
Duke Energy

Signed: _____ Date: 12/7/09
James Anderson, President
Utility Workers Union of America, Local 600

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

Michael A. Ciccarella
513.287.5022 (Tel)
513.287.1760 (Fax)

March 31, 2011

Mr. Jim Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: *On Call Rotation – Local IT Support*

Dear Mr. Anderson:

Per our recent discussion, the Company is establishing an on call rotation for employees in the Local Information Technology job progression. As we discussed, the employee in the LIT I classification is excluded from this rotation due to business needs at this time. However, it is acknowledged and agreed that the Company has the sole discretion to include employee(s) in the LIT I classification in the rotation if business requirements change in the future.

While on call, employees will be compensated at the rate of $16.50 per day. In addition, the minimum call out will be two hours. If a second call out is required within two hours of the first call out, it will be considered a continuation of that first call out. As previously agreed to, employees will be permitted to respond from locations other than a Duke Energy facility. If an employee does not travel in order to respond, then no travel time will be paid.

Employees failing to respond to a call out in a timely manner may be subject to disciplinary action, up to and including discharge.

Sincerely,

Michael A. Ciccarella
Labor Relations Consultant
Duke Energy

For the Union:

James Anderson
President, UWUA Local 600

4/5/11
Date

A-74

DESIGN ENGINEERING AND
CONSTRUCTION PLANNING

Duke Energy Corporation
139 East Fourth Street
Cincinnati, OH 45202

December 20, 2012

Mr. Jim Andersen
President
Local 600
Utility Workers Union of America
810 Brighton Street
Newport, KY. 41071

Re: Foreign Utility Assistance

Dear Mr. Andersen:

This letter documents our discussions and agreement concerning emergency work performed for other utilities. The following guidelines will apply when employees represented by UWUA Local 600, are called upon to work for a foreign utility in emergency situations.

Compensation Guidelines:

- All hours of travel or work will be paid at the rate of time and one-half.
- After 16 consecutive hours of work, Article XII, Section 2(c) will continue to apply.
- Compensation when traveling begins when the employee begins driving toward their destination and ends when the employee arrives at the final destination of the day.
- When employees reach their destination and are to begin work, compensation will begin when the employee leaves the host Company staging area. If the staging area is away from the place of lodging and crews have to be transported to the staging area, then time begins when the employee leaves the place of lodging.
- Compensation ends for the work day when the employee returns to the host Company's staging area. If the staging area is away from the place of lodging and crews have to be transported, then the time will stop when the employee returns to the place of lodging.

DESIGN ENGINEERING AND
CONSTRUCTION PLANNING

Duke Energy Corporation
139 East Fourth Street
Cincinnati, OH 45202

- Employees required to work ten consecutive hours or more, shall be furnished a meal or compensation in lieu thereof (in accordance with the Contract), and an additional meal or compensation in lieu thereof, for each contiguous five hour interval worked thereafter until released from duty.
- Employees are not eligible to receive a daily per diem allowance.

Crew Assignments:

- Management will determine which bidding areas will be eligible to participate in a deployment, and the number of employees and crews from each of the bidding areas.

- During their deployment, employees are expected to comply with the Duke Energy Code of Business Ethics and related policies and procedures.

This letter will be interpreted and applied to comply with all laws. To the extent that this letter conflicts with any applicable law, the law will prevail. The current Contract will remain in effect for issues not addressed herein.

Sincerely,

Marc W. Arnold
Director Design Engineering OH/KY

cc: L. Gregory
R. Atkins
M. Ciccarella

DUKE ENERGY.

Duke Energy
139 East Fourth St.
Cincinnati, OH 45202

May 8, 2014

Mr. Jim Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: *Senior Work Management Support Specialist*

Dear Mr. Anderson:

I am writing in regard to our conversations regarding the establishment of the Senior Work Management Support Specialist within Midwest Delivery Operations. As we have discussed, the minimum hourly rate for this position will be $31.02 and a maximum rate of $31.52 per hour. Merit increases will be administered as outlined in the Collective Bargaining Agreement. Furthermore, Sidebar Letter A65 (Competency Based Selection) will be applicable to this position. Also as discussed, the Company will agree that the first three positions will be limited to qualified UWUA represented employees plus any additional positions for two years after entering this agreement. In the event that three positions are not filled within two years, the agreement will be extended until such time as three total positions are offered. This agreement in no manner restricts the Company's right to revise this job description in the future as provided for in the Collective Bargaining Agreement or any applicable sidebar letter.

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.

Sincerely,

Michael Ciccarella

Michael A. Ciccarella
Senior HR Consultant
Labor Relations KY/OH/Carolina

For the Union:

Signed: _____ Date: 5/8/14

James Anderson, President
Utility Workers Union of America, Local 600

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

April 15, 2015

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Separation of Delivery Operations and Gas Operations

Dear Mr. Anderson:

During the 2015 negotiations, the parties discussed the separation of Midwest Delivery Operations and Gas Operations relating to clerical functions performed by Office Coordinators, Customer Projects Recourse Specialists, and employees assigned to the Order Completion role.

As discussed, the work being performed by the above referenced classifications is being divided between the Midwest Delivery Operations (Electric) and Gas Operations (Gas) business units. As such, two new positions are being established in the Gas Operations Clerical Bid Area, Gas Office Coordinator (Gas QC) and Gas Operations Support Specialist (GOSS). Employees in the Office Coordinator classification currently assigned to Gas Operations will be reclassified as Gas Office Coordinators. The Customer Projects Resource Specialists (CPRS) currently assigned to Gas Operations will be re-classified into the new Gas Operations Support Specialist position. Employees currently performing the Order Completion role will remain in their respective classifications in the Customer Relations Bid Area.

The wage levels for the new positions remains the same as the existing Office Coordinator and CPRS classifications. The Company maintains all rights provided under the Collective Bargaining Agreement and applicable sidebar letters to revise job descriptions and/or discontinue filling these job classifications based on future business needs. Should such material revisions occur to the job descriptions, UWUA Local 600 may request a re-evaluation by the Job Evaluation Committee as provided for in the Agreement.

In order to give incumbent employees a final opportunity to move between the electric and gas bidding areas, the next three vacancies in either bidding area for an OC or a Gas QC will be filled by cross bidding (hand raising) as a combined area. The process for each vacancy will continue until the original posting is filled. This same process will also apply for the next CPRS or GOSS vacancy. Once this commitment is fulfilled, vacancies will be filled using the Competency Based Selection process in accordance with Sidebar Letters A21 (CPRS) and A65 and hand raising will apply only within the individual bid area.

In the event of a work force reduction, the Office Coordinator and Gas Office Coordinator classifications will be combined for the purpose of determining any rollbacks or layoffs. The same will apply for the CPRS and Gas Operations Support Specialist classifications.

Sincerely,

Jay R. Alvaro
Director, Labor Relations
Duke Energy

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

April 15, 2015

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Global Positioning Satellite (GPS)

Dear Mr. Anderson:

During the 2015 contract negotiations, the parties discussed the use of Global Positioning Satellite (GPS) system and other types of technology being contemplated for use in Company vehicles.

The primary purpose of the GPS and similar technology is to allow the Company the ability to more efficiently manage and assign work and to enhance safety by allowing us to locate a vehicle in the event we have lost contact with someone or a vehicle has been stolen. As discussed, it is not the Company's intent to constantly monitor employee's whereabouts using the GPS or other technology for the purpose of issuing corrective action.

Although its primary use is for managing work, the Company may review and rely on technology and/or the information obtained through its use to aid in an investigation where there is reason to believe an employee may have violated a Company policy or work rule, and the violation may be substantiated or disproven by such a review. To the extent the Company does rely on such information, the Company will treat similarly-situated employees in the same manner. Any such information, upon which the Company relies for purpose of imposing corrective action, will be provided upon request by the Union in accordance with applicable law.

In accordance with the March 29, 2007 GPS Letter, the Company is providing notice to the Union that the amount of history maintained in these systems may be longer than 30 days.

Sincerely,

Jay R. Alvaro
Director, Labor Relations
Duke Energy

Sidebar Letter A-80

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Engineering Specialist Progression

Dear Mr. Kowolonek:

During the 2015 and 2019 negotiations, the parties discussed the Company's decision to establish an Engineering Specialist Job Progression in the Customer Projects Bidding Area and the Transmission & Distribution Bidding Area. This progression will consist of the Engineering Specialist I, II, and III classifications. The wage levels for these newly created positions will be as follows:

Job Classification	Wage Level	Maximum Hourly Rate as of 3/31/19
Engineering Specialist III	T9	$37.89
Engineering Specialist II	T8	$36.83
Engineering Specialist I	T4	$30.39

Wage progression will be as outlined in Article VIII of the Agreement and Sidebar Letter A40, with selections determined by the Company in accordance with Sidebar Letter A65. Employees are required to successfully complete all training programs required by the Company and to promote to the Engineering Specialist II position in a timely manner. Employees successfully completing the requirements for the Engineering Specialist III position will automatically promote to that position. In addition, the Company maintains all rights provided under the Collective Bargaining Agreement and applicable sidebar letters, including but not limited to the right to revise the Engineering Specialist job descriptions based on future business needs. Should such material revisions occur, UWUA Local 600 may request a re-evaluation by the Job Evaluation Committee as provided for in the Agreement.

Employees in the Engineering Specialist I classification may be assigned to a specific headquarters for training purposes as determined by the Company. Employees in the Engineering Specialist I classification will receive all training necessary as identified by the Company to safely perform assigned duties and meet all requirements to promote to the Engineering Specialist II position.

Due to a restructuring of how work is performed by the Company, the Company does not anticipate any future postings for Customer Project Apprentice positions. Incumbent employees will be grandfathered under their existing job description, and will be eligible to continue to receive the negotiated wage increase applicable to employees in the Technical Unit. Existing employees in the progression not at the maximum rate of pay will be eligible to continue receive merit increases as outlined in the December 28, 2012 letter regarding this subject. Also, incumbent employees in the Customer Project Associate and Customer Project Apprentice classifications must continue to meet all Company expectations as previously required, including but not limited to the requirement to progress.

As agreed, when the Company fills a position in the "Engineering Specialist II" classification, the senior qualified Technician in good standing will be promoted to T&D Design Technician. Furthermore, when the Company fills a position in the "Engineering Specialist III" classification, the senior qualified T&D Design Technician in good standing will be promoted to Senior T&D Design Technician. In all cases, employees must be in qualified and in good standing to be eligible for a promotion. This process will continue until all incumbents in the following classifications: Technical Apprentice, Design Technician, Technician, and, T&D Design Technician as of the date the Collective Bargaining Agreement is ratified until all eligible employees have had the opportunity to progress to the Sr. T&D Design Technician position. The T&D progression will be closed to Technical Apprentices and Technicians hired after April 15, 2015. It is the intent of the Distribution Design organization to utilize the Engineering Specialist progression for all such future hires.

For the purposes of "hand-raising" (bidding on headquarters or location) within the Customer Projects Bid Area, the Customer Projects Coordinator and the Engineering Specialist III classifications will be combined. In the event of a work force reduction, the Engineering Specialist progressions in the Customer Projects Bid Area and the Transmission & Distribution Bidding Area will be combined.

Additionally, the Company would use this process to fill any newly created job classifications that are at or above the NB or T4 wage level (or its equivalent). The selection process for Customer Projects Resource Specialist, Customer Project Coordinator and the Gas Operations Trainer, will remain as outlined in the applicable side bar letters.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201

April 15, 2015

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Customer Relations Representative/Clerk C Positions

Dear Mr. Anderson:

During the 2015 negotiations, the parties discussed the filling of future vacancies in the Customer Relations Representative C and the Customer Relations Clerk C classifications.

Based on these discussions, the parties have agreed that future openings in the Customer Relations Representative C and Customer Relations Clerk C classifications will be filled by the Company using the Competency Based Selection process.

The first three (3) positions will be filled using the Competency Based Selection process among the incumbent Order Processing Representatives in good standing. Should there only be one Order Processing Representative apply for each of the first three positions and he or she meets the minimum qualifications and is in good standing they will be the successful candidate. Order Processing Representatives selected by the Company for the first 3 opportunities will have their rate of pay reduced to the maximum wage rate of the Customer Relations Representative/Clerk C classification. In the event that no Order Processing Representative in good standing applies for one or more of the first three positions, the Company may fill the vacancy by a Union wide posting using the Competency Based Selection process.

Sincerely,

Jay R. Alvaro
Director, Labor Relations
Duke Energy

Sidebar Letter A82

Duke Energy
Labor Relations
139 East Fourth St
Cincinnati, OH 45201

April 1, 2019

Mr. Steve Kowolonek
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: Inclement Weather

Dear Mr. Kowolonek:

At Duke Energy, our goal is a zero injury and illness safety culture for our employees and the communities we serve. In order to address the UWUA Local 600's concerns regarding inclement weather, when the Company determines there is a safety concern during periods of heavy or continuous storms or excessive cold weather, the Company will not require employees to perform construction or maintenance work in exposed locations outdoors, unless such work is necessary to protect life, property, or continuity of service. Employees are encouraged to communicate with their supervisors or managers to report and discuss any weather situations they believe may be unsafe. It is expressly understood and agreed that the services to be performed by the employees covered by this Contract pertain to and are essential to the operation of a public utility and to the welfare of the public.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

DUKE ENERGY

Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

March 12, 2018

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: *Alternate Schedule*

Dear Mr. Anderson:

I am writing in regard to our conversations regarding an alternate work schedule consisting of 4 nine hour days and one 4 hour day. As discussed, this schedule will be administered as follows;

- The four hour day will be determined by business needs and may not necessarily be a Monday or Friday.
- Meal compensation will remain at ten hours as outlined in the Collective Bargaining Agreement including the four hour day.
- Where possible, seniority will be used in the selection of schedules absent business needs as determined by the Company. Should it be necessary to deviate from seniority, the Company will notify the Union the reason for the deviation and afford the Union an opportunity to offer alternatives.
- The double-time day will be Sunday.
- Personal/diversity days must be taken in full days regardless of the employee's schedule and cannot be taken in smaller increments.
- Employees working this schedule will revert to an eight hour schedule during all workweeks that contain a holiday recognized by the Company in an effort to maintain consistency throughout the bargaining unit.

The availability of this schedule to various workgroups and employees within those groups will be based on business needs. The Company retains all rights under the Agreement and applicable sidebar letters including the right to discontinue this schedule. 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.

Sincerely,

Michael A. Ciccarella
Senior HR Consultant

For the Union:

Signed: _____ Date: 3/12/18

James Anderson, President

Labor Relations

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

September 13, 2016

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: *Gas Marketing Progression*

Dear Mr. Anderson:

The Gas Marketing progression, consisting of the Gas Marketing Specialist and Senior Gas Marketing Specialist classifications, was established in 2015 in order to assist in the expansion of Duke Energy's commercial gas operations. Since that time, the roles have evolved to the extent that the Company has determined that combining the classifications will provide the maximum flexibility in meeting customer needs.

Per our conversation, the existing classifications will be combined into one classification. Current educational requirements for the Gas Marketing Specialist call for a minimum of 45 credit hours with an Associate's Degree obtained within three years. The requirement for the revised job description will be a minimum of 45 credit hours with an Associate's Degree in engineering, technology, construction management, or business obtained within eighteen months of entry into the classification. Absent extenuating circumstances as solely determined by the Company, employees who fail to obtain the required degree within the eighteen month time frame are subject to discharge. The Company retains all rights under the Collective Bargaining Agreement to modify the duties and qualifications including acceptable degree requirements. Should the Company contemplate such revisions, notice will be given to the Union prior to any changes being made.

The wage rate for employees entering the classification will be the T7 minimum hourly rate. As outlined in the Patrick P. Gibson letter (Sidebar Letter A40) employees will be granted a merit increase in accordance with the Collective Bargaining Agreement if progress, measured by demonstrated ability and performance, has been satisfactory after six months. After one year, and again based on satisfactory performance, the employee's wage rate will be adjusted to the T8 minimum hourly rate provided that all educational requirements are met. For those employees not meeting the educational requirement at the twelve month mark, the wage adjustment will be made when the employee completes the requirement. As stated above, this must occur within eighteen months of entering the classification.

Incumbent Gas Marketing Specialists with more than one year of classified seniority and meeting all qualifications of the revised job description will have their wage rate adjusted to the T8 minimum hourly rate. Any current Gas Marketing Specialist not meeting the educational requirement of the revised job description will continue to have three years from entry into the classification to meet the requirement. Upon meeting the education requirement and all other qualifications, the employee will have their wage rate adjusted to the T8 minimum hourly rate. Employees in this category will maintain their seniority.

As stated previously, the Company maintains all rights provided under the Collective Bargaining Agreement and applicable sidebar letters to revise or discontinue job descriptions, including this one, based on future business needs. Should such material revisions occur to the job description, UWUA Local 600 may request a re-evaluation by the Job Evaluation Committee as provided for in the Agreement.

In addition, UWUA Local 600 agrees to withdraw Grievance #399 pertaining to the establishment of the Gas Marketing progression.

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

Sincerely,

Michael Ciccarella

Michael A. Ciccarella
Senior HR Consultant
Labor Relations

For the Union:

Signed: _____ Date: 9/14/16

James Anderson, President
Utility Workers Union of America, Local 600

DUKE ENERGY.

Duke Energy
139 East Fourth St
Cincinnati, OH 45201
Labor Relations

September 26, 2017

Mr. James Anderson
President
Utility Workers Union of America
Local 600
810 Brighton Street
Newport, Kentucky 41071

RE: *Lighting Specialist Progression*

Dear Mr. Anderson:

I am writing in regard to our conversations regarding the establishment of the Lighting Specialist progression. As discussed, this will be a separate bid area consisting of the Lighting Specialist I (Wage Level T5) and Lighting Specialist II (Wage Level T8) job classifications. All applicable provisions of the Collective Bargaining Agreement, including Sidebar Letter A65 - Competency Based Selection, will apply to these positions.

The initial posting will be for two Lighting Specialists IIs and be restricted to qualified employees in the Distribution Design OH/KY and the Distribution Design (Subdivision) departments. Should the successful candidate be in a classification with a wage level higher than T8, then they will be grandfathered in their current classification and be eligible for contractual wage increases applicable to that classification. For all other purposes under the Collective Bargaining Agreement these grandfathered employees will be considered as Lighting Specialists IIs. As such, they will have no rollback rights within their former work groups. Conversely, these employees would not be included in any surplus/rollback scenario within their prior work group. The ability of employees with more than fifteen years of service to displace employees outside of their bidding area is not impacted. Employees in the Technician or T&D Design Technician classifications accepting a Lighting Specialist position will not be eligible to promote as outlined in Sidebar Letter A81.

The Company maintains all rights provided under the Collective Bargaining Agreement and applicable sidebar letters to revise or discontinue job descriptions, including these, based on future business needs. Should such material revisions occur to the job description, UWUA Local 600 may request a re-evaluation by the Job Evaluation Committee as provided for in the Agreement.

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.

Sincerely,

Michael Ciccarella

Michael A. Ciccarella
Senior HR Consultant
Labor Relations KY/OH/Carolina

For the Union:

Signed: _____ Date: 10/2/17

James Anderson, President
Utility Workers Union of America, Local 600

Contract

between

Duke Energy Ohio, Inc.
Duke Energy Kentucky, Inc.

and

USW, AFL-CIO-CLC

on behalf of

Local No. 12049
&
Local No. 5541-06

May 15, 2016

to

May 15, 2021

DUKE ENERGY.

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USW
2016 – 2021
CONTRACT

This Contract, dated June 2, 2016, is agreed upon between Duke Energy Ohio, Inc., Duke Energy Kentucky, Inc., hereinafter referred to as the "Company," and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW), hereinafter referred to as the "Union."

The Company and the Union recognize that in order for the parties to meet the challenge of competition, the need for long-term prosperity and growth, and establish employment security, each must be committed to a cooperative labor management relationship that extends from the bargaining unit members to the executive employees. The Company and the Union agree that employees at all levels of the Company must be involved in the decision making process and provide their input, commitment, and cooperation to improving safety, productivity and helping the Company become the lowest cost producer and highest quality provider of energy service.

ARTICLE I – PURPOSE AND RESPONSIBILITIES

Section 1. (a) It is the intent and purpose of the parties hereto that the terms and conditions of this Contract will promote and improve the economic relations between the Company and its employees who are members of the Union, to the mutual benefit of both parties. To that end, there is established herein the basic agreements as to hours of work, rates of pay, working conditions, and a method of providing for the peaceful and satisfactory adjustment of differences of opinion and interpretations of this Contract that may arise from time to time to be observed by the parties hereto during the life of this Contract.

Section 2. (a) It is expressly understood and agreed that the services to be performed by the employees covered by this Contract pertain to and are essential to the operation of a public utility and to the welfare of the public dependent thereon and in consideration thereof, as long as this Contract and conditions herein be kept and performed by the Company, the Union agrees that under no conditions and in no event, whatsoever, will the employees covered by this Contract, or any of them, be called upon or permitted to cease or abstain from the continuous performance of the duties pertaining to the positions held by them under this Contract. The Company agrees on its part to do nothing to provoke interruptions of or prevent such continuity of performance of said employees, insofar as such performance is required in the normal and usual operation of the Company's property and that any difference that may arise between the above-mentioned parties shall be settled in the manner herein provided.

(b) The Company agrees that it will not attempt to hold the Union financially responsible or institute legal proceedings against the Union because of a strike, slowdown or work stoppage not authorized, abetted or condoned by the Union. The Union agrees that, in the event of an unauthorized work stoppage, it will in good faith and without delay exert itself to bring the work stoppage to a quick termination and insist that the

employee(s) involved cease their unauthorized activities. To that end, the Union will promptly take whatever affirmative action is necessary. Furthermore, the Union agrees that any employee or employees who agitate, encourage, abet, lead or engage in such a strike, work stoppage, slowdown or other interference with the operations of the Company shall be subject to such disciplinary action as the Company may deem suitable, including discharge, without recourse to any other provision or provisions of the Contract now in effect.

(c) No employee shall be required to cross a picket line to perform work that is not necessary to provide the normal services of the Company. A supervisor shall notify individuals who are picketing that Company employees must provide service and shall make arrangements for employees to safely cross the picket line to perform such work. The Company agrees, in the case of new construction work involving Field Operations Forces, to notify the Sub-District Office of the Union not less than 24 hours in advance of any situation requiring the crossing of a picket line.

ARTICLE II – RECOGNITION OF THE UNION

Section 1. (a) The Union is recognized as the sole and exclusive collective bargaining agency for those employees who are employed under the classifications listed in the job descriptions manual. A-41

This Contract shall be final and binding upon the successors, assignees or transferees of the Union and the corporate entity of the Company.

(b) Employees in the following categories are specifically excluded from the collective bargaining unit represented by the Union: clerical, dispatchers, draftsmen, foremen, and all supervisory employees with authority to hire, promote, discharge, discipline or otherwise effect changes in the status of employees, or effectively recommend such action.

(c) The Company recognizes the Union as the sole collective bargaining agency in matters concerning wages, hours of work and working conditions for all employees, as defined above, in the following Departments, Divisions and Sections:

LOCAL UNION 12049

DUKE ENERGY OHIO AND KENTUCKY
- Gas Operations
  - Field Operations
  - Corrosion Control
  - Systems Operations
  - Production - Gas Plants

  - Compliance and Service Delivery OH/KY
  - Service Delivery
  - Meter Services

(d) There shall be no discrimination, interference, restraint or coercion by the Company or its agents against any employee because of membership in the Union.

(e) There shall be no discrimination, interference, restraint or coercion by the Company or the Union or their agents against any employee or officer of the Union because of race, color, religion, sex, disability, national origin or ancestry or for any other reason. References to the masculine gender are intended to be construed to also include the feminine gender whenever they appear throughout the Contract.

(f) Nothing in this Contract shall be deemed to require the Company or the Union to commit an unfair labor practice or other act which is forbidden by, or is an offense under, existing or future laws affecting the relations of the Company with the employees bargained for by the Union.

ARTICLE III – RECOGNITION OF MANAGEMENT

Section 1. (a) The Union recognizes that the management of the Company, the direction of the working forces, the determination of the number of employees it will employ or retain in each classification and the right to hire, suspend, discharge, discipline, promote, demote or transfer, and to release employees because of lack of work or for other proper and legitimate reasons are vested in and reserved to the Company.

(b) The above rights of Management are not all-inclusive, but indicate the type of matters or rights which belong to and are inherent to Management. Any of the rights, powers, and authority the Company had prior to entering this Agreement are retained by the Company, except as expressly and specifically abridged, delegated, granted or modified by this Contract.

ARTICLE IV – UNION SECURITY AND CHECK-OFF

Section 1. (a) Any employee who is a member of the Union on the effective date of this Contract, shall, as a condition of continued employment, maintain membership in the Union to the extent of paying the periodic membership dues uniformly required of all Union members subject to the annual 10 day escape period hereinafter described.

(b) Any employee who is not a member of the Union on the effective date of this Contract, and who chooses not to become a member, shall be required as a condition of continued employment, to pay to the Union each month, as a contribution toward the cost of the administration of this Contract, a service charge equal in amount to the monthly dues uniformly required of Union members.

(c) New employees, hired by the Company after the effective date of this Contract, shall be required to join the Union as a condition of continued employment on the 31st day of employment in a job classification represented by the Union.

(d) The Union agrees that any present or future employee who is now or may become a member of the Union may withdraw from membership in the Union between December 15 and December 31, inclusive of each year, by giving notice of this desire to do so by registered or certified mail to the Labor Relations area of the Company. After such withdrawal, an employee shall not be required to rejoin the Union as a condition of continued employment.

(e) The Company, for all employees in the bargaining unit who have furnished the Company with voluntary check-off authorization cards, shall deduct from those employees' pay each week, dues or service charges and promptly remit the same to the International Secretary-Treasurer of the Union on a monthly basis. The initiation fee of the Union shall also be deducted and remitted to the International Union.

(f) The amount of dues or initiation fees to be deducted by the Company, within the limitations set forth on the voluntary check-off cards, shall be computed on the basis of the formula provided by the International Union. An initiation fee in an amount specified by the Union will also be deducted from the employee's pay. The Company will cooperate with the Union to change the dues computation period upon proper notice from the International Representative.

(g) The Union agrees that neither it nor any of its officers or members will intimidate or coerce any employees of the Company into joining the Union. The Company agrees that neither it nor any of its management representatives will attempt to persuade any employee from joining the Union.

(h) The Union agrees that in the event of any strike, work stoppage, slowdown, picketing or any other interference to the work or the operations of the Company by any individual employee or group of employees in the bargaining unit represented by the Union, this section of the Contract is then and there and by reason thereof automatically canceled and of no further force and effect; provided, however, that the Company may upon the presentation of proof satisfactory to the Company, within 10 days thereafter, that the Union did not directly or indirectly authorize, permit, endorse, aid or abet said strike,

work stoppage, slowdown, picketing or interference referred to, reinstate this section of the Contract, which section, if reinstated will, from and after the date of reinstatement, be of the same validity, force and effect as if it had not been canceled. In this connection, it is the expressed intention of the parties that for the purpose of making this cancellation provision effective without affecting the other sections of the Contract, this Contract is to be considered a severable Contract. Should the automatic cancellation of this section occur, it is the intention and agreement of the parties that all other sections and provisions of the Contract remain in full force and effect as therein provided.

(i) The Union shall indemnify and save the Company harmless against any and all claims, demands, law suits, or other forms of liability that may arise out of or by reason of action taken by or not taken by the Company in reliance upon any check-off authorization cards signed by the individual employees and furnished to the Company by the Union for the purpose of complying with any of the provisions of this Section.

ARTICLE V – CLASSIFICATION AND WAGES

Section 1. (a) The wage schedules described in the Contract in effect immediately prior to the date of this Contract, including all adjustments to those wages which were due to increases in the C.P.I. during the term of that Contract shall be amended as follows:

Wage Level	As of May 15, 2015	Effective May 15, 2016	Effective May 15, 2017	Effective May 15, 2018	Effective May 15, 2019	Effective May 15, 2020
1	$22.68	$23.13	$23.65	$24.19	$24.79	$25.35
2	$23.14	$23.60	$24.13	$24.68	$25.29	$25.86
3	$23.51	$23.98	$24.52	$25.07	$25.70	$26.28
4	$24.54	$25.03	$25.59	$26.17	$26.82	$27.43
5	$26.24	$26.76	$27.37	$27.98	$28.68	$29.33
6	$26.97	$27.51	$28.13	$28.76	$29.48	$30.14
7	$28.02	$28.58	$29.22	$29.88	$30.63	$31.32
8	$29.47	$30.06	$30.74	$31.43	$32.21	$32.94
9	$30.37	$30.98	$31.67	$32.39	$33.20	$33.94
10	$30.79	$31.41	$32.11	$32.83	$33.66	$34.41
11	$32.22	$32.86	$33.60	$34.36	$35.22	$36.01
12	$33.79	$34.47	$35.24	$36.03	$36.94	$37.77
13	$35.52	$36.23	$37.05	$37.88	$38.83	$39.70
14	$36.01	$36.73	$37.56	$38.40	$39.36	$40.25
15	$36.53	$37.26	$38.10	$38.96	$39.93	$40.83
16	$37.57	$38.32	$39.18	$40.07	$41.07	$41.99

Level 5–Construction Assistant, Mechanic III (incumbent); Level 6–Meter Specialist III; Level 7–Gas Systems Operations Mechanic III, Mechanic Operator III; Level 8–Premise Mechanic, Gas Plant Operator III; Level 11–Gas Plant Operator II, Meter

Specialist II; Level 12–Gas Systems Operations Mechanic II, Mechanic Operator II; Level 13–Service Mechanic "B", Welder II, Gas Plant Operator I, Meter Specialist I; Level 14–Tool Repair Specialist, Welder I; Level 15–Gas Systems Operations Mechanic I, Mechanic Operator I, Service Mechanic "A"; Level 16–Inspecting Mechanic.

(b) Any employee in the bargaining unit represented by the Union who was on or below the maximum hourly wage rate of his job classification on May 15, 2016, shall receive an hourly increase in accordance with the increase applicable to the maximum wage rate of his job classification in accordance with the provisions of the Contract.

(c) The hourly wage rate increases referred to herein shall not apply to the minimum hourly wage rates of starting job classifications.

(d) Employees shall be provided the higher of a 25¢ promotional increase above the maximum wage rate of the job classification from which they promote, or the minimum wage rate of the job classification to which they promote. This provision will not apply when the maximum wage rate of a job is not at least 25¢ above the maximum wage rate of the job classification from which it promotes.

(e) Whenever the difference between the minimum and maximum wage rates of any hourly rated job classification is not divisible by ten, the hourly wage rates will be by 10¢ steps, with the exception of the last step to the maximum hourly wage rate of the job classification. In such case the increase to the maximum hourly wage rate will include the 10¢ increment plus the odd amount necessary to equal the maximum hourly wage rate, provided, however, that the total amount of the increase is less than 20¢.

(f) Employees who are below the maximum hourly wage rate of their job classification shall continue to receive such length of service increases as they may be entitled to under the operation of the job classification and wage evaluation plan.

(g) The shift differentials paid to employees on scheduled shifts on classified jobs will be paid as follows:

Name and Definition of Shift		Current	Effective First Day of Pay Period Following Ratification	Effective			
				5/15/2017	5/15/2018	5/15/2019	5/15/2020
Day Shift	Where the majority of the scheduled hours worked are between 8:00 a.m. and 4:00 p.m.	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Afternoon Shift	Where the majority of the scheduled hours worked are between 4:00 p.m. and 12:00 Midnight	$1.65	$1.70	$1.75	$1.75	$1.80	$1.80
Night Shift	Where the majority of the scheduled hours worked are between 12:00 Midnight and 8:00 a.m.	$1.70	$1.75	$1.80	$1.80	$1.85	$1.85

Sunday Premium

When the majority of the regularly scheduled hours in a shift are on Sunday, a Sunday premium will be paid to an employee for all scheduled straight time hours worked on that shift as follows:

Current	Effective First Day of Pay Period Following Ratification	Effective			
		5/15/2017	5/15/2018	5/15/2019	5/15/2020
$1.80	$1.90	$1.90	$2.00	$2.00	$2.00

(h) The Company shall prepare occupational classifications and job descriptions which will define, as nearly as possible, the nature of the work involved under each classification. All required changes in job classifications or promotional sequences will be initiated by the Company.

A-28

(i) When a job description has been revised by the management, a representative of employees will be given an opportunity to suggest changes to the revised job description before it is submitted to the Company's Job Evaluation Committee. After the management has reviewed the changes to the job description, if any, suggested by the Union representative, the job description will be submitted to the Company's Evaluation Committee. The Union representative shall have an opportunity to submit written comments regarding the duties of the job to the Company's Evaluation Committee. There will be no recourse to the grievance and arbitration procedure because of the language of a job description or the evaluation of a job classification.

(j) The Job Evaluation Committee of the Company will be responsible for evaluating all new or revised job classifications. Prior to the evaluation of revised job descriptions, the representative of the Union may accompany the management representative to explain his written comments to the Committee. The evaluation established by this Committee will be used to determine a proposed maximum wage rate for each new or revised job classification. The wage rate resulting from this evaluation will be communicated to the Union as far in advance as possible, but not less than 30 days, of the proposed effective date for the installation of the new or revised classification.

(k) The Union shall maintain a Classification Committee consisting of not more than five members who may review the evaluation and wage rate of any new or revised classification. The Union's Committee may, by request, meet with the Company's Committee as soon as possible at a mutually convenient time, but within 30 days, after the Union has been notified by the Company of the proposed new or revised classification for the purpose of presenting any information relevant to the evaluation of the new or revised classification, which has been included in the previous written comments of the Union representative. The Union will be notified after the Company's Committee has reviewed the information presented by the Union. All wage rates so established shall be final and binding and not subject to the grievance and arbitration procedure. However, if any revised wage rates are reduced as a result of the evaluation(s), they will not be placed into effect until the Company and the Union have had an opportunity to negotiate them during full contract negotiations, even though the revised job classification will be in effect. Employees, presently in, or promoting to, such job classifications will continue to receive wage adjustments in accordance with the other provisions of the Agreement just as if the wage rate had remained at the same level until a new Agreement is reached.

It is understood that the right to maintain, revise or abolish any job classification or to create new classifications is the exclusive right of management.

(l) Where the Union deems an employee, or employees, to be improperly classified, it may file a grievance which shall be handled under the grievance procedure of this Contract.

(m) Members of the Union's Committee and a reasonable number of witnesses shall not suffer a loss of pay when engaged in meetings during their working hours with the Company's Job Evaluation Committee.

Section 2. (a) No employee shall regularly be called upon to perform work beyond the scope of his classification or training. Employees temporarily advanced to a higher

classification for four hours or more in any one day shall receive either the minimum rate of pay applicable to that classification or 25¢ per hour above the maximum wage rate of their job classification, whichever is greater, but no more than the maximum wage rate of the job to which the employee is upgraded. Employees temporarily assigned to a job scaled at a lower rate of pay than their own shall not suffer financially through such a transfer.

(b) When a temporary assignment in a job classification within the bargaining unit exceeds 90 consecutive days, the assignment being temporarily filled shall be considered a vacancy and filled permanently in accordance with the posting procedure.

(c) When an employee covered by this Contract voluntarily accepts a temporary assignment to a supervisory position, he shall be paid the same rate of his classified assignment at the time of the temporary assignment. A-62

(d) An employee, when permanently promoted to a job classification and qualifying in all respects with the exception of time spent in the preceding classification as required in the qualification section of the job description, shall be considered as having the equivalent of such required time.

ARTICLE VI – SENIORITY

Section 1. (a) System Service shall date from the time an employee first earns compensation in the employ of the Company, except as such system service may be lost in accordance with Section 6 of this Article.

(b) Classified Seniority shall date from the time an employee is permanently employed in a specific job classification. Whenever employees are accepted for job postings and their promotion is delayed by no more than 30 days or when a delay beyond 30 days is caused solely by the Company, their new classified seniority date will be adjusted to place them in their proper seniority position in relation to other employees who promoted as a result of the same posting.

(c) In the event that two or more employees achieve classified seniority on the same date, the respective seniority rank of such employees shall be determined by the Union. The Union shall promptly notify the Company in writing of its determination.

(d) Nothing in this Contract shall be construed in such a way that would enable an employee to use classified seniority for the selection of a particular job assignment. In justifiable cases, however, when requested by an employee, a supervisor will give consideration in making job assignments to the requirements of the job to be done, the physical condition, the qualifications and the classified seniority of the employee.

(e) All new employees and all employees transferring from other bargaining units into a job classification represented by the Union shall be classed as probationary employees for a period of one year and shall have no system service and seniority rights during that period. After one year of continuous service as probationary employees, such employees shall be classified as regular employees and their system service and seniority record shall include their previous employment as probationary employees. The Company

shall have the right to lay off or discharge probationary employees and there shall be no responsibility for reemployment of such employees after they are discharged or laid off during the probationary period. No unqualified probationary employee shall act as a second employee in any two-employee crew in the Field Operations or Systems Operations Sections.

(f) In order to avoid possible grievances, the Company will discuss in advance with the representatives of the Union, demotions, layoffs, and recalls from layoffs.

Section 2. (a) Classified seniority shall be administered separately in the following Departments, Divisions, and Sections: A-87

LOCAL UNION 12049

DUKE ENERGY OHIO AND KENTUCKY
- Gas Operations
  - Field Operations
    - Ohio – Kentucky District
  - Corrosion Control
    - Ohio District
  - Systems Operations
    - Ohio - Kentucky District
  - Production - Gas Plants
    - Ohio - Kentucky District

- Compliance and Service Delivery
  - Service Delivery OH/KY
    - Service Delivery
      - Ohio – Kentucky District
    - Meter Services
    - Gas Measurement Center
      - Ohio District

LOCAL UNION 5541-06

DUKE ENERGY OHIO AND KENTUCKY
- Gas Operations
  - Field Operations
  - Systems Operations
  - Production - Gas Plant

- Compliance and Service Delivery
  - Service Delivery

(b) In the cases of promotions, within each District as described above, the Union agrees that the strict classified seniority interpretations may be waived when a specific employee is unqualified for a particular promotion but in such event the Company and the Union shall discuss the matter fully and come to agreement first.

(c) The classified seniority status of employees permanently assigned from one District to another District shall be fixed without delay by discussion between the Company and the Union Grievance Committee.

(d) For a period of six months following a promotion, when an employee who has been assigned to a job classification not bargained for by the Union returns to a job classification in which they have classified seniority, their seniority will be adjusted to a date that is one day less than the classified seniority date of the employee with the least classified seniority in the job classification within the bargaining unit to which the employee is assigned. If the employee returns to the bargaining unit greater than six months from said promotion, they shall be placed at the minimum wage rate in a job classification no higher than Service Mechanic B, Meter Specialist II, Mechanic Operator II, Gas Systems Operations Mechanic II and Gas Plant Operator II. For purposes of bidding and downbidding, all previous seniority is lost and the employee will be ranked in seniority as a newly hired employee. No employee may return to a bargaining unit job classification if, as a direct result, an employee represented by the Union would be laid off.

Section 3. (a) An employee who has accepted a new position, will be given the first 10 working days of training, to evaluate the new position. It at the end of such period, the employee requests, they shall be restored to their previous position and previous classified seniority rank. This provision does not apply to employees who are in positions of automatic progression. An employee who has satisfactorily met all the requirements for entrance into a job classification shall be given a period of 30 days in which to master the new assignment. If, at the end of such period, the employee is unable to fulfill the assignment; he shall be restored to his previous position and previous classified seniority rank. A-27

(b) The Company shall have the right to require examinations, either oral, written or practical, to determine the fitness of employees for promotions. When such examinations are deemed necessary by the Company, the equipment and facilities necessary for such examinations will be provided by the Company. The Company agrees that the employee shall have the right to review the results of departmental tests upon request. If an employee indicates, within five days after receiving the results of a departmental examination, that he feels the examination was not fairly administered, the Company agrees to reexamine the employee. A Union designated witness may be present only during the practical portion of the retest. The employee, upon request, shall receive counseling based upon tests administered by the Staffing Services area of the Company or by outside consultants. In the case of a downbid, an employee who does not pass an examination shall be required to retake that examination after three months. An employee who does not pass the examination a second time will not be eligible for reexamination for 12 months and for subsequent two year intervals thereafter and will not be eligible to bid on other bargaining unit positions until they have successfully passed the examination. After three unsuccessful attempts to pass the test, the employee can elect to forfeit the bid. A-61

(c) When a permanent promotion is to be made to a job classification bargained for by the Union, a notice of the opening shall be posted by the Company on all bulletin boards for two weeks. A copy of these notices will be mailed to the Presidents of the Local A-80

Unions. The period of posting may be reduced to seven days, provided that any employees with greater classified seniority who may be off duty during the entire seven-day posting period are notified of the posting by a copy of the posting notice mailed by registered or certified mail to their home address on record in Human Resources.

(d) All bids related to posted openings should be made in duplicate and presented to the responsible supervisor who will sign both copies, retain one and return the duplicate to the employee for the record of the Local Union.

(e) When a posted opening occurs in a job classification, employees already in that job classification within the Seniority District may exercise their classified seniority rights to cross bid for the opening if the opening exists at another headquarters. The most senior employee already in the job classification within the Seniority District who cross bids and can qualify will be selected. Only one cross bid will be accepted for each posting. Resultant openings, which the Company desires to fill, will be filled by promotion of qualified employees from the next lower job classification or other qualified employees in the same promotional sequence in the Seniority District where the resultant opening exists.

(f) When a posted opening cannot be filled from among the qualified employees in the Seniority District in which the opening exists, the opening will be filled from qualified employees from other Seniority Districts within the Section. When the opening cannot be filled from within the Section, the opening will be filled in accordance with the appropriate provisions of this Contract.

(g) Subject to the approval of the Company and the Union, any employee may waive his right to promotion if such waiver does not prevent other employees from acquiring experience in the job classification held by him. Such waiver must be submitted to the Company and the Union in writing.

(h) When an employee waives his right to an opening in a job classification, the next employee shall be entitled to such opening, on a classified seniority and sufficient qualification basis, and so on until the position is filled.

(i) An employee waiving his right under this provision cannot later claim that particular job opening as a classified seniority right; however, the employee making such waiver shall not prejudice his right to accept future vacancies or positions that may occur, on a basis of his classified seniority and qualifications.

(j) An employee permanently established in a job classification under the provisions of this section of the Contract shall not be replaced later by an employee who may have developed sufficient classified seniority or qualifications.

Section 4. (a) The Company will post at least semi-annually and will maintain lists at locations mutually agreeable to the Company and the Union showing the system service and classified seniority of each employee. If exception is not taken to the list as posted within 30 days from the date of posting, the list shall be considered as correct. Copies of these lists shall be forwarded to the Local Union President and Recording Secretary.

(b) The Company will furnish annually, upon request, to the Financial Secretary of the Local Union a complete mailing list of all employees in the bargaining unit.

Section 5. An employee's classified seniority and system service standing shall not be jeopardized due to time off for injury, sickness or leave of absence.

Section 6. An employee will lose his system service and classified seniority who:

(1) Quits of his own accord.

(2) Is discharged for just cause.

(3) Employees who leave the Company involuntarily shall not lose accrued system service or classified seniority if, upon recall, they respond within six days, provided it is not obligatory on the Company to issue such a call after two years after the date of layoff. Notification of recall will be sent by registered or certified mail.

Section 7. (a) Layoffs and demotions shall be made on the basis of classified seniority. Reassignments shall also be made on the basis of classified seniority and sufficient qualifications. In case of layoff, an employee shall have the right to be returned to any job classification previously held by him in the course of his employment with the Company if his classified seniority is sufficient to qualify him for such job. An employee, however, shall not have the right to be demoted or assigned to any job classification which he has not previously held but will be given consideration by the Company for a Mechanic III position, at the maximum rate, before new employees are hired. Such an employee's classified seniority as a Mechanic III would be the same as the employee's system service.

(b) Every effort shall be made to continue the present policy of avoiding seasonal layoffs by finding other work for any employees likely to be thus affected, should such occasion arise.

Section 8. Any employee who may make application to the Staffing Office for transfer to a starting job not represented by the Union, for which he may be qualified, will be given preference for consideration before a new employee is hired for the job.

ARTICLE VII – HOURS OF WORK

Section 1. (a) Eight or 10 consecutive hours, exclusive of lunch time, shall constitute a working day, and four or five such days, totaling 40 hours, shall constitute a working week. Regular employees available and able to work, shall be assured of a 40 hour work week. It is understood that this provision will not affect in any manner the right of the Company to make temporary or permanent reductions in forces when considered necessary by the Company. A-4

(b) It is recognized that shift work is essential for employee groups covered by this Contract, in order to provide for continuous operation and service. However, insofar as A-8 A-52 A-81 A-88

possible, day work shall prevail. Where shift work is necessary, the Union and the Company shall cooperate in providing the necessary manpower, with the required ability, to fill day, afternoon, and night as well as weekend work schedules.

(c) Except when changing schedules or agreed otherwise, employees shall have consecutive off days, but not necessarily in the same work week.

(d) The work week of an employee for payroll purposes shall be from midnight Sunday to midnight the following Sunday. Employees working on a shift beginning two hours or less before midnight will be considered as having worked their hours following midnight. Employees working on a shift ending two hours or less after midnight will be considered as having worked their hours before midnight.

(e) The work week of an employee for purposes of determining off-days shall begin on midnight Sunday and consist of seven consecutive days in which the employee is scheduled to work five days and be off two days or scheduled to work four days and be off three days.

(f) Schedules for all employees will be based on the time prevailing in the City of Cincinnati.

(g) The first eight hours of work per day will be at straight time for regular scheduled work days, time and one-half for the employee's first scheduled off-day in the work week and double time for the employee's second scheduled off-day in the work week. Any time in excess of eight hours per day will be paid at the rate of time and one-half, except the employee's second scheduled off-day worked, which will be paid at double time. For employees who work a four day-10 hour schedule, the first 10 hours of work per day will be at straight time for regular scheduled work days, double time for the employee's second consecutive scheduled off-day and time and one-half for all other scheduled off-days. Any time in excess of 10 hours per day will be paid at the rate of time and one-half except the employee's second consecutive scheduled off-day worked which will be paid at double time. A-89

(h) In no case will an employee be forced to take time off in lieu of time worked outside his Regular Scheduled Work Day, but should an employee elect not to work during his Regular Scheduled Work Day he shall not receive pay for such time.

(i) Employees required to work more than 16 consecutive hours will be paid double time for all time worked in excess of, and continuous with, the 16 consecutive hours.

(j) When overtime occurs within a job classification where more employees are qualified and available to work than are necessary at the moment, the Company and Union have agreed to maintain a system of selecting the employees within the job classification at each headquarters who are to work, in a sincere effort to equalize overtime work, through a set of overtime guidelines that have been established and are contained in a separate document. The employees will be notified in advance, whenever possible, when they are required to work overtime. In the event the available overtime is not offered to the entitled employee(s) under the established overtime guidelines, the A-18 A-63 A-64

Company will offer the affected employee(s) make-up overtime. All make-up overtime must be offered and worked by the employee within six months of the time the disparity occurred.

(k) Overtime lists shall be posted weekly, in each headquarters, showing the overtime hours worked or waived during the previous week by each employee at the headquarters. Probationary employees shall not be included in the overtime lists.

(l) A call-out shall be defined as notice to report for unscheduled work given to an employee by telephone or messenger after he has left his headquarters or place of reporting or in case of an off-day, after what would have been his scheduled hours on that day.

(m) Employees called out for overtime work, other than for planned overtime, shall be paid a minimum of four hours at the appropriate overtime rate. A-60

(n) Travel time of one-half hour each way, at the appropriate overtime rate of pay, will be allowed on a call-out when such call-out exceeds four hours of continuous work that is not contiguous with a regularly scheduled shift. Employees will not be compensated for any travel time on a call-out which occurs on a regular holiday or when the employee is not released from work before his regularly scheduled shift, nor will travel time be allowed when overtime is worked continuously at the end of a regularly scheduled shift.

(o) Planned overtime shall be defined as time worked upon notice to an employee given before leaving his headquarters or place of reporting, or in case of an off-day, during or before what would have been his scheduled hours on that day, that he is to report outside of his regular schedule on any succeeding day. Such time worked shall be paid for at the appropriate overtime rate but not for less than four hours unless such planned overtime extends into or directly follows the employee's regularly scheduled work day, when it shall be paid for at the appropriate overtime rate for the actual hours worked.

ARTICLE VIII – WORKING CONDITIONS

Section 1. CHANGE IN SCHEDULE: (a) Each employee shall have a specific hour for reporting for work, and shall be entitled to not less than 24 hours notice of any change. Employees, whose schedules are changed to include an off day on the next succeeding day, shall receive such notification within 15 minutes prior to or after the start of their regularly scheduled hours of work on the day previous to such a change.

(b) If an employee is required to commence working on a schedule which was changed without 24 hours notice, he shall receive the appropriate premium pay for all consecutive hours worked. Employees, who are not notified within 15 minutes prior to or after the start of their regularly scheduled hours of work of a schedule change that includes an off day on the next succeeding day, shall receive the appropriate premium pay for all hours worked during their next scheduled work day.

Section 2. TRANSFERS AND REASSIGNMENTS: (a) Each employee shall have a specific headquarters for reporting for work. There shall be no unreasonable, A-54

disciplinary or discriminatory transfers, but the right of the Company to effect transfers, reassignments and logical site reporting to properly run its business is recognized. The Company will discuss transfers, reassignments and logical site reporting in advance with representatives of the Union except in instances where the employees with the least classified seniority are selected or where the employees volunteer. Employees may be assigned to report to a logical site reporting location for any assignment expected to be a minimum of three days.

(b) Transfers which are for periods of 14 consecutive calendar days or less will be considered temporary transfers. Transfers of 15 consecutive calendar days or more to either permanent or temporary headquarters, planned in advance, will be considered reassignments. Notification of availability of a reassignment will be posted at least 2 weeks in advance of the requirement. Eligible employees may request a preference for the reassignment. If there are no voluntary requests, the qualified individuals lowest on the classified seniority list will be assigned.

(c) During periods of temporary transfers or reassignments, the employees will report to and work out of the new headquarters. Such employees will be paid one hour's pay at the straight time rate and mileage at the prevailing rate based on the round trip distance between the employee's regular headquarters and temporary headquarters for each day of a temporary transfer and for the first 14 consecutive calendar days of a reassignment to a temporary headquarters. If a temporary reassignment exceeds three months, the employee will be paid in a similar manner when they return to their regular headquarters. Neither the one hour's pay nor the mileage applies for temporary transfers or reassignments of employees whose normal assignment is to home site report.

When it is necessary to temporarily assign probationary employees to a headquarters other than their own or to a job site reporting location that is farther from their regular headquarters, such employees will be paid mileage at the amount per mile approved by the Internal Revenue Service, based on the additional round trip mileage the employee is required to drive. No mileage compensation will be paid for the temporary assignment if the other reporting location is closer to the employee's home.

(d) When it is necessary to temporarily assign employees to a logical site reporting location that is further from their home than their regular headquarters, such employees will be paid mileage at the prevailing rate based on the additional round trip mileage employees are required to drive. No mileage compensation will be paid for the temporary assignment if the other reporting location is closer to the employee's home.

(e) Logical site reporting will be offered on a voluntary basis. If there is an insufficient number of volunteers, assignments will be made on a junior qualified basis. When assigning the junior qualified, unusual or extenuating circumstances will be taken into consideration.

(f) Employees may be assigned to drive Company vehicles from and to the job site from home or sites close to home. If Company vehicles are used in such a manner, the mileage provisions for logical site reporting are not applicable. An option to the mileage provision is that employees may, during a logical site reporting assignment, A-82

pick up and return a Company vehicle to their regular headquarters, provided travel is on their own time.

Section 3. FOREMEN'S DUTIES: Foremen's duties shall be restricted to direct supervision except for Foremen's and employees' training, in cases of emergency, or for such incidental work as may occasionally be required.

Section 4. SAFETY AND HEALTH: (a) The Company shall make all reasonable provisions for the safety and health of the employees. A suitable number of raincoats, hats, boots, gloves and water facilities and any other safety equipment required by the Company shall be provided on the job. Adequate locker, toilet and shower facilities shall be provided at all permanent headquarters from which the men operate or in the shop where they are employed. A reasonable effort will be made to provide similar facilities at temporary headquarters.

(b) Employees shall be held responsible for the equipment assigned to them.

(c) In order to promote health and safety among the Company's employees, the Company and the Union agree that a Joint Safety Advisory Committee will be established. This Committee shall meet quarterly upon the Union's request to the chairman of the committee, who shall be the Safety Director of the Company. The purpose of the Joint Safety Advisory Committee is to give consideration to those general accident prevention programs and policies that affect the safety and health of the employees represented by the Union. The Joint Safety Advisory Committee shall not deal with individual or group grievances. It is agreed that the administration of the accident prevention and medical policies, programs and procedures are vested in and reserved to Management. It is further agreed that employees engaged in the Joint Safety Advisory Committee meetings during working hours shall suffer no loss of pay for such time.

(d) The Company agrees that an employee is authorized to call for assistance if, in the employee's judgment, his safety is endangered.

Section 5. CONTRACTING OUT: (a) No employee shall be deprived of work through contracting with outside parties. When it is necessary to use private equipment, such equipment shall be manned and operated by employees, provided qualified employees are available and said equipment can be obtained on this basis. A-13

(b) In order to meet the unusual amount of work due to deferred maintenance and an abnormal expansion of new construction, the Company contemplates that it will be necessary to continue to contract for some of this work. This is believed necessary in order to avoid the building up of a large temporary force to meet an unusual condition. If such a force were built up it would either be necessary to lay off the additional employees hired when the work was caught up, or it might become impossible to assure 40 hours work per week for 52 weeks per year for regular employees as provided for under this Contract. A-36

(c) It will continue to be the policy of the Company, when contracting for work, not to contract for any work which is ordinarily done by its regular employees if contracting for the work would result in the layoff of any regular employees.

(d) In deciding what work shall be contracted by outside forces the Company will take into consideration the necessity of meeting the completion requirements of the work in order that the service needs of the customers may be met. The Company will make reasonable efforts to utilize our normal working force where possible to do this work.

(e) The question of what proportion of this work will be done on an overtime basis will depend on the urgency of the work, weather conditions, volume and nature of the work and the availability of the working force.

Section 6. MEAL COMPENSATION: Employees working extra time shall be entitled to a suitable lunch or compensation therefore at the conclusion of two hours in excess of eight working hours; similar lunch or money at each five-hour interval thereafter until released from duty. Employees who work a four day-10 hour schedule shall be entitled to a suitable lunch or compensation in lieu thereof, whenever they work one hour or more in excess of their normal workday; similar lunch or money at each five hour interval thereafter until released from duty. On call-out of employees for emergency work on an off-day, such employees called out to work shall be furnished a suitable lunch or compensation in lieu thereof after each five hour interval until released from duty. The meal compensation allowance shall be as follows:

Current	Effective First Day of Pay Period Following Ratification	Effective			
		5/15/2017	5/15/2018	5/15/2019	5/15/2020
$10.75	$11.25	$11.25	$11.50	$11.50	$11.50

Section 7. TRANSPORTATION: Except when employees are engaged in a logical site reporting assignment, all transportation of employees from shop to job or job to job, or job to shop shall be provided by the Company when same is required in the line of duty.

Section 8. WITNESSING FOR COMPANY: Regular pay and reasonable or required expenses will be allowed employees who may be summoned or requested to testify for the Company. A-1

Section 9. JURY DUTY: Employees required to serve on a jury shall be compensated on the basis of their regular wage.

Section 10. PAYDAYS: Paydays shall continue as at present, i.e., one every other calendar week. Paychecks will be mailed to the employee's home address. Employees on a volunteer basis may elect direct deposit. Employees hired on or after January 1, 2006 will be required to use direct deposit. Checks will be directly deposited into one or more bank accounts employees shall designate and authorize. Direct Deposit advices will be mailed to the employee's home address if she/she has elected to receive a printed copy.

Section 11. RETROGRESSION: Should an employee, who has given long service to the Company, become physically unable to satisfactorily and safely perform the regular duties of his job classification, an effort will be made by the Company to find work of a less strenuous nature for which he is qualified. The employee's hourly rate will be red-circled at the time of his assignment to a job of a lower classification until his hourly rate is equal to the maximum hourly wage rate of the job classification to which he has been assigned.

Section 12. JOB ABOLISHMENT: Should an employee have his job abolished, an effort will be made by the Company to find another job classification for which the employee is qualified. An employee assigned to a job of a lower classification as a result of his job being abolished will maintain his present hourly rate until the maximum hourly wage rate for the job classification to which he has been assigned is equal to the employee's present hourly rate or until he qualifies and receives a promotion. A-90

Section 13. GENERAL ILLNESS: (a) Regular employees who are actively working on January 1, regular employees who return to work from an authorized extended absence on or after January 1, probationary employees who become regular employees on or after January 1, shall be paid as gross wages, for absent time due to bona fide illness or injury, a maximum annual amount equal to 40 hours at their regular Straight Time Pay. Such payment shall be made by the Company on the nearest practicable regular pay day following the date such employee becomes eligible. A-5 A-9

(b) After an employee has been continuously disabled, subject to medical determination, and unable to return to work for more than seven consecutive calendar days, the employee will receive Short-Term Disability consisting of up to 26 weeks of pay per incidence with payment based on the schedule below or until the employee is able to return to work, whichever comes first. During the seven consecutive calendar day waiting period, it is intended that no employee will incur a loss of more than five scheduled days of straight time pay.

The administration of short-term disability compensation will be as follows:

Years of Service	Maximum Weeks at 100% Pay per Occurrence	Weeks at 66 2/3% Pay
0-1	None	All
1-5	10	Balance
6-10	15	Balance
11-14	20	Balance
15 or more	26	N/A

(c) After an employee has been continuously disabled, subject to medical determination, and is unable to return to work for more than 27 consecutive weeks, and has exhausted Short-Term Disability Benefits, the employee will receive Long-Term Disability benefits as described in the Company's Long-Term Disability Plan Description.

(d) Compensation will not be provided for illnesses resulting from such causes as: illegal use of drugs or alcohol, willful intention to injure oneself, the commission of a crime, elective or cosmetic procedures not covered by the medical plan, the employee's refusal

to adopt such remedial measures as may be commensurate with his disability, or permit reasonable examination by the Company.

(e) In order to facilitate the scheduling of the work forces, an employee who will be absent from work shall notify the Company within a reasonable period of time before his scheduled shift if possible and shall likewise give the Company reasonable advance notice of his return to work. Unless an employee notifies the Company concerning the cause of his absence before the end of the first scheduled working day of such absence, his waiting period and subsequent claim for sick leave pay shall not begin until such notice is received.

(f) Failure to present a certificate from a physician licensed to practice medicine prior to the end of the fifth scheduled working day or failure to provide a legitimate excuse will cause the employee's Short-Term Disability to be denied until the time such certificate is received.

(g) If an employee requests work of a less strenuous nature for a temporary period following an illness or disability, the Company will make an effort to find such work providing the employee's physical condition is satisfactory and is approved by the Company physician.

Section 14. HOSPITAL AND MEDICAL PLANS: (a) Any health care plans (medical or dental) that the Company unilaterally implements at its sole discretion for the general non-represented employee population shall also be provided to the bargaining unit employees at the same costs and plan design structure as for the non-represented employees. It is expressly understood that the right to add, eliminate, and alter or to make any other changes to these health care plans or to employee costs for the plans, is reserved to the Company. A-14 A-78

(b) The Company's part of the monthly premiums for the health care plans will continue to be paid while an employee is receiving illness or accident compensation, provided the employee was covered by such plan immediately prior to the employee's sickness or industrial accident.

(c) For the term of this Contract, post-retirement health care under the health care plans sponsored by Duke Energy Corporation will be made available to all union Employees hired prior to January 1, 2012 in accordance with the terms of the letter from the Company to the Union dated April 4, 2005, Sidebar Letter A-71 dated August 1, 2007, Sidebar Letter A-71a dated June 3, 2011 and the "2016-2021 Post Retirement Health Care Letter" dated June 2, 2016. Union employees who are hired on or after January 1, 2012, will not be eligible for either the Traditional Option (as defined by the applicable sidebar letters) or the HRA Option (as defined by the applicable sidebar letters), but such employees shall be eligible for access (at unsubsidized rates) to post-retirement medical, dental and vision coverage as described in the "2016-2021 Post Retirement Health Care Letter" if they have attained age 50 and completed at least five years of service as of the date of their retirement. A-71 A-71a A-76 A-91 A-92

Section 15. INSURANCE, HEALTH & WELFARE BENEFITS: Any insurance, health and welfare benefit plans under the Duke Energy Active Health & Welfare Benefit A-68

Plans not specifically referenced elsewhere in this Contract (e.g. life insurance, supplemental, accidental death and dismemberment, long term disability, and dependent life insurance) that the Company maintains and/or implements for the general non-unionized employee population shall also be provided to the bargaining unit employees at the same benefit levels, costs, and plan design structure as for the non-unionized employees. The Company has the right to add, eliminate, and alter or to make any other changes to these insurance, health and welfare benefit plans or to the employee costs for the plans, consistent with any changes it makes for the general, non-unionized employee population.

Section 16. INDUSTRIAL ACCIDENTS: An injured employee who is unable to work because of an industrial accident will be paid a supplement in an amount equal to one half of the difference between what he/she would have received at regular work and the amount received as compensation for such injury, for a period not to exceed 26 weeks. This supplemental industrial accident compensation will begin after an initial seven calendar day waiting period and will continue for not more than 26 weeks of continuous disability. However, if an industrial accident disability continues for 14 or more calendar days, the employee will receive this supplemental industrial accident compensation for the initial seven-day waiting period.

Section 17. INCLEMENT WEATHER: The Company will not require employees to work out of doors in heavy or continuous storms or excessively cold temperatures in exposed locations, unless such work is necessary to conform to the law or applicable regulations, to protect life, property, or to guarantee service to the customers. Employees covered by this Contract shall not be required to lose time due to such weather conditions, but the Company may provide work indoors or under adequate shelter at their regular rate of pay. A-7 A-65

Section 18. Upon the death of the designated relatives of an employee, the employee, upon request, may be entitled to the stipulated maximum number of calendar days off for which he is entitled to receive regular pay for not more than the indicated number of consecutive working days, including the day of the funeral. If prior arrangements are made, an employee may include a maximum of one day following the funeral as one of the consecutive working days off, and in the case of a spouse, child, mother, father, brother or sister, two days following the funeral. No pay will be granted for regular scheduled off days.

Relationship	Maximum Consecutive Calendar Days Off	Maximum Consecutive Working Days Off With Pay
Spouse or Domestic Partner	7	5
Child, Stepchild or Foster Child	7	5
Mother, Stepmother or Foster Mother	7	5
Father, Stepfather or Foster Father	7	5
Brother, Stepbrother	7	5
Sister, Stepsister	7	5
A legal dependent residing in the employee's household	7	5
In-Laws (father, mother, brother, sister, son or daughter)	5	3
Grandchild, Step Grandchild	6	4
Grandparent/Spouse's Grandparent	4	2

With supervisory approval, bereavement may be taken in segments. For example, an employee may take time off on the day of the death, return to work and then take off additional time to attend the funeral. If an employee has worked four hours or more and is notified of a death in his family, and leaves the job, the day will not be charged as one of the consecutive working days. If, however, he has not worked four hours, the day will be charged as one of the consecutive working days for which he is entitled to receive regular pay.

Section 19. BULLETIN BOARDS: The Company agrees to furnish bulletin boards at all division headquarters. The use of these boards is restricted to the following: notices of Union meetings, notices of Union election, notice of changes within the Union affecting its membership, or any other official notices issued on the stationery of the Union and signed by the Regional Director or any duly elected or appointed official of the Local Union. There shall be no other general distribution or posting by members of the Union of pamphlets or literature of any kind except as provided for herein.

Section 20. UNION OFFICE: (a) Members of the Union selected for full time office shall be entitled to unpaid leaves of absence without prejudice or loss of seniority. Such leaves of absence shall be limited to a period of one year, and shall be renewed at the conclusion thereof, if necessary. At no time shall the operations of the Company be interfered with by such leaves of absence. All requests for such leaves of absence shall be in writing and submitted at least one week in advance.

(b) Except as it may conflict with other provisions of this Contract, the President, Vice President, Recording Secretary, and elected Grievance Committee men shall not be required to work regular afternoon and night shifts. However, not more than two employees from each headquarters may exercise this privilege.

Section 21. ADDRESSES AND TELEPHONE NUMBERS: Each employee in a job classification represented by the Union shall be responsible for maintaining an up-to-date address and telephone number on file at the Company. Forms to report changes will be provided by the Company and made available to employees at each headquarters.

Section 22. PERSONAL DAY: (a) An employee who has completed six months of continuous service shall be entitled to four compensated personal days off each calendar year. Requests for personal days must be made at least seven calendar days prior to the date requested and must be approved by management. However, because of extenuating circumstances, a day off with less than a seven calendar day notification may be approved by an employee's supervisor. Arrangements for all personal days must be made with supervision on or before November 1 of each year or it shall be lost. The Company reserves the right to limit the number of employees who can be off on a specific day. If a personal day is not used during a year, it shall be lost and no additional compensation shall be granted.

(b) An employee who has completed six months of continuous service shall be entitled to one compensated Diversity Day off each calendar year. Requests for this day must be made at least seven calendar days prior to the date requested and must be approved by management. However, because of extenuating circumstances, less than a seven calendar day notification may be approved by an employee's supervisor. The Company reserves the right to limit the number of employees who can be off on a specific day. If the Diversity Day is not used during a year, it shall be lost and no additional compensation shall be granted.

Section 23. TEAMS: The purpose of bargaining unit teams is to promote an environment of continuous improvement in the work place for the mutual benefit of the Company, its customers, and the Union. Performance of special functions and duties within the team is voluntary. The teams will not be involved in any issue or take any action or make any decision which will subordinate the interests and viability of the Union. The teams will not engage in collective bargaining or deal with management over bargainable issues, as all parties recognize this to be the exclusive role of the Union. A-40

ARTICLE IX – ADMINISTRATION AND GRIEVANCE ADJUSTMENT

Section 1. (a) The Union shall maintain a system of Stewards whose duties shall be to represent the Union in seeing that the provisions of this Contract as they apply on the job are observed at all times. The Union shall have a Grievance Committee composed of five* members. This committee shall meet with the management of the Company on all matters pertaining to the provisions of this Contract, and any and all matters of dispute between the Union and the Company under the terms and during the life of this Contract. The Recording Secretaries for the Local Unions may also attend such meetings. A-15 A-21

(b) If an employee, after consulting with the immediate supervisors, feels that a grievance exists, the avenue of grievance adjustment shall be: first, between the employee and the officially designated steward, and the foreman or supervisor; second, between members of a Union Grievance Committee consisting of not more than five** members and the Department Management; third, between the Union Grievance Committee, Agents of the Union and officials of the Company. The Recording Secretaries for the Local Unions may also attend second and third step grievance meetings. If a

satisfactory settlement cannot be reached before the second step of the procedure outlined above, the grievance shall be reduced to writing by the Union.

(c) An employee, who is considered by the Union or the Company necessary to the proper settlement of the grievance, shall be present at the grievance meetings.

(d) The Union Grievance Committee and the Recording Secretaries of the Local Unions when engaged during their regular working hours in grievance meetings with Management shall not suffer a loss of pay for such time.

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*The Grievance Committee of Local Union 5541-06 shall consist of not more than three members.
**The Grievance Committee of Local Union 5541-06 shall consist of not more than three members.

ARTICLE X – ARBITRATION

Section 1. (a) If the parties are unable to resolve the grievance following the third step, the Union, within 30 workdays of receipt of the third-step response, may notify Labor Relations in writing of its desire to advance the grievance to arbitration.

(b) Upon receipt of the Union's notification the parties will promptly petition the Federal Mediation and Conciliation Service (FMCS) for a panel of seven arbitrators and an arbitrator will be selected by the parties. In the event that no acceptable arbitrator appears on the panel of arbitrators submitted by FMCS either party may request an additional panel from FMCS.

(c) The arbitrator so selected shall hold a hearing as promptly as possible on a date satisfactory to the parties. If a stenographic record of the hearing is requested by either party, the initial copy of this record shall be made available for the use of the arbitrator and the party requesting the records. The cost of this initial copy and its own copy shall be borne by the requesting party, unless both parties desire a copy. If both parties desire a copy they shall equally share the cost of the arbitrator's copy, and shall each bear the cost of any copies of the record they desire.

(d) After completion of the hearing and the submission of the post-hearing briefs, the arbitrator shall render a decision and submit to the parties written findings that will be binding on both parties to the Agreement.

(e) The arbitrators' and other joint expenses mutually agreed upon shall be borne equally by both parties.

(f) The arbitrator shall have no authority to add to, detract from, alter, amend, or modify any provision of this Agreement. It is also mutually agreed that there shall be no work stoppage or lockouts pending the decision of the arbitrator or subsequent thereto.

ARTICLE XI – DISCIPLINE AND DISCHARGE

Section 1. (a) The Company will not discipline or discharge an employee save for just cause. Written notice of any discharge or disciplinary action involving lost time taken by the Company against any employee shall be furnished to the Union and the employee within two working days.

(b) Appeal from discharge must be taken within five working days in the form of a written notice from the Union to the Company. The Company and the Union shall strive to reach a just decision within 10 days following the appeal. Failing therein, the matter shall be submitted to arbitration as provided above.

(c) This Section shall not apply to disciplinary action taken in accordance with Article I, Section 2, of this Contract.

ARTICLE XII – HOLIDAYS

Section 1. (a) The following days are observed as regular holidays which will be recognized on the indicated dates. The Company may change the date for recognizing a holiday if the date indicated is changed by a legislative enactment or if the prevailing community practice is not consistent with the indicated date. A-10 A-16 A-17

Holiday	Date Recognized
New Year's Day	January 1
Memorial Day	Last Monday - May
Independence Day	July 4
Labor Day	First Monday - September
Thanksgiving Day	Fourth Thursday - November
Day after Thanksgiving	Friday after Thanksgiving
Christmas Eve	December 24
Christmas Day	December 25

(b) If the recognized date of a holiday occurs on a Saturday or Sunday the Company will have the option of observing that holiday on another date which the Company determines to be consistent with the community practice or paying eight hours of regular straight time pay in lieu thereof for the holiday.

(c) Regular employees whose duties do not require them to work on holidays will be paid eight hours straight time holiday pay provided the employees have worked their scheduled day before, or his scheduled day after the holiday. Employees who are on a four day-10 hour schedule will receive 10 hours of straight time pay if a holiday falls within their regular scheduled work week but they are not required to work the holiday, provided the employees have worked their scheduled day before, or their scheduled day after the holiday. Employees whose regular scheduled work week does not include the paid holiday will receive eight hours of straight time holiday pay. Regular employees who are scheduled to work on a recognized holiday will be paid at time and one-half for the first eight hours worked in addition to their straight time holiday pay.

(d) An employee called out to work on a recognized holiday for a period of four hours or less will be paid for four hours at time and one-half in addition to his straight time holiday pay. An employee called out to work on a recognized holiday for a period of more than four hours but less than eight hours will be paid for eight hours at time and one-half in addition to his regular straight time holiday pay.

(e) Employees who are required to work more than eight hours on a recognized holiday will be paid at the rate of double time for all such work in excess of eight hours.

(f) When necessary, employees will be granted a reasonable time off with pay to vote in a national, state or local election.

(g) Excluding planned projects and appointments prompted by customer requests, no field construction, field maintenance or routine customer service work shall be performed on the actual calendar holidays for Labor Day, Thanksgiving Day and Christmas Day, except that which is necessary to protect life, property or continuity of service.

ARTICLE XIII – VACATIONS

Section 1. (a) Every effort will be made to grant vacations at a time suitable to the employee, but should the number leaving on vacation in any one period handicap the operations of the Company, the Company reserves the right to limit the number receiving vacations. Preference for vacations shall be granted within a classification at a headquarters on a system service basis.

(b) Vacations for employees will be granted with pay during the calendar year in which they complete the specified number of years of continuous service on the following basis:

(1) Employees with less than one year of continuous service with the Company shall be entitled to one day of vacation for each month worked, with a maximum of 10 days total.

(2) Employees with one year of continuous service with the Company shall be entitled to a vacation of two weeks.

(3) Employees with seven or more years of continuous service with the Company shall be entitled to a vacation of three weeks.

(4) Employees with 15 or more years of continuous service with the Company shall be entitled to a four week vacation or, if required to work by the Company, payment of one week's wages (40 hours at straight time) in lieu thereof for the fourth week.

(5) Employees with 21 or more years of continuous service with the Company shall be entitled to a five week vacation or, if required to work by the Company, payment of one week's wages (40 hours at straight time) in lieu thereof for the fifth week.

(6) Employees with 32 or more years of service with the Company shall be entitled to a six week vacation or, if required to work by the Company, payment of one week's wages (40 hours at straight time) in lieu thereof for the sixth week.

(c) An employee accrues entitlement of 1/12 of their current year's vacation for each full month the employee is employed during the current calendar year or is on STD, or leave of absence. Any employee leaving the Company's service during any calendar year shall receive payment for any unused portion of accrued vacation for that current year. However, in the event of an employee's death, the estate of the employee will be paid the unused portion of the employee's total vacation allotment for the current year.

(d) The anniversary of employment shall determine the employee's vacation status.

(e) In order for an employee to qualify for a vacation, the employee must have been on the Company payroll as a full-time regular or probationary employee on the last day in the calendar year previous to the vacation, and must have been available whenever necessary for the Company medical examinations and reports.

(f) An employee who is eligible for more than a three week vacation may be required to take the vacation in excess of three weeks outside the preferred vacation period, which is the period from June 1 to September 30.

(g) An employee who meets all the qualifications for vacation, and is on a Leave of Absence for illness on the last day in the calendar year previous to the vacation, will be entitled to vacation.

(h) When a holiday falls within an employee's vacation such employee shall receive either an additional day's pay to compensate for the loss of such holiday or the paid vacation period shall be extended for one day, at the discretion of the Company.

(i) Vacations must be selected for full weeks. However, an employee entitled to two or more weeks of vacation in a calendar year may arrange to take five days of that vacation in one day increments. Requests for these days must be made at least seven calendar days prior to the date requested and must be approved by supervision. However, because of extenuating circumstances, a day off with less than a seven calendar day notification may be approved by an employee's supervisor. An employee entitled to four or more weeks of vacation in a calendar year may arrange to take an additional five days of that vacation in one day increments. Requests for these additional five days must be made seven or more calendar days prior to the date requested and must be approved by supervision. The decision to grant or not grant a one day vacation by supervision shall not be subject to the grievance and arbitration procedure. The Company reserves the right to limit the number of employees who can be off on a specific day and may, but cannot be required to, grant a one day increment on a work day

preceding or following a holiday or other vacation. Such one day increments must be utilized before an employee's scheduled vacation in a particular year is exhausted.

(j) An employee's vacation (full week) will start when the employee is released from duty on his last regularly scheduled working day prior to the scheduled vacation, and shall end at the start of his first regularly scheduled working day following the scheduled vacation. However, prior to the beginning of his scheduled vacation, an employee may indicate, in writing to his supervisor that he desires to be considered for work on what would have been normal off days at the beginning or end of his scheduled vacation.

ARTICLE XIV – NATIONAL DEFENSE

Section 1. (a) Employees who volunteer for or are drafted in the armed services of the United States, or are conscripted by the United States Government, shall retain all rights and privileges under this Contract, including seniority standing and shall be entitled to vacation pay due.

(b) The Company in recognition of service rendered to the Nation, agrees to restore all employees to their former positions, except those dishonorably discharged, who notify the Company within the time specified by applicable legislation of their desire to return to work. An employee who leaves the Service ill, injured or unable to work shall retain all rights of his former job until he is able to work. An injured, weakened or partially disabled employee shall be offered light duty, if he is physically able to perform such work. All Company sponsored life and AD&D insurance coverage for employees starting an approved military leave of absence will be continued for a period of up to six months with the same cost sharing as before the leave began.

(c) The foregoing provisions shall apply only to employees who are eligible for statutory re-employment rights.

ARTICLE XV – DEPARTMENT STEWARDS

The Union shall furnish the Company with a list of Department Stewards and this list shall be kept current. It is further agreed that only regular employees of the Company who are covered by this Contract shall be designated as Stewards.

ARTICLE XVI – RETIREMENT BENEFITS

Section 1. RETIREMENT INCOME PLAN: (a) Eligible employees represented by the Union hired or rehired before January 1, 2017, will participate or continue to participate in the existing Cinergy Corp. Union Employees' Retirement Income Plan (hereinafter called the "Retirement Income Plan") as amended and restated effective January 1, 2014 and subsequently amended to make legally-required changes as required by appropriate federal legislation and regulation governing such plans or technical changes, under the terms set forth in the "Amendment to A-71 Retirement Plan and HRA Conversion

Agreement" dated June 2, 2016. Employees hired or rehired on or after January 1, 2017 will not be eligible to participate in the Retirement Income Plan.

(b) In consideration of the additional benefits incorporated in the Retirement Income Plan, the parties to this Contract agree that the Company will not reduce the benefits and the Union will not request any change in the Retirement Income Plan until the expiration of the Contract in effect on May 15, 2021.

Section 2. RETIREMENT SAVINGS PLAN: (a) The Company agrees to establish and maintain an employee savings plan, subject to the provisions of the appropriate federal legislation and regulation governing such plans, to be known as the "Duke Energy Retirement Savings Plan", hereinafter called the "Retirement Savings Plan."

(b) The Retirement Savings Plan is described in the Company's publication the "Duke Energy Retirement Savings Plan", Summary Plan Description and Prospectus.

(c) The Company hopes and expects to continue the Retirement Savings Plan indefinitely but it must reserve the right to alter or amend it or merge it into any other Savings Plan at any time. Any reduction or discontinuance of Company contributions during the term of the Contract will be subject to collective bargaining. However, under no circumstances shall any part of the corpus or income held by the Trustee of the Retirement Savings Plan be recoverable by the Company or be used for or diverted to any purposes other than for the exclusive benefit of the employee participants or their beneficiaries as provided in the Retirement Savings Plan.

ARTICLE XVII – INTERRUPTION OR PYRAMIDING BENEFITS

Section 1. (a) With the exception of shift differential premium, and a holiday occurring during an employee's vacation, it is agreed that under no circumstances shall any Section of this Contract be interpreted to provide the pyramiding of a benefit or premium payment to employees covered by this Contract. For example, no employee may claim sick pay while receiving vacation pay or holiday pay while receiving sick pay.

(b) It is further agreed that there shall be no interruption in the payment of one benefit in order that the employee may receive payment for another benefit. For example, no employee may interrupt his vacation to begin sick leave or interrupt his sick leave to include a holiday. The only exceptions to the provision are that an employee's sick pay may be interrupted to include vacation pay and that vacation pay may be interrupted to include death in family pay as set forth in the Contract. In the event of a death of a relative as defined in Article VIII, Section 18 occurs after the start of an employee's vacation, any compensable bereavement time off under the Contract would interrupt the vacation and replace the unused planned vacation days. The rescheduling of the unused vacation days interrupted by the death must be approved in advance by supervision and shall not impact normal administration of vacation in one-day increments as provided in Article XIII, Section 1(i).

ARTICLE XVIII – DURATION

Section 1. (a) The Contract shall become effective as of May 15, 2016, and all the provisions thereof shall continue in full force and effect until May 15, 2021, and thereafter for successive three year periods unless one of the parties hereto on or before the 60th day next preceding any contract anniversary date shall notify the other party hereto, in writing, of its desire to modify or terminate the same.

(b) Joint conferences between representatives of the Company and the Union shall be promptly started following any of the above notifications for the purpose of reaching a mutually satisfactory agreement.

(c) On or before May 15, 2021, this Contract may be extended by mutual agreement of the parties for a specific number of calendar days. If a tentative agreement on the terms of a new Contract has been reached on or before May 15, thereafter the Union shall have one-half of the specified number of days in which to submit the Contract to its membership for ratification and in case of failure to ratify, in order that the Company shall have the remaining one-half of the specified number of days as notice before a work stoppage occurs.

IN WITNESS WHEREOF, the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW), AFL-CIO-CLC, on behalf of Local Unions 12049 and 5541-06, and Duke Energy Ohio, Inc. and Duke Energy Kentucky, Inc., do hereby, by their duly authorized agents, in the premises, execute and sign this 2016 – 2021 Contract in duplicate this 7th day of July 2016.

DUKE ENERGY OHIO, INC.
DUKE ENERGY KENTUCKY, INC.
Cincinnati, Ohio

Jay R. Alvaro
Director Labor Relations

Lisa A. Gregory
Human Resources Principal

UNITED STEELWORKERS (USW),
AFL-CIO-CLC

Leo W. Gerard
President

Thomas Conway
Vice President – Administration

Stan Johnson
Secretary/Treasurer

Fred Redmond
Vice President – Human Affairs

David McCall
Director, District 1

David W. McLean
Sub 5 Director

Ronnie Wardrup
Staff Representative

John Waits

Steve Bowermaster

Jeff Berkemeier

Steve Benkert

Norman Barnes

Gary Tuttle

Russ Zimmer

Scott Newkirk

Dan Gilday

Appendix A

Historical Documents Preserved

And Made A Part Of This Agreement

For Interpretation And Application

The index and marginal references in the Labor Agreement to documents in Appendix A are intended only for convenience in administering the Labor Agreement. The index and marginal references and Appendix A are not intended to list every document that could be applicable to any factual situation arising under a given Article or Section of the Labor Agreement. It is also not intended that each document referenced in an Article or Section will be applicable to any or all factual situations covered by the referenced Article or Section. No inferences, presumptions, or conclusions shall be drawn by the Company, the Union, or any arbitrator from the indexing of, a marginal reference to, or failure to reference any document listed in Appendix A.

Appendix A

HISTORICAL DOCUMENTS PRESERVED AND MADE PART OF THIS AGREEMENT FOR INTERPRETATION AND APPLICATION INDEX BY CONTRACT CLAUSE

A-DOC #	CLAUSE	ISSUE	DATE
A-41	Article II, Section 1	Union Security – Company Neutrality	10/07/96
A-28	Article V, Section 1	Training Union on Job Evaluation Procedure	05/13/94
A-62	Article V, Section 2	Supervisory Upgrades	08/01/07
A-87	Article VI, Section 2(a)	Seniority Departments	06/02/16
A-27	Article VI, Section 3	Notification to the Union of Posted Job Openings	05/13/94
A-61	Article VI, Section 3(b)	Promotional Retraining	01/18/02 (10/07/96) (05/13/94)
A-80	Article VI, Section 3(c)	Gas Operations Promotional Sequences and New Position	06/02/16 (04/18/11)
A-4	Article VII, Section 1	Continuity of Work and Overtime	07/05/79
A-8	Article VII, Section 1	Inspecting Mechanic Job Class – No Shift Rotation	05/17/82
A-52	Article VII, Section 1	Work Hours	01/18/02 (10/07/96) (05/13/94)
A-81	Article VII, Section 1(b)	Field Operations – Schedule Replacement Guidelines	06/03/2011
A-88	Article VII, Section 1(b)	Work Hours Beyond Normal Scheduled Shift	06/02/16
A-89	Article VII, Section 1(g)	Emergency Work Outside of Ohio/Kentucky Service Territory	06/02/16
A-18	Article VII, Section 1(j)	Scheduling Make-up Overtime	05/23/91
A-63	Article VII, Section 1(j)	Overtime Guidelines –Field and Systems Operations, Contractor Construction, Corrosion, Gas Production and Measurement Center	06/02/16 (06/03/2011) (06/14/07)
A-64	Article VII, Section 1(j)	Service Delivery Overtime Guidelines	06/02/16 (06/15/07)
A-60	Article VII, Section 1(m)	Call Out Pay	01/18/02
A-54	Article VIII, Section 2	Voluntary Transfers Between Headquarters	06/02/16 (01/18/02) (10/07/96) (05/13/94)
A-82	Article VIII, Section 2(f)	Home Site Reporting Guidelines	06/02/16 (06/03/2011)
A-13	Article VIII, Section 5	Company Monitor Contractor Safety	05/23/91
A-36	Article VIII, Section 5	Inspecting Mechanics - AMRP	06/03/2011 (10/07/96) (05/13/94) (05/23/91)
A-1	Article VIII, Section 8	Witness Pay for Criminal Cases	06/11/73
A-90	Article VIII, Section 12	Welders Returning to C&M	06/02/16
A-5	Article VIII, Section 13	One-time Use of Sick Pay for Chemical Addiction Rehab.	07/05/79
A-9	Article VIII, Section 13	Employee Notification of Absence Expectations	05/24/85

A-DOC #	CLAUSE	ISSUE	DATE
			(05/18/76)
A-14	Article VIII, Section 14(a)	Company May Replace Health Care Plans	05/23/91
A-78	Article VIII, Section 14(a)	Health Care Security	06/03/2011
A-71	Article VIII, Section 14(c)	Retirement Plan and HRA Conversion Agreement	06/03/2011 (08/01/07)
A-71 Amendment	Article VIII, Section 14(c)	Post Retirement Healthcare	06/03/2011
A-76	Article VIII, Section 14(c)	Post-Retirement Medical Benefits	04/04/05
A-91	Article VIII, Section 14(c)	2016-2021 Post Retirement Healthcare Letter	06/02/16
A-92	Article VIII, Section 14(c)	Amendment to A-71 "Retirement Plan and HRA Conversion Agreement"	06/02/16
A-68	Article VIII, Section 15	$9,000.00 Paid-Up Post-Retirement Life Insurance Coverage	08/01/07
A-7	Article VIII, Section 17	Inclement Weather	07/05/79
A-65	Article VIII, Section 17	Inclement Weather – Service Delivery	08/01/07
A-40	Article VIII, Section 23	Participative Management Team Guidelines	10/07/96 (05/13/94)
A-15	Article IX, Section 1	Personal Attorneys During Grievances and Arbitrations	05/23/91
A-21	Article IX, Section 1	Timeliness of Grievance Procedure	05/13/94
A-10	Article XII, Section 1	No Holiday Pay Eligibility for Unavailability	05/24/85
A-16	Article XII, Section 1	Double Time Rate and Consecutive Holidays	05/23/91
A-17	Article XIII, Section 1	Holiday Occurs During Scheduled Vacation Period	05/23/91
A-2	Misc.	Customer Service Route Bidding	06/11/73
A-22	Misc.	Family and Medical Leave Act	05/13/94
A-23	Misc.	Construction Assistants – Duties and Pay Rate	05/13/94 (05/23/91)
A-25	Misc.	Inspecting Mechanics To Not Cross Union Local Areas	05/13/94
A-35	Misc.	Mechanic III	06/02/16 (10/07/96)
A-51	Misc.	Downbidding to Entry-Level Jobs	06/02/16 (06/03/11) (01/18/02) (10/07/96) (05/13/94) (05/23/91)
A-55	Misc.	Pay for Non-Industrial Medical Appointments	01/18/02 (10/07/96) (05/13/94)
A-57	Misc.	Paid Lunch Periods	01/18/02 (10/07/96) (05/24/85)
A-58	Misc.	Martin Luther King, Jr. Day	01/18/02 (10/07/96) (05/13/94)
A-67	Misc.	Union Employee Annual Incentive Program (UEIP)	06/03/2011 (08/01/07)

A-DOC #	CLAUSE	ISSUE	DATE
A-67a	Misc.	Amendment to A-67 Letter Regarding the Union Employee Annual Incentive Program (UEIP)	06/02/16
A-69	Misc.	Sabbatical Vacation Bank and Vacation Credit Programs	08/01/07
A-70	Misc.	Sale of Assets	06/03/2011 (08/01/07)
A-72	Misc.	Discontinue Automatic Progression	08/01/07
A-73	Misc.	Benefit Claims Disputes	04/04/05
A-75	Misc.	Clothing Allowance	06/02/16 (06/03/2011) 04/04/05
A-77	Misc.	Special Union Wide Lump Sum Opportunity	06/02/16 (06/03/2011)
A-83	Misc.	Apprentice Mechanic Operator III	02/25/13
A-84	Misc.	Separation of Gas and Electric Customer Premise Work	03/20/14
A-85	Misc.	Safety Shoe Policy	06/02/16
A-86	Misc.	Global Positioning Satellite (GPS) Technology	06/02/16

Appendix A

HISTORICAL DOCUMENTS PRESERVED AND MADE PART OF THIS AGREEMENT FOR INTERPRETATION AND APPLICATION INDEX BY DOCUMENT NUMBER

A-DOC #	CLAUSE	ISSUE	DATE
A-1	Article VIII, Section 8	Witness Pay for Criminal Cases	06/11/73
A-2	Misc.	Customer Service Route Bidding	06/11/73
A-4	Article VII, Section 1	Continuity of Work and Overtime	07/05/79
A-5	Article VIII, Section 13	One-time Use of Sick Pay for Chemical Addiction Rehab.	07/05/79
A-7	Article VIII, Section 17	Inclement Weather	07/05/79
A-8	Article VII, Section 1	Inspecting Mechanic Job Class – No Shift Rotation	05/17/82
A-9	Article VIII, Section 13	Employee Notification of Absence Expectations	05/24/85 (05/18/76)
A-10	Article XII, Section 1	No Holiday Pay Eligibility for Unavailability	05/24/85
A-13	Article VIII, Section 5	Company Monitor Contractor Safety	05/23/91
A-14	Article VIII, Section14(a)	Company May Replace Health Care Plans	05/23/91
A-15	Article IX, Section 1	Personal Attorneys During Grievances and Arbitrations	05/23/91
A-16	Article XII, Section 1	Double Time Rate and Consecutive Holidays	05/23/91
A-17	Article XIII, Section 1	Holiday Occurs During Scheduled Vacation Period	05/23/91
A-18	Article VII, Section 1(j)	Scheduling Make-up Overtime	05/23/91
A-21	Article IX, Section 1	Timeliness of Grievance Procedure	05/13/94
A-22	Misc.	Family and Medical Leave Act	05/13/94
A-23	Misc.	Construction Assistants – Duties and Pay Rate	05/13/94 (05/23/91)
A-25	Misc.	Inspecting Mechanics To Not Cross Union Local Areas	05/13/94
A-27	Article VI, Section 3	Notification to the Union of Posted Job Openings	05/13/94
A-28	Article V, Section 1	Training Union on Job Evaluation Procedure	05/13/94
A-35	Misc.	Mechanic III	06/02/16 (10/07/96)
A-36	Article VIII, Section 5	Inspecting Mechanics - AMRP	06/03/2011 (10/07/96) (05/13/94) (05/23/91)
A-40	Article VIII, Section 23	Participative Management Team Guidelines	10/07/96 (05/13/94)
A-41	Article II, Section 1	Union Security – Company Neutrality	10/07/96
A-51	Misc.	Downbidding to Entry-Level Jobs	06/02/16 (06/03/11) (01/18/02) (10/07/96) (05/13/94) (05/23/91)
A-52	Article VII, Section 1	Work Hours	01/18/02 (10/07/96) (05/13/94)

A-DOC #	CLAUSE	ISSUE	DATE
A-54	Article VIII, Section 2	Voluntary Transfers Between Headquarters	06/02/16 (01/18/02) (10/07/96) (05/13/94)
A-55	Misc.	Pay for Non-Industrial Medical Appointments	01/18/02 (10/07/96) (05/13/94)
A-57	Misc.	Paid Lunch Periods	01/18/02 (10/07/96) (05/24/85)
A-58	Misc.	Martin Luther King, Jr. Day	01/18/02 (10/07/96) (05/13/94)
A-60	Article VII, Section 1(m)	Call Out Pay	01/18/02
A-61	Article VI, Section 3(b)	Promotional Retraining	01/18/02 (10/07/96) (05/13/94)
A-62	Article V, Section 2	Supervisory Upgrades	08/1/07
A-63	Article VII, Section 1(j)	Overtime Guidelines –Field and Systems Operations, Contractor Construction, Corrosion, Gas Production and Measurement Center	06/02/16 (06/03/11) (6/14/07)
A-64	Article VII, Section 1(j)	Service Delivery Overtime Guidelines	06/02/16 (06/15/07)
A-65	Article VIII, Section 17	Inclement Weather – Service Delivery	08/01/07
A-67	Misc.	Union Employee Annual Incentive Program (UEIP)	06/03/2011 (08/01/07)
A-67a	Misc.	Amendment to A-67 Letter Regarding the Union Employee Annual Incentive Program (UEIP)	06/02/16
A-68	Article VIII, Section 15	$9,000.00 Paid-Up Post-Retirement Life Insurance Coverage	08/01/07
A-69	Misc.	Sabbatical Vacation Bank and Vacation Credit Programs	08/01/07
A-70	Misc.	Sale of Assets	08/01/07
A-71	Article VIII, Section 14(c)	Retirement Plan and HRA Conversion Agreement	06/03/2011 (08/01/07)
A-71 Amendment	Article VIII, Section 14(c)	Post Retirement Healthcare	06/03/2011
A-72	Misc.	Discontinue Automatic Progression	08/01/07
A-73	Misc.	Benefit Claims Disputes	04/04/05
A-75	Misc.	Clothing Allowance	06/02/16 (06/03/11) (04/04/05)
A-76	Article VIII, Section 14(c)	Post-Retirement Medical Benefits	04/04/05
A-77	Misc.	Special Union Wide Lump Sum Opportunity	06/02/16 (06/03/2011)
A-78	Article VIII, Section 14(a)	Health Care Security	06/03/2011
A-80	Article VI, Section 3(c)	Gas Operations Promotional Sequences and New Position	06/02/16 (04/18/11)
A-81	Article VII, Section 1(b)	Field Operations – Schedule Replacement	06/03/2011

A-DOC #	CLAUSE	ISSUE	DATE
		Guidelines	
A-82	Article VIII, Section 2(f)	Home Site Reporting Guidelines	06/02/16 (06/03/11)
A-83	Misc.	Apprentice Mechanic Operator III	02/25/13
A-84	Misc.	Separation of Gas and Electric Customer Premise Work	03/20/14
A-85	Misc.	Safety Shoe Program	06/02/16
A-86	Misc.	Global Positioning Satellite (GPS) Technology	06/02/16
A-87	Article VI, Section 2(a)	Seniority Departments	06/02/16
A-88	Article VII, Section 1(b)	Work Hours Beyond Normal Scheduled Shift	06/02/16
A-89	Article VII, Section 1(g)	Emergency Work Outside of Ohio/Kentucky Service Territory	06/02/16
A-90	Article VIII, Section 12	Welders Returning to C&M	06/02/16
A-91	Article VIII, Section 14(c)	2016-2021 Post Retirement Healthcare Letter	06/02/16
A-92	Article VIII, Section 14(c)	Amendment to A-71 "Retirement Plan and HRA Conversion Agreement"	06/02/16

June 11, 1973

Mr. William F. Billingsley
Representative
United Steelworkers of America
3333 Vine Street, Room 311
Cincinnati, Ohio 45220

Dear Mr. Billingsley:

During the 1973 negotiations the committees of the Company and the Union discussed the Company's policy concerning allowing an employee, who is subpoenaed, to be off work to testify in a court proceeding which does not directly involve the Company.

Employees who are continually in contact with the public may occasionally witness acts which could lead to criminal arrests or observe personal injury or property damages which could result in litigation. In most instances, the actions observed by employees while within the scope of their employment can be recorded through written statements, affidavits, or in limited situations, depositions. Such gathering of factual information would not ordinarily involve absence from work.

In a very small proportion of cases, employees could be subpoenaed to testify in court proceedings. In criminal litigation the governmental body for whom an employee is subpoenaed may be unable to make the employee entirely whole for his lost earnings during the time of his testimony. However, in civil litigation, it is not uncommon for the party who causes the witness to be subpoenaed to reimburse the witness for resulting lost earnings and expenses.

Employees are not encouraged to go out of their way to make themselves available as witnesses to any incident which could ultimately be litigated. On the other hand, the Company does not want to penalize an employee who may be called upon to testify in the very unfrequent situations when he is not reimbursed for his expenses and loss of regular pay by the party who subpoenaed him. The Company will evaluate such cases on an individual basis to determine whether such civic minded and responsible employees should receive their regular pay when they are off work to testify.

Very truly yours,

Arthur R. Ehrnschwender

A-1

June 11, 1973

Mr. William P. Billingsley
Representative
United Steelworkers of America
1333 Vine Street, Room 311
Cincinnati, Ohio 45220

Dear Mr. Billingsley:

During the 1973 negotiations the committees of the Company and the Union discussed the possibility of allowing Servicemen in the Customer Service Section of the Gas Operating Department to choose their routes on a seniority basis.

Upon the acceptance of the 1973-76 Contract, the department management and a committee of the Union will meet in an effort to draw up guidelines for the implementation of such a system. Providing a mutually agreeable set of guidelines is reached, the Company is willing to allow the assignment of routes on the basis of seniority for a trial period of one year. If this trial period proves satisfactory to the Company, the procedure will be continued during the term of the 1973-76 Contract.

Very truly yours,

Arthur R. Ehrnschwender

cc: T. Mounts
W. Eyelston

A-2

THE CINCINNATI GAS & ELECTRIC COMPANY



CINCINNATI, OHIO 45201

ARTHUR R. EHRNSCHWENDER
VICE PRESIDENT
ADMINISTRATIVE SERVICES

July 5, 1979

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
3300 Central Parkway
Cincinnati, Ohio 45225

Dear Mr. Spurlock:

During the 1979 negotiations, representatives of the Company and the Union discussed the allocation of overtime assignments.

The Company intends that overtime shall continue to be assigned in accordance with the long and well-established procedures of equalization within classifications at individual divisions or headquarters. While the low employee on the overtime list may not be called for a particular overtime occasion, the Company expects overtime to be relatively equalized over a period of time. Normally, it is not important to the Company which person in a designated classification performs an assignment as long as the individual is qualified. While a specific individual with certain skills may occasionally be necessary to perform a particular assignment, the occasions where that is required are limited. It is also understandable that employees who begin a particular overtime assignment may, for purposes of continuity, finish that work, even if the completion occurs at another time.

In making overtime assignments, all employees must understand the Company's needs. However, personal commitments of the employees involved also warrant serious consideration. Supervisors should attempt to avoid overtime assignments to individuals who have made previous personal commitments if others are readily available. It is understandable that individuals and families develop appointments and social obligations of importance. Although employees have a responsibility to be available for overtime assignments, supervisors should give recognition, when feasible, to employees' personal commitments. If operating needs require an individual to break his personal appointment, the least the responsible supervisors can do is to explain the reasons for this infringement to the individual.

In those areas where overtime scheduling has functioned most effectively, supervisors and employees have developed a mutual interest and pride in meeting the operational needs of the Company while giving maximum recognition to the personal interests of the employees. Supervisors attempt to notify employees of the need for overtime as far in advance as possible. Employees frequently suggest schedules or volunteer for planned assignments. Employees often trade assignments

with supervisors' permission. This type of cooperative effort can provide the basis for a healthy and productive atmosphere in any headquarters. With such a cooperative atmosphere, incidents of disciplinary action because an employee is excessively absent from overtime assignments will be minimized.

It is thought that this letter will clarify the Company's policy concerning overtime assignments.

Very truly yours,

Arthur R. Ehrnschwender

THE CINCINNATI GAS & ELECTRIC COMPANY

CINCINNATI, OHIO 45201

ARTHUR R. EHRNSCHWENDER
VICE PRESIDENT
ADMINISTRATIVE SERVICES

July 5, 1979

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
3300 Central Parkway
Cincinnati, Ohio 45225

Dear Mr. Spurlock:

During the 1979 negotiations, representatives of the Company and the Union discussed the compensation policy for employees who undertake treatment for alcoholism.

While sick compensation has not previously been granted for the treatment of alcoholic conditions, the Company will alter that arrangement when an employee obtains treatment at an appropriate detoxification facility under the direction of the Company Medical Director or in coordination with the Medical Director and the employee's personal physician. Available sick pay may hereafter be used for the first continuous absence when an employee undertakes to correct an alcoholic problem through an approved program. If the initial rehabilitation effort at a treatment center is not successful, the employee will not be granted additional available sick pay.

The Company is willing to extend this extra effort to help afflicted employees and their families, to eliminate the burden imposed upon the fellow employees, and to minimize lost productivity and absenteeism caused by alcoholism. An employee who is unwilling to accept the responsibility for his own behavior or who refuses to participate in a necessary program will, as in the past, jeopardize his continued employment with the Company.

The Union is encouraged to make the Company Medical Director aware of individuals thought to have alcoholism problems. With such assistance, fellow employees may be given a chance for which they may be forever grateful.

Very truly yours,

Arthur R. Ehrnschwender

A-5

THE CINCINNATI GAS & ELECTRIC COMPANY

CINCINNATI, OHIO 45201

ARTHUR R. EHRNSCHWENDER
VICE PRESIDENT
ADMINISTRATIVE SERVICES

July 5, 1979

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
3300 Central Parkway
Cincinnati, Ohio 45225

Dear Mr. Spurlock:

During the 1979 negotiations, representatives of the Company and the Union attempted to clarify the inclement weather policy applicable to employees in the Construction & Maintenance Division of the Gas Operating Department. As has always been the case, any or all employees will be expected to work without regard to weather conditions when it is necessary to protect life, property, or continuity of service.

Employees will not be required to perform normal work when the headquarter's thermometer reads five degrees or less. However, after considering the current and anticipated weather conditions, crews will leave their headquarters and proceed to their assigned job sites. When the temperature is six degrees and rising and the wind is calm or light, all crews will begin working. If the temperature is ten degrees or less and the wind is strong and gusty, the crews at the job sites will not be required to perform normal work. Whenever the temperature reaches 11 degrees, employees will begin working regardless of wind conditions. The Company will make an effort to provide indoor duties, conduct training or provide outdoor work under protective conditions during inclement weather conditions for the remaining individuals.

During conditions of dry or light snow, employees will be required to continue to work unless storm conditions develop that are too severe to permit a job assignment to be completed safely. During conditions of drizzle or light rain employees will be required to continue working unless the precipitation is great enough to soak their clothes. During periods of moderate or heavy rain, crews will be dispatched or assigned duties as stated above for cold weather conditions. Every effort will be made by the Area Supervisor to assign work at locations suitable to existing weather conditions where an assignment may be safely performed. When a crew arrives at a job site, the crew leader will evaluate the weather conditions. Unless the weather conforms to the long established Company definition of inclement (unmerciful, severe, harsh, tempestuous, rough, stormy, boisterous, or otherwise hard to bear) the work will be performed as assigned. If weather conditions become inclement according to the above definitions at any time after work has been under way, the crew leader may stop operations, seek shelter in Company equipment, and communicate this fact to the Construction & Maintenance Dispatcher. The crew's supervisor will thereafter determine if the weather is inclement. In all cases the supervisor's evaluation will prevail. The Gas Operating departmental management will continually counsel with supervisors in an effort to assure fairness and continuity of judgment regarding inclement weather.

A-7

With the exception of the newly established temperature minimums, the management in the Gas Operating Department does not intend to amend the administration of the inclement weather provisions. These procedures were described in the recent arbitration decision and award resulting from a hearing on January 10, 1978 and were explained to employees at group meetings at the various headquarters earlier this year. The past administration clearly reflects that no employees have been required to jeopardize their health or safety because of the requirement to perform normal work during adverse weather conditions. In fact, statistical information reflects that the proportion of total non-productive time attributed to inclement weather increased in recent years. The continued good judgment of crew leaders and cooperation with supervisory personnel will avoid future misunderstandings about inclement weather.

Very truly yours,

Arthur R. Ehrnschwender

THE CINCINNATI GAS & ELECTRIC COMPANY



CINCINNATI, OHIO 45201

ARTHUR R. EHRNSCHWENDER
SENIOR VICE PRESIDENT

May 17, 1982

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
3300 Central Parkway
Cincinnati, Ohio 45225

Dear Mr. Spurlock:

During the 1982 negotiations, the committees for the Company and the Union discussed the possibility of implementing a new bargaining unit job classification. As a result of these discussions, the Company will agree to write a job description for a new job classification of Inspecting Mechanic during the first year of the 1982-1985 Contract. This job classification will be evaluated in the normal manner but the maximum wage rate resulting from such evaluation will not be subject to arbitration.

This new job classification will ultimately be responsible for performing the inspecting duties currently being accomplished by exempt employees. These exempt employees will continue to accomplish the inspecting duties they are now performing. When the Company determines that there is a need for additional or replacement personnel to perform these inspecting duties, the new bargaining unit job classification will be posted and filled through the established bidding procedure.

Employees who will subsequently fill this job classification will not be permitted to demote in accordance with the agreement in my letter dated May 17, 1982. Employees in this job classification will not take part in the Mechanic Operator shift rotation.

It is understood that this proposal will satisfy the Union's request to the mutual benefit of both parties.

Very truly yours,

Arthur R. Ehrnschwender

Arthur R. Ehrnschwender

A-8

THE CINCINNATI GAS & ELECTRIC COMPANY



CINCINNATI, OHIO 45201

ROBERT E. BYRNES
VICE PRESIDENT
ADMINISTRATIVE SERVICES

May 24, 1985

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
821 Ezzard Charles Drive
Cincinnati, Ohio 45203

Dear Mr. Spurlock:

During the 1985 negotiation meetings between the Company and Local Unions 12049 and 14214 the committees discussed Article VIII, Section 13(g) of the Contract concerning the requirement that employees' notify the Company that they will be tardy or absent from work.

As discussed, the Company expects employees who will be late or absent from work to notify the Company before the beginning of a scheduled shift to indicate their contemplated absence from work. This notification by an employee allows supervision an opportunity to make last minute scheduling adjustments with full knowledge about which employees will be absent and which employees have been delayed in reporting to work.

The Company and the Union agreed that it is the employees' responsibility to provide such advance notification about their work intentions. Furthermore, the Union assured the Company that it would encourage its members to so notify the Company of their work intentions. Supervisors will counsel with those employees on an individual basis who continuously report absences after the start of a work schedule to determine the reasons that such notification was not given earlier. Employees who disregard their obligation to report their absences from work prior to the beginning of their work schedule will continue to subject themselves to disciplinary action.

It is thought that this letter adequately describes the concern expressed by the Company during these negotiations and will clarify the understanding of the parties concerning Article VIII, Section 13(g).

Very truly yours,

Robert E. Byrnes

Robert E. Byrnes

cc: C. Goyette
L. Byrd, Jr.

A-9

THE CINCINNATI GAS & ELECTRIC COMPANY

CINCINNATI, OHIO 45201

ROBERT E. BYRNES
VICE PRESIDENT
ADMINISTRATIVE SERVICES

May 24, 1985

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
821 Ezzard Charles Drive
Cincinnati, Ohio 45203

Dear Mr. Spurlock:

During the 1985 negotiations, the committees of the Company and Local Unions 12049 and 14214 discussed the holiday pay eligibility requirements contained in Article XII, Section 1(c).

As agreed, Mr. S. Smith's arbitration case shall have no force and effect on determining the eligibility requirements for holiday pay for situations similar to the circumstances in that case, such as a leave of absence or military service, where it is positively known that an employee is not available to the Company to perform work on a holiday.

It is thought that this letter adequately states the accord reached between the parties as to holiday pay eligibility.

Very truly yours,

Robert E. Byrnes

Robert E. Byrnes

cc: C. Goyette
L. Byrd, Jr.

A-10

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

John P. Roos
Manager, Personnel Relations

May 23, 1991

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1991 negotiation meetings, the committees of the Company and the Union discussed the work practices of contractors and employees.

The Union voiced a concern that contractors are not in compliance with the safety standards applied to employees, especially while working side by side on the same job. The Company has a continuing concern for the safety and well being of its employees and is constantly monitoring work areas, conditions and procedures. During these negotiation meetings, the Company assured the Union that its supervision will strictly monitor the construction practices of contractors in order to assure compliance with the appropriate safety rules and work habits.

Safety on the job must be a continuous activity, not only for supervision of the Company but for every employee. It is only through cooperation of our employees that we are able to maintain our outstanding safety record. The Company will continue to strive to conduct its operations in a safe and efficient manner.

These assurances by the Company should alleviate the concerns of the Union in this matter.

Very truly yours,

John P. Roos

cc: J. Dearth
R. Zimmer

A-13

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

John P. Roos
Manager, Personnel Relations

May 23, 1991

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1991 negotiation meetings, representatives of the Company and the Union discussed eliminating the need for management to confer with the Union in the event that a health care provider is replaced by other medical coverage.

During these discussions, the Company and the Union shared concer over the astronomical increase in medical costs that occurred in the past three years. As a result of these discussions concerning the elimination of Article VIII, Section 14 (b) of the Contract, the Union assured the Company that it would cooperate and objectively evaluate any health care carriers that the Company suggested as a substitute for existing health care providers.

It is thought that this accord will be mutually beneficial to both parties.

Very truly yours,

John P. Roos

cc: J. Dearth
R. Zimmer

A-14

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

John P. Roos
Manager, Personnel Relations

May 23, 1991

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1991 negotiation meetings the committees of the Company and the Union discussed the representation of employees by personal attorneys or outside agencies during the grievance and arbitration procedures.

As a result of these discussions, the parties agreed that the Union is the sole bargaining representative for its members and therefore no outside representation will be permitted during such meetings. This in no way restricts the Union's ability to have an attorney represent its own interests during the grievance and arbitration procedures.

It is believed that by proceeding in this manner the concerns expressed during these meetings have been alleviated.

Very truly yours,

John P. Roos

cc: J. Dearth
R. Zimmer

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

John P. Roos
Manager, Personnel Relations

May 23, 1991

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1991 negotiation meetings, representatives of the Company and the Union discussed holiday pay for employees who are required to work on both of two consecutive holidays.

As a result of these discussions, the parties agreed that when employees work consecutive hours contiguous with the hours worked on the previous day holiday, all hours over eight (8) will be paid at the double time rates. This would only apply for hours worked on the day after Thanksgiving and the Company recognized holiday of Christmas Day.

It is thought that this correspondence adequately describes the accord reached by the parties concerning this subject.

Very truly yours,

John P. Roos

cc: J. Dearth
R. Zimmer

A-16

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

John P. Roos
Manager, Personnel Relations

May 23, 1991

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1991 negotiations, the committees of the Company and the Union discussed employees taking vacations which include a Company recognized holiday.

In order for the Company to effectively and efficiently direct the work force, it must maintain its right to make the determination as to whether an employee will receive either eight hours additional pay or one additional vacation day when an employee schedules a vacation which includes a holiday. However, during these meetings the Company agreed that employees can make their preference known to supervision as to whether they want to receive either eight hours additional pay or an additional vacation day. The supervisor will give consideration to the employee's request.

By proceeding in this manner it is thought that the Union's concern in this matter will be alleviated.

Very truly yours,

John P. Roos

cc: J. Dearth
R. Zimmer

CG&E The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 Cincinnati, Ohio 45201-0960

John P. Roos
Manager, Personnel Relations

May 23, 1991

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1991 negotiation meetings, representatives of the Company and the Union discussed the scheduling of make-up overtime assignments.

During these meetings, the Union voiced a concern regarding the delayed granting of make-up overtime assignments as a result of heavy periods of regular overtime assignments.

The Company must be the sole judge as to the necessity for overtime work. However, the Company assured the Union that it would make every attempt to schedule make-up overtime assignments which are determined by supervision to be appropriate at the earliest practicable time. Additionally, the Company agreed that employees will be scheduled for make-up overtime assignments within six (6) months from the date granted by supervision.

This commitment by the Company should address the concerns expressed by the Union during these negotiations about make-up overtime.

Very truly yours,

John P. Roos

cc: J. Dearth
R. Zimmer

A-18

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 • Cincinnati, Ohio 45201-0960

May 13, 1994

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road, Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1994 negotiation meetings, the committees for the Company and the Union discussed the implementation of time limits within the various steps of the grievance procedure.

The Company believes that the objective of the grievance procedure, to mutually and equitably resolve differences that may arise in the administration and interpretation of the Agreement, can be most favorably fulfilled without the imposition of mandatory time limits.

However, as a result of these discussions, the Company did give its assurance that it will strive to respond to all grievances as expeditiously as possible.

It is understood that unavoidable delays by both parties may occur for various legitimate reasons. Any such circumstances must necessarily be accommodated without prejudice to the position of any party to the grievance.

It was also agreed that if, in the future, the Union believes that grievances are not being resolved in a timely manner, the Company would be willing to meet with the Union in order to resolve this issue.

It is anticipated that, with this accord, the interval in processing grievances will be reduced.

Very truly yours,

Edward R. Schuette

Edward R. Schuette

cc: S. Newkirk
R. Zimmer

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 • Cincinnati, Ohio 45201-0960

May 13, 1994

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
27162 Reading Road
Suite 610
Cincinnati, OH 45237

Dear Mr. Spurlock:

During the 1994 negotiation meetings, the parties discussed the administration of the Family Medical Leave Act (FMLA).

During the discussions, the Company assured the Union that its administration of the FMLA does not reduce the employee benefits provided for by the Contract. Furthermore, the Company assured the Union of its continued commitment to considering the particular circumstances involved with individual employees, who may be experiencing hardship and whose circumstances may warrant leave in addition to the FMLA annual allotment.

It is believed that the above commitment by the Company alleviates the Union's concerns in this matter.

Very truly yours,

Edward R. Schuette

Edward R. Schuette

cc: S. Newkirk
R. Zimmer

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 • Cincinnati, Ohio 45201-0960

May 13, 1994

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road, Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1994 negotiation meetings, the committees for the Company and the Union discussed the revision of the Construction Assistant job description.

As discussed, the job description of the Construction Assistant will be revised so that employees, who are assigned to that job classification, may also be trained to perform other duties commensurate with their skills and abilities, within their medical limitations. However, employees in the Construction Assistant job classifications will not perform work of job classifications at higher wage levels than their previous job.

As stated during these negotiations, at some point in time, as determined by the Company, the number of Construction Assistants may reach a saturation point. As discussed, we are rapidly approaching that saturation point. If such a saturation point is reached, the Company will discontinue placing people in that job classification.

In addition, the Company assured the Union that if problems are detected as a result of the administration of the Construction Assistant job duties, the Company would be willing to meet with the Union to discuss this issue at that time. Furthermore, as stated during these negotiations, and in accordance with the original intent of the parties when the Construction Assistant job classification was established, only employees with 15 or more years of service will be red-circled when demoted to the Construction Assistant job classification. Employees with less than 15 years of service, when demoted to the Construction Assistant job classification, will be placed at the maximum wage rate of that job.

It is believed that this correspondence should alleviate the concerns of the Union in this matter.

Very truly yours,

Edward R. Schuette

cc: S. Newkirk
R. Zimmer

A-23

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 • Cincinnati, Ohio 45201-0960

May 13, 1994

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road, Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

As discussed during the 1994 negotiation meetings, there are presently 15 Inspecting Mechanics in Gas Operations. These employees are performing the following functions: locating facilities, preparing permit drawings, inspecting exposed pipelines on bridges, inspecting pipelines and locating and plotting gas facilities as a result of Ohio House Bill 538. These Inspecting Mechanics are located throughout our system, but primarily at Monfort Heights, Dana Avenue and Todhunter Road.

As discussed, during the term of the 1994-1997 Contract, Inspecting Mechanics will be paid fifty-five cents (.55¢) above the maximum wage rate of their job classification.

Inspecting Mechanics will also protect facilities by their presence and direction of contractors working around gas facilities. This Inspecting Mechanic job will not be submitted for re-evaluation since the job description adequately defines the duties required in performing House Bill and system protection work. There will be two (2) Inspecting Mechanics performing House Bill work. They are John Fagaly located at Fairfield and Mose Barrett located at Dana. These two individuals will continue performing this work. Mr. Fagaly will perform work only in the Northern local and Mr. Barrett will perform work anywhere in Local 12049's service territory. At this time we do not anticipate a change of headquarters. The Company will train the remaining Inspecting Mechanics to perform House Bill work. The number of Inspecting Mechanics performing House Bill work may increase or decrease at any time due to work needs. The remaining incumbent Inspecting Mechanics will be assigned to specific geographic areas and duties for the purposes of work assignment. If the House Bill work load decreases, the Inspecting Mechanics performing that work will be assigned to perform any activity within their job description.

The Inspecting Mechanic will locate underground facilities for contractors performing work for the Company. This includes marking gas facilities for contractors installing and replacing gas mains and services.

Inspecting Mechanics will be required to work in any geographical area assigned, i.e., Kentucky, Indiana, Ohio, except across Union Locals. Back-up Inspecting Mechanics will only be used as determined by business needs.

Future openings or replacements in the Inspecting Mechanics job classification when deemed necessary by the Company, will be filled by qualified employees from the Mechanic Operator I job classification, in accordance with the contractual posting procedure, within Local 12049 or within Local 14214. Also, the Company reserves the right to determine the headquarters as to where the replacements or openings will be filled, in Local 12049 or in Local 14214.

It is believed that this correspondence addresses our discussion at the negotiations.

Very truly yours,

Edward R. Schuette

Edward R. Schuette

cc: S. Newkirk
R. Zimmer

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 • Cincinnati, Ohio 45201-0960

May 13, 1994

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1994 negotiation meetings, the committees of the Company and Local Unions 12049 and 14214 discussed notification to the bargaining unit of posted job openings, transfers and reassignments.

As was agreed, during the term of the 1994-1997 Contract, the results of posted job openings, transfers and reassignments will be forwarded to the Presidents of the Local Unions as soon as practicable.

By proceeding in this manner it is thought that the Union's concern in this matter will be alleviated.

Very truly yours,

Edward R. Schuette

cc: S. Newkirk
R. Zimmer

CG&E ■ The Energy Service Company

The Cincinnati Gas & Electric Company
P.O. Box 960 • Cincinnati, Ohio 45201-0960

May 13, 1994

Mr. Thomas Spurlock
Staff Representative
United Steelworkers of America
7162 Reading Road
Suite 610
Cincinnati, Ohio 45237

Dear Mr. Spurlock:

During the 1994 negotiations, representatives of the Company and the Union discussed the possibilities of a training program for the members of the Union job evaluation committee.

The procedures for establishing, revising, and evaluating job classifications is clearly set forth in Article V, Section 1 of the current Contract. As indicated, the Union may submit written comments regarding the duties of a revised job description to the Company's evaluation committee and may review the evaluation and wage rate of any new or revised classification considered by the Company's committee.

At the negotiation meetings, the Union expressed concern about its understanding of the job evaluation process. To understand the procedures, the Company will agree to provide a training program for members of the Union committee who may be unfamiliar with how the job evaluation system works. In addition, if the chairman of the Union's classification committee periodically requests information concerning which factor points were changed when its committee is scheduled to meet with the Company's committee to review the evaluation of a job, the Company official responsible for the administration of the wage and salary program will provide the designated Union representative with such information.

It is thought that proceeding as outlined in this letter will satisfy the Union's request about training in the job evaluation procedure during the term of the 1994-1997 Contract.

Very truly yours,

Edward R. Schuette

cc: S. Newkirk
R. Zimmer

A-28

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

Mr. John Waits
President
Local 12049
United Steelworkers
Eastern Avenue Headquarters

Re: Mechanic III

Dear Gentlemen:

Reference is made to the discussion between the parties pertaining to changes to the Mechanic III job responsibilities, rate of pay and line of promotion.

As agreed, the specially negotiated wage rate for a Mechanic III job classification will be revised. Effective January 1, 2015, any employee moving into that job classification, will be paid at the starting rate of $18.50 per hour. At intervals of six months, if progress, measured by demonstrated ability and performance, has been satisfactory, the employee will be eligible for a $0.25 merit increase until reaching the maximum pay rate of $19.50 per hour.

In addition, all employees entering into a Mechanic III position on or after May 15, 2016, will be employed with the understanding that they must be able to successfully promote to the Meter Specialist II, Gas Systems Operations Mechanic II, Gas Plant Operator II, Mechanic Operator II or Service Mechanic B within the timeframes outlined within the qualifications of the respective job descriptions. At a minimum, failure to qualify for this purpose would include situations where two successive written examinations or two successive practical demonstrations were not passed. Employees will be allowed a maximum time period of three months between the two successive examinations and/or demonstrations. Employees will not be permitted to request waiver of their rights to promotion.

The employment of any individual who does not successfully meet the requirements to promote from a Mechanic III position to a Meter Specialist II, Gas Systems Operations Mechanic II, Gas Plant Operator II, Mechanic Operator II or Service Mechanic B, will be terminated.

Employees will be promoted on the first day of the pay period following successful completion of the timeframes outlined in the respective job descriptions unless deemed not qualified or sooner, as determined by the Company. If a promotion is delayed due to the Company, the effective date of the promotion will be back dated to the first day of the pay period following successful completion of the timeframes outlined in the respective job description. If a promotion is delayed because an employee is deemed not qualified or has been unable to successfully complete a promotional exam, the effective date of the promotion will be the first day of the pay period following successful promotion.

Based on the foregoing, this letter supersedes any prior letters or agreements among the parties relating to this matter including current sidebar letter A-35 (Mechanic III Pay Rate and Work CG&E Wide).

It is thought that the above adequately describes the parties agreement on this matter.

Sincerely,

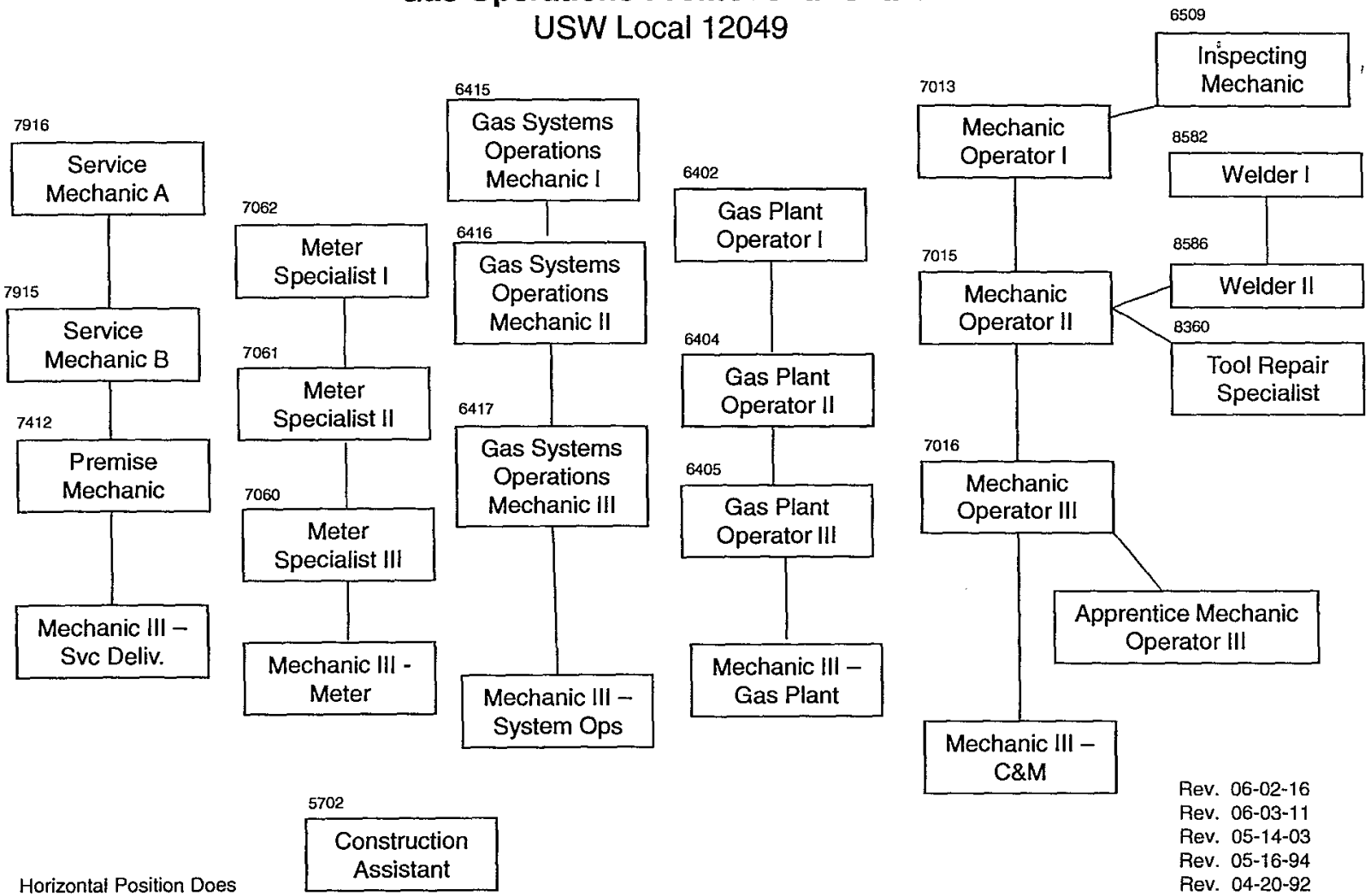
Lisa A. Gregory

Lisa A. Gregory
Human Resources Principal

cc: G. Hebbeler
C. Lange
D. Smiley

Gas Operations Promotional Chart

USW Local 12049

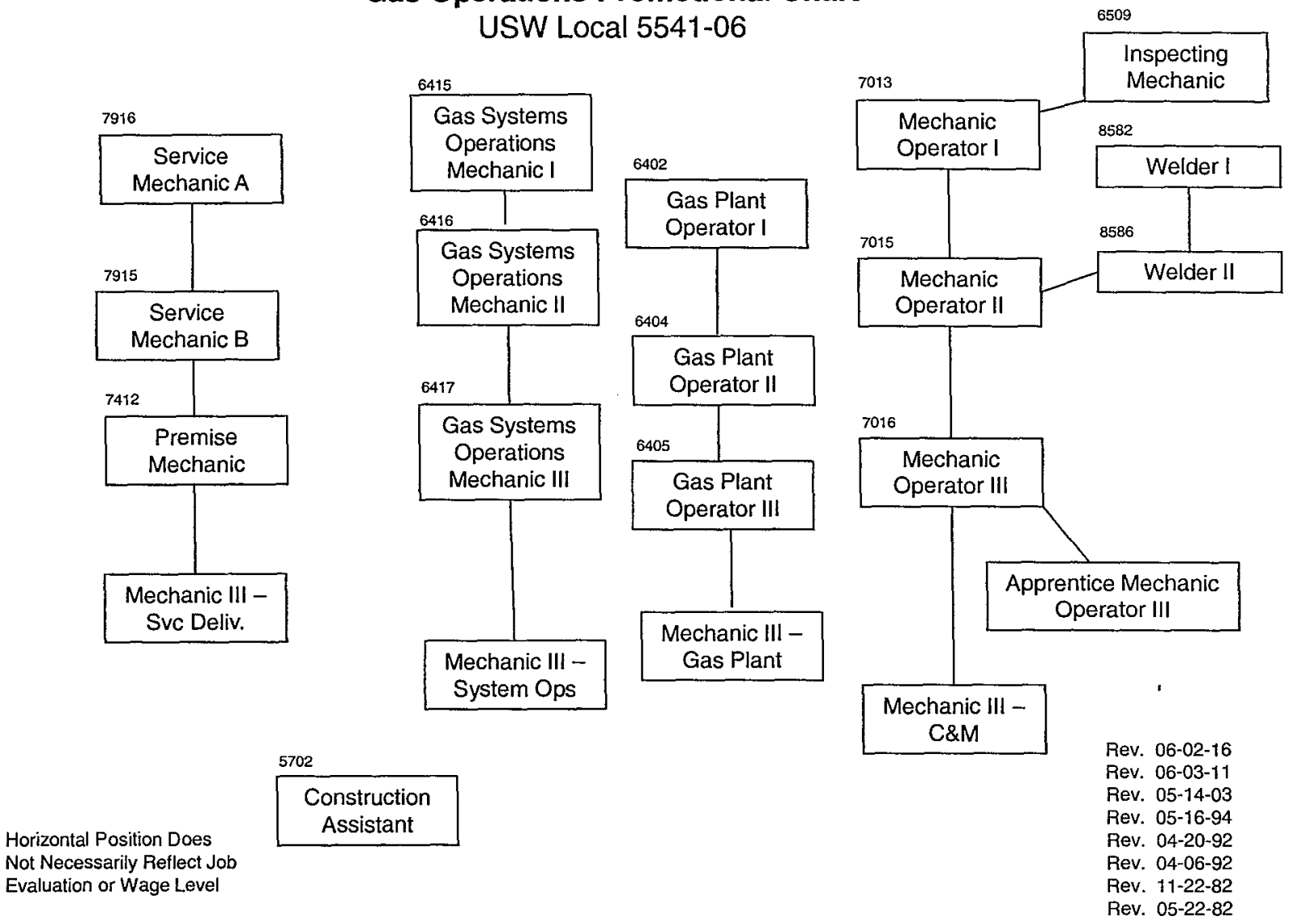


Horizontal Position Does Not Necessarily Reflect Job Evaluation or Wage Level

Rev. 06-02-16
Rev. 06-03-11
Rev. 05-14-03
Rev. 05-16-94
Rev. 04-20-92
Rev. 04-06-92
Rev. 11-22-82
Rev. 05-22-82

Gas Operations Promotional Chart

USW Local 5541-06



Horizontal Position Does Not Necessarily Reflect Job Evaluation or Wage Level

Rev. 06-02-16
Rev. 06-03-11
Rev. 05-14-03
Rev. 05-16-94
Rev. 04-20-92
Rev. 04-06-92
Rev. 11-22-82
Rev. 05-22-82

LISA A GREGORY
Director Labor Relations

Duke Energy
EMM80 / 139 East Fourth St.
Cincinnati, OH 45202

513-287-3934

June 3, 2011

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

Mr. Mike McAlpin
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

Re: Inspecting Mechanic Agreement - AMRP

Dear Gentlemen:

This letter documents our discussions and agreements related to employees in the Inspecting Mechanic classification and the impacts on work and this job that are expected to occur towards the end of and after the Accelerated Main Replacement Program (AMRP).

In the fall of 2000, the Company met with the leadership of each of the Duke affiliated local unions to discuss the need to significantly increase the number of Inspecting Mechanics to enhance the inspection program for an Accelerated Main Replacement Program. During those discussions, several items were agreed upon to successfully implement and complete the Program. All items to date have been successfully implemented by both parties. This document is to memorialize those items necessary to wind down the Program and implement post AMRP activities.

If it is necessary to "Roll Back" any Inspecting Mechanics, that person will return to a Mechanic Operator I (MOI) position at the district from which they were promoted. Roll Backs will occur by low classified Inspecting Mechanic seniority. If the district headquarters is no longer maintained, the person will be assigned to the district that absorbed the territory of the discontinued district. They are listed as follows:

Little Miami absorbed by Eastworks
Glendale absorbed by Monfort
Dana absorbed by Eastworks
19th Street absorbed by Erlanger
Florence absorbed by Erlanger

As discussed in 2000, during presentations and during discussions with the successful candidates, Inspecting Mechanics will maintain their current accrued seniority if a roll back to the MOI position is necessary. In addition, Inspecting Mechanics would have their pay redlined until the MOI wage rate increased to the point of surpassing the Inspecting Mechanic pay. At that time, the person would receive a wage increase up to the max rate of pay for a MOI.

As part of the original agreements, Inspecting Mechanics were to maintain their CDL license. A valid medical card is required to perform the MOI duties. Employees rolling back under this

Letter will be given 6 months to obtain their medical card. If employees cannot obtain their medical cards in six months, the Company's Job Adjustment and Workplace Modification Program (JAWM) will be triggered. The JAWM Program is a two-tiered program for the Company to engage in an interactive dialogue with employees who may require job adjustments or workplace modifications due to a physical or mental health issue that impacts an employee's work.

Management will make every effort to project the resource needs for the following year and avoid roll backs in the middle of the year. This will allow a smooth transition for the employee to be placed on the shift schedule. However, there may be those occasions when a roll back may occur in the middle of the year. When this occurs, management will not rework the schedule for the current year. Management will fill a vacancy in the shift schedule with the rolled back employee up to two times in that calendar year but, not two consecutive times. All other vacancies will be filled using the established Schedule Replacement Guidelines. If there is more than one rolled back employee in a district, they will alternate shift coverage until they have exhausted their obligation to work two scheduled vacancies for that calendar year. For rolled back employees who scheduled their vacation in advance, the Company will follow existing guidelines for filling shift vacancies. After the Company schedules a rolled back employee for a shift vacancy, the Company will not grant vacation for the employee's shift during the vacancy the employee is scheduled to work.

If a temporary Inspecting Mechanic is needed in the future, trained and qualified Mechanic Operator I's will be upgraded based on classified Mechanic Operator I seniority. The Company will pay temporarily upgraded "rolled back inspectors" at the top of the Inspecting Mechanic pay grade until the assignment is complete. After the temporary upgrade is over, the employee will return to their pay rate prior to being upgraded. The employee also will be provided with any promotional opportunities they would have received in the MOI position. If a Mechanic Operator I is upgraded and he/she did not previously hold the classification of Inspecting Mechanic, normal temporary upgrade guidelines will apply (Article V, Section 2).

Employees who are scheduled for shift work during a temporary upgrade assignment lasting 30-days or less will not be eligible for the upgrade and the next senior, qualified person will be selected. If the temporary upgrade assignment will last 31-days or more, upon completion of the scheduled shift, the most senior person will replace the more junior person on the upgrade assignment. Employees must pass an inspecting test to be temporarily upgraded to an Inspecting Mechanic role.

It is believed that the procedures outlined in this letter properly describe the agreement reached between the parties concerning this issue.

Very truly yours,

Lisa A. Gregory
Director, Labor Relations

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

October 7, 1996

Mr. Don Turner
Mr. James Newport
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.

Dear Gentlemen:

During the 1996 discussions concerning work flexibility and employment security, the Company and the Union discussed the continuation of participative management teams.

During these discussions, the parties agreed that together we face a changing regulatory environment, aggressive competitive forces and rising customer expectations.

To meet these challenges and to ensure both the Company and the Union's continued mutual success and security, the parties commit to achieving maximum customer, employee and shareholder productivity and quality of our work and its environment.

In making this commitment, the parties recognize a need for the Company, the Union and all employees to support and strive for a more cooperative atmosphere of increasing openness, trust and mutual respect, where all employees can fully utilize their creativity, talents and initiative in a safe and fulfilling work environment.

The parties agreed during these negotiations to continue the use of the participative team process to further these goals. It is also agreed that the following jointly developed guidelines will continue to be used for the participative team process:

> When any team is formed to address an issue, individuals should be told that membership on the team is voluntary. Persons selected should be respected by their co-workers. Before the team begins its work, members must be informed that it is their responsibility to honor the collective bargaining agreements.

When forming a team to address non-contractual issues, team members should be selected objectively based on the issues and subjects to be addressed by the group.

When contractual issues arise after the start of the process, bargaining unit leaders and the Employee Relations and Safety Department must be notified as soon as it is apparent that a contractual issue is involved. Team membership should be reviewed to see if changes need to be made because of the new contractual issue.

The Company and the Union officers will select team members from their respective units to develop recommendations concerning contractual issues. The Employee Relations and Safety Department will be notified when a team is being formed in order to determine its level of involvement. Any recommendations made by the teams that would change or modify the collective bargaining contract will be subject to negotiations between the parties.

These commitments made by both the Company and the Union will enable both parties to be successful in our endeavor to reach our goals in serving our customers, employees and shareholders.

Very truly yours,

Kenneth E. Williams /TJH

Kenneth E. Williams
Manager
Employee Relations

cc: R. Zimmer
S. Newkirk

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

October 7, 1996

Mr. Don Turner
Mr. James Newport
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.

Dear Gentlemen:

Reference is made to our 1996 discussions concerning employment security and work flexibility. During these discussions the parties discussed the issue of Union Recognition in a changing business environment to meet future competitiveness in our industry.

During the discussions, the Company confirmed its commitment to recognize the Union as the sole and exclusive collective bargaining agent for those employees who are employed in jobs currently under its jurisdiction. The Company also assured the Union of its ongoing commitment to honor any agreements it may enter into with the Union. The parties also discussed the need for new and innovative ways to meet future business needs in order to remain viable within a competitive environment. These new ways of conducting business may not only require significant changes within the current organization, but may also result in the Company's expansion into other business ventures.

During the discussions, the Company gave assurance to the Union that in the event of such future expansions of our business, should the Union attempt to represent or organize employees outside of its current jurisdiction, the Company will not interfere with such legitimate activity and will encourage a policy of neutrality among its supervisory/managerial workforce. However, the Company must maintain its right to respond to employee inquires in an honest and open manner.

Hopefully, as a result of the discussion on this subject, the Union's concerns in this area have been resolved.

Very truly yours,

Kenneth E. Williams /TJH

Kenneth E. Williams
Manager
Employee Relations

cc: R. Zimmer
S. Newkirk

A-41

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

Mr. John Waits
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

Re: Downbidding to Entry-Level Jobs

Dear Gentlemen:

During the 2016 contract negotiations, representatives of the Company and United Steelworkers and its Locals 12049 and 5541-06 (the "Union") discussed the downbidding process and the desire to make starting level job opportunities available in the various divisions of the Gas Operations and Service Delivery areas to qualified employees who desire to change their type of work. This letter replaces the previous letter of agreement titled "Downbidding to Entry-Level Jobs Second Amendment" which was last revised December 23, 2013 and all earlier versions as well as the downbidding process described in the "Disconnect Non-pay, Succession and Special Meter Reads Agreement" letter dated May 14, 2003.

For the duration of the 2016 – 2021 Contract, the Company will permit any employee with eight (8) or more years of service and classified as a Meter Specialist II, Mechanic Operator II, Gas Systems Operations Mechanic II, Gas Plant Operator II, Welder II or any higher job classification in these sequences, to submit their name for consideration through the established bidding procedure when job openings occur within the established rotation sequence in the Service Mechanic "B", Gas Systems Operations Mechanic III, or Gas Plant Operator III job classifications. Additionally, any employee with eight (8) or more years of service and classified as a Service Mechanic "B" or any higher job classification in this sequence, to submit their name for consideration through

the established bidding procedure when job openings occur within the established rotation sequence in the Gas Systems Operations Mechanic III or Gas Plant Operator III job classification.

The Company will consider employee requests for a posted opening in the established rotation sequence, on the basis of the system service within the seniority district. These employees will be required to successfully complete the departmental training program, and all required tests, before they are re-classified as a Service Mechanic "B", Gas Systems Operation Mechanic III or Gas Plant Operator III. Upon implementation of this letter in June, 2011, the Company filled the first posted eligible job from qualified downbid applicants before considering applicants seeking to promote under the existing promotional sequence within the seniority district. After that first posted job, the Company has alternated between the downbid process and the promotional sequence process to fill Service Mechanic "B", Gas Systems Operations Mechanic III or Gas Plant Operator III postings. Effective with postings filled after May 15, 2016, the selected employees will have their classified seniority adjusted such that the downbids on the posting will be the most senior ahead of those promoting.

In addition, the Company agreed to allow employees in Local 12049 with eight (8) or more years of service and classified as a Mechanic Operator II, Gas Systems Operations Mechanic II, Gas Plant Operator II, Welder II, Service Mechanic "B" or any higher job classification in these sequences to downbid to the Meter Specialist III job classification through the downbidding procedure as described in this letter. When eligible employees submit such downbids to the Meter Specialist III classification, the Company will fill the position based on USW system service seniority within the seniority district.

In all situations described in this letter, the following applies:

1. Employees who are accepted for the vacant position shall retain their present salary until they successfully pass the test for the new position. At that time, they will be demoted to the maximum wage rate of the job for which they have been accepted. However, employees who demote in accordance with this agreement with 15 or more years of service will have their wage rates red-circled.

2. If the acceptable candidates fail to qualify for the position, they will return to their original headquarters without loss of seniority.

3. While in training, the employees will retain the salary and job title of their current position.

4. The Company will post opportunities for the Service Mechanic B, Tool Repair Specialist, Meter Specialist III, or Gas Systems Operations Mechanic III on the current rotation and will fill the first posting following the date of this Letter with any downbids for Gas Plant Operator III as described above. For the second posting following the date of this Letter, the Company will use the promotional sequence within the Gas Plant Operator III classification, and will alternate between the downbid process and the promotional sequence for future postings per the current process within the other classifications mentioned above. If a posting is not filled by the designated sequence and/or there are no downbids, the turn will be forfeited. This will be tracked by each job classification and each local.

5. Prior to the first downbid opportunity as described above, management will post a one-time opportunity for existing Premise Mechanics to promote to Service Mechanic B. If eligible employees choose not to pursue this promotional opportunity, the one-time opportunity will be forfeited. The Company reserves the right to cancel any postings not filled under this Paragraph. This has been completed but will remain in this letter for historical purposes.

It is acknowledged that the Company must maintain the right to limit the number of such individuals in any job at any one time, in order to make certain that the promotional sequence does not become blocked in any way.

It is anticipated that the procedures outlined in this letter properly describe the accord reached between the parties concerning this issue, for the term of this Contract.

Very truly yours,

Lisa A. Gregory
Human Resources Principal

cc: Gary Hebbeler
Chuck Allen

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

January 18, 2002

Mr. Dave McLean
Mr. Eldon House
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.
CG&E

Re: Work Hours

Dear Gentlemen:

During the 2002 – 2007 contract negotiations, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed work hours of bargaining unit employees in both local unions. This correspondence cancels and supersedes correspondence from Messrs. Morgan and Randolph of June 4, 2001 to Messrs. McAlpin and Helsinger and the letter of October 7, 1996 from K. Williams to D. Turner on this subject.

Based on discussions for the 2002 – 2007 labor agreement, work schedules will be implemented as follows.

Construction & Maintenance

Accept as specified below, the Construction & Maintenance Group will use both the 4-day 10-hour schedule and the 5-day 8-hour schedule. On or about May 1 of each year, that work group will commence a 4-day 10-hour schedule. It is believed that working the 4-10's during the prime construction season allows for the most efficient means to carryout that type of work. The shorter workweek and fewer trips to/from jobs will lessen the environmental impact from driving during summer months when environmental issues are at a peak. It will also save on fuel costs during the summer season when the cost for fuel is at a maximum. Additionally, the fact that school will be out will lessen disruptions to setting up job sites prior to 8:00 a.m. Employees, who value the third off day each week, will continue to be able to benefit from that schedule during the summer time season. The 4-10 work hours will remain from 7:00 a.m. until 5:00 p.m. at this time.

On or about November 1 of each year, the Construction & Maintenance Group will be scheduled to work the 5-day 8-hour schedule, with work hours of 7:00 a.m. to 3:00 p.m. For the reduced amount of construction projects during the winter months, the 5-day 8-hour work schedule is more conducive for achieving the maintenance type work that tends to be done during the colder months season. Additionally, the shorter work day during the winter months will allow for employees to arrive at home at an earlier time each day to tend to personal business. Management will continuously monitor and evaluate the effectiveness of the 8-hour schedules

including the start time for work hours and maintains the right to adjust the work hours as deemed necessary to meet business needs.

For business needs, the new gas service inspecting group (spotters) will be an exception to the seasonal schedule. Visual inspecting work must be accomplished on a 5-day 8-hour work schedule in order to meet the daily demands for those jobs, which have to be carried out within two days of a request. The four-day workweek has caused the need to take employees from Construction & Maintenance to assist in performing visual inspecting work on a regular basis, thus impacting the number of employees dedicated to construction and maintenance work on any one day.

Gas Production, Systems Operations and Corrosion Control

For the same reasons discussed above, and for the need to provide support for the construction & maintenance crews, Gas Systems Operations employees' work schedules will be the same as listed for Construction & Maintenance above and will also change on the referenced seasonal basis. The 5-8's schedule during the winter months allows for better coverage for cold weather related system adjustments and the need to implement the rotating shift during the winter season.

Contractor Construction Management

The Inspecting Mechanics will remain assigned to a 5-day 8-hour schedule year round. That work schedule maximizes our ability to provide inspecting services to the contractor work force. The 5-8's will enhance the availability of the inspecting work force at reduced overtime costs and at a minimum disruption to the Construction & Maintenance Group.

Service Delivery, Meter Operations, Gas Measurement Center

Employees in these work groups will continue to work their current work schedules at this time, as long as business needs are being accomplished.

It is believed that the work schedules as outlined above are a reflection of the consideration given to the Unions' input and employee comments while implementing work schedules that will help improve the organization's overall effectiveness. It must be noted, however, that the Company must maintain its right to make other work schedule adjustments in the future to meet business needs.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations, Safety
And Disability Programs

cc: D. Helsinger
M. McAlpin

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Voluntary Transfers Between Headquarters

Dear Gentlemen:

This letter documents our discussions and agreements related to employees in the same job classification being permitted to voluntarily transfer between headquarters.

As was agreed, employees will be permitted to submit transfer requests to be assigned to another headquarters. On an annual basis, during the first week of August, a notice will be posted advising those employees who wish to change headquarters to submit a transfer request, in writing, to the Labor Relations Department. All such requests must be submitted on or before August 31st of each year. These requests for transfer will be evaluated in the same manner as cross bids for posted job openings. Reassignments between headquarters will be made as soon as determined practical by Management but no later than January 7th. The provisions of Article VI, Section 2 will govern the classified seniority of all employees who are transferred. These reassignments are not subject to the grievance and arbitration procedure. Once a reassignment between headquarters is made, the transferred employee will assume the work assignments, vehicle assignments and holiday and other schedules that were assigned to the employee with whom the trade is made. Both employees must be actively employed at the time of the move in order for the transfer to occur.

This procedure in no way alters the contractually provided right of the Company to unilaterally effect transfers and reassignments and to effectively conduct its business. Additionally, this procedure does not alter the long established practice of assigning new employees in the starting level job, Mechanic III, to the various headquarters of Gas Operations.

It was also agreed that the provisions of Article VIII, Section 2 will not apply to these transfers. It must be understood that a transferred employee's scheduled vacation may have to be changed, if, during that period, the number of employees leaving on vacation from an individual's new headquarters handicaps the operation of the department.

It is believed that this letter properly describes the agreement reached between the parties concerning this matter.

Sincerely,

Lisa A. Gregory

Lisa A. Gregory
Human Resources Principal

cc: Chuck Allen
Terri Barnes
Gary Hebbeler

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

January 18, 2002

Mr. Dave McLean
Mr. Eldon House
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.
CG&E

Re: Compensation for Non-industrial Medical Appointments

Dear Gentlemen:

During the 2002 – 2007 contract negotiations, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed the compensation of employees performing limited duty work, while attending necessary medical appointments during working hours for non-industrial illness or injury.

It was agreed that when such appointments cannot be made outside of the normal working hours, employees will be paid sick pay for time away from the job for verifiable appointments. However, such compensation will only be granted after an employee has met the applicable sick pay waiting period for the same condition as necessitates such follow-up appointments.

It was also agreed that employees will make every effort to schedule such appointments during off duty hours. If this is not possible, such appointments should be made either at the beginning or at the end of their shifts. In addition, it was agreed that employees would only be eligible to receive sick pay for time lost to these appointments if they present verification that they attended them.

It is believed that this adequately describes the accord reached above for the 2002 – 2007 Contract regarding sick pay for doctor visits during normal working hours.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations, Safety
And Disability Programs

cc: D. Helsinger
M. McAlpin

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

January 18, 2002

Mr. Dave McLean
Mr. Eldon House
United Steelworkers of America
1329 E. Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.
CG&E

Re: Paid Lunch Periods

Dear Gentlemen:

During the 2002 – 2007 contract negotiations, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed the continuation of the paid lunch periods for bargaining unit employees.

The Company and Union agreed that the paid lunch periods would continue at this time. The Company, however, expressed concern about increased costs and loss of productivity that could result from employees not carrying out the "eat on the run" concept as it was intended.

During the discussions, it was agreed that the "eat on the run" concept was the basis upon which the parties agreed to implement the paid lunch periods in 1996. Under that concept, it is expected that employees should have their lunch provisions available prior to leaving the headquarters each working day. When necessary, stopping during the working day to purchase lunch is permissible, but must occur only in transit between job sites and the time spent doing so should be held to a minimum. Lunch is to be consumed at or between job sites during the working day in an approximate 15-minute time period.

As a result of the discussions, the Company committed to re-emphasizing with the work force the above expectations of employees. In turn, the Union agreed it would reinforce with employees the importance of obtaining lunch before leaving the work headquarters in order to maximize productivity during the working day.

The Company agreed to discuss with the Union issues pertaining to the paid lunch periods on a quarterly basis in an attempt to identify and resolve any problems associated with this practice.

It is believed that the above adequately describes the agreement reached during the discussions on the subject of lunch periods.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations, Safety
And Disability Programs

cc: D. Helsinger
M. McAlpin

A-57

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

January 18, 2002

Mr. Dave McLean
Mr. Eldon House
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.
CG&E

Re: Martin Luther King, Jr. Day

Dear Gentlemen:

During the 2002 – 2007 contract negotiations, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed the Union's proposal to add Martin Luther King, Jr. Day as a holiday.

As was agreed during these meetings, an additional holiday will not be added. As a result of the discussions at these meetings, however, it was agreed that the Company would give consideration to allowing as many employees as practicable to take their personal day off with pay on Martin Luther King, Jr. Day, during the term of the 2002 – 2007 Contract. All requests for a personal day must be made by employees at least 7 days prior to this date. In the event that more employees request a personal day on that date than the Department can permit off, system service will be utilized in determining which employees at a specific work location will be granted the time off from work. It was further agreed that the number of personnel to be permitted off on that day will be determined by the department so as to insure safe and efficient operations.

By proceeding in this manner it is thought that the concerns of the Union in this area will be met.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations, Safety
And Disability Programs

cc: D. Helsinger
M. McAlpin

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

January 18, 2002

Mr. Dave McLean
Mr. Eldon House
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.
CG&E

Re: Call Out Pay

Dear Gentlemen:

During the 2002 – 2007 contract negotiations, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed the issue of multiple call outs within one four-hour period.

An employee who is called out for an overtime assignment will receive four hours' pay at the appropriate overtime rate. However, the Company clarified with the Union that employees called out more than one time within the same four-hour time period are not entitled to the payment of a second four-hour callout minimum. In those instances employees are paid additional overtime for any overtime worked beyond the initial four-hour period.

In most cases, if employees complete the overtime assignment within the four-hour period the Company will continue to release employees to return home rather than requiring them to remain at the headquarters for the entire four-hour period. However, employees are expected to remain available for the remainder of the four-hour period for additional assignments. If they are called out again during the initial four-hour period, it will be considered a continuation of the initial overtime assignment.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations, Safety
And Disability Programs

cc: D. Helsinger
M. McAlpin

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

January 18, 2002

Mr. Dave McLean
Mr. Eldon House
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

CINERGY.
CG&E

Re: Promotional Retraining

Dear Gentlemen:

During the 2002 – 2007 contract negotiations, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed the guidelines for promotional retraining of employees within the bargaining unit.

As agreed, an employee who does not pass a promotional examination shall be given the opportunity to meet with a trainer, on his or her own time, for remedial training.

In addition, for the term of the 2002 – 2007 Contract, the Safety and Technical Training area of the Regulated Business Unit will provide a one-time retraining opportunity, upon the employee's request, if a minimum of 12 months has transpired since the first re-test or 15 months from the original test. There must be an available posted opening and a scheduled training class. Travel pay will be provided as specified within the Contract.

Retesting will cover all of the material in the training program. Promotions will then become effective, after successful completion of the test, in accordance with the current posted job opening.

It is believed that this correspondence adequately describes the accord reached by the parties concerning this subject.

Very truly yours,

John E. Polley

John E. Polley
General Manager
Labor Relations, Safety
And Disability Programs

cc: D. Heisinger
M. McAlpin

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

August 1, 2007

Mr. Dave McLean
Sub District 5 Director
Mr. Tim Bray
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

RE: Supervisory Upgrades

Dear Gentlemen:

During the 2007 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the Union's concerns relative to the use of bargaining unit employees to fill in as temporary supervisors during non-core hours.

The Union stated that, under normal conditions on the day shift, certain issues are created when employees from the bargaining unit are put in the position of performing supervisory duties. However, the Union expressed even greater concern over the potential for more serious issues if employees are upgraded and placed in a temporary supervisor role during non-core hours, such as the night shift, when no other management resources are available on the premises.

Based on the Union's concerns, the Company stated its intent to avoid, when possible, using employees in the temporary supervisor role under circumstances where no other management resources are readily available. While management must maintain its right to assign work as needed, when making temporary supervisory assignments in the future, consideration will be given to the scope of duties assigned during non-core hours if other management resources are not available.

Very truly yours,

Jay R. Alvaro
Managing Director
Labor Relations

cc: M. McAlpin, USW, Local 12049
T. Caudill, USW, Local 5541-06

A-62

June 2, 2016

Overtime Guidelines - Field and Systems Operations, Contractor Construction, Corrosion, Gas Production and the Measurement Center, USW's 12049 & 5541-06

1. When overtime occurs within a job classification, the Company agrees to maintain a system of selecting the employees within the job classification, in a sincere effort to equalize overtime work. The Company will make a documented attempt to contact the available low overtime employee by telephone, as indicated by the overtime list, to offer the overtime work. Each employee is responsible for providing supervision with a single telephone number (land line or cell) for the Company to use when making the calls.

2. Overtime Headquarters:

Monfort Heights	Erlanger	Queensgate
Todhunter	Valley View	
Erlanger Gas Plant	Eastern Avenue	

3. Each Headquarters will maintain a separate overtime list for the assigned personnel. Accumulated overtime shall consist of all overtime, casual, scheduled, call out and waived.

4. Crew Leaders (MOI, GPOI, GSOI and MSOI) and Helpers will be shown on one overtime list. Once a Crew Leader has been acquired, based on low overtime, then management will follow the low overtime order to contact and acquire the appropriate low overtime person to complete the task at hand.

5. All overtime listings revert to zero (0) hours during the first pay period of each year, and shall be accumulated on an annual basis.

6. At the first of each year, employees will be placed in the order of their seniority by job classification on one list. Other groups such as Welders, Inspecting Mechanics, etc. will be on separate list.

    a. The classified seniority standing of MOI's, MOII's, MOIII's, etc. (from highest classification to lowest classification) will be used to place the employees in order of call-out priority, most senior first.

b. The new overtime list will be posted on Wednesday of the first full week of the year, and each Wednesday thereafter recording the overtime worked or waived the previous week.

7. Employees will not be contacted to work overtime (scheduled or call-out) when they are on one (1) or more weeks' vacation, off due to illness, voluntary, or death in the family. Employees on less than one week vacation and/or personal days will be eligible for call-out on the day(s) they are off at the end of the regular shift. Employees taking a week or more of vacation must notify their immediate supervisor in writing prior to that start of vacation of their desire to work scheduled overtime during the vacation week.

8. When calling out a crew or a single employee, the existing low overtime list shall be used. A sincere effort will be made to follow the overtime list in order, however, in emergency situations, as determined by the Supervisor, only the first five (5) employees will be called before choosing someone. Any employee that supervision makes the documented attempt to reach by phone, or those who are contacted and turn down the overtime assignment, shall be waived the amount of overtime worked by the employee that replaces him or her. If no employee agrees to work the required overtime, the lowest qualified employee on the overtime list will be required to work. If, for some reason, no attempt is made to contact the low overtime person for a particular overtime assignment, that employee shall be provided the appropriate amount of make-up overtime.

   Employees who do not wish to be considered for overtime opportunities may submit to their supervisor a written waiver to that effect. Under normal circumstances no effort will be made to call those employees and they shall be waived the appropriate amount of overtime in each instance attempts to contact them would otherwise have occurred. However, such a waiver in no way limits management's right to require the employee to report for overtime when circumstances are deemed necessary by supervision. Nor does the waiver provide the employee the right to refuse to report when required. In addition, management may limit the number of employees who can submit waivers at a headquarters if its business needs are impeded. Except as stated above, employees who submit a waiver will not be called for overtime opportunities for the remainder of the calendar year in which the waiver has been submitted. Employees must submit a new waiver at the beginning of each calendar year to be removed from the overtime call out list.

9. Employees, who are working overtime, may be required to respond to emergency situations in other headquarters. However, in the case where a crew works in excess of four hours of overtime in the other headquarter area, the Company shall provide make-up overtime in the appropriate amount to the employee(s) within that area who was low on the overtime list.

   The make-up overtime shall be the amount of time worked in the other headquarter area. The four hour period commences at the time the crew is dispatched to the other headquarter area.

   This language applies only to shift work and call-outs and does not apply to casual overtime.

10. Up to four hours per day of casual overtime may be worked by employees represented by USW 12049 working in other headquarters within the 12049 local territory.

    In addition, up to four hours per day of casual overtime may be worked by employees represented by USW 12049 and 5541-06 working within the Gas Service area regardless of Union boundaries. Management will use the least senior available employees, represented by USW 5541-06, in USW 12049's local territory, when practical. The arrangement provided for in this paragraph will be reviewed on a semi-annual basis. If any party elects to withdraw for just cause from this four hour casual overtime arrangement, a six-month written notice will be provided, by the party withdrawing, to the remaining parties that have agreed to this arrangement. Six months following written notice, the parties will revert back to the two hour casual overtime agreement, for the term the Contract.

11. If the need to work casual overtime becomes known before the end of the shift, the Supervisor is not required to ask the low overtime person.

    Supervisor discretion and consideration of overtime will be used in the assignment.

12. Employees transferred from one headquarters to another, as a permanent assignment, will be assigned at the average overtime for that classification.

    Temporary Reassignments: Overtime will be posted and worked at the temporary headquarters (the employee's actual overtime hours should travel with them.)

13. When posting for volunteers for scheduled overtime, all employees shall be charged for overtime waived.

14. Any employee voluntarily transferring from one seniority district to another district will be placed at one (1) hour more than the highest overtime in that classification at the new location. If the employee is forced to the new district, they will be averaged as in #11 above.

15. When scheduled or call-out overtime is needed, management will follow the low overtime order to contact and acquire the appropriate low overtime person to complete the task at hand.

16. Newly hired employees will not be eligible for call-outs or the schedule until they have worked for six (6) months after they have been trained, tested and fully qualified. After their release from training, they will be permitted to work their first off day when all other qualified employees have been given an opportunity. They are permitted to work casual overtime during the six month period.

17. If overtime is required to fill a shift vacancy or to add additional personnel the overtime list shall be used.

18. When planned overtime occurs employees will need to comply with current D.O.T requirements for hours of rest between shifts in order to be eligible

19. When scheduled or call-out overtime for welders is required, the following procedure will be used. The Northern local welder overtime list should be used for the northern area. The Kentucky overtime list should be used for Kentucky. The Central overtime list should be used for the central area. Central area will backup the north and south, and vise versa.

SERVICE DELIVERY
USW OVERTIME GUIDELINES
June 2, 2016

1) Gas Operations Work Management Support is the primary resource for maintaining, logging, tracking, obtaining, and reporting Gas Service Delivery Worker overtime. Occasionally, the Gas Operations Field Services Supervisor will request personnel to work overtime. When this occurs, it is the Gas Operations Field Services Supervisor's responsibility to forward the required information; i.e., personnel who will work the overtime, personnel who waived the overtime, etc. to Gas Operations Work Management Support.

2) Each Work Area (North, South, and Central) will have a separate, single overtime list containing the names of the Workers in low overtime order (lowest being first on the list), the call-out contact telephone number provided by the employee, and associated prior week and year-to-date accumulated overtime hours. All overtime listings revert to zero (0) hours during the first pay period of each year, and shall be accumulated on an annual basis.

3) All overtime worked and waived, with the exception of overtime hours worked by employees normally scheduled to work on holidays, will be accumulated and reported on the overtime list(s) on a weekly basis (Wednesday of each week). Overtime hours worked will be determined from the prior week's time reporting data. Overtime hours waived will be determined from annotations on the previous week's overtime report. Employees who are informed of their need to work an overtime assignment will be charged waived overtime for instances when they are contacted in person (or in person by phone), or by a system generated message (ARCOS) and are allowed to waive the overtime assignment. The number of compensated hours earned by the individual(s) who accepted that overtime assignment will determine the number of hours waived. If one individual is required to work an overtime assignment, the number of hours waived will be equal to the hours worked during that individual assignment. If more than one individual is required to work an overtime assignment, the number of hours waived will be equal to the average number of hours between the highest individual's and lowest individual's number of hours worked during that overtime assignment. (Example: Five employees are required to work an overtime assignment with employee A working 9.0 hours, employee B working 7.0 hours, employees C & D working 4.0 hours and employee E working 2.0 hours; the waived overtime would be calculated: 9 hours + 2 hours = 11 hours / 2 = 5.5 hours). Tenths of a hour will be rolled-up to the nearest 5/10 of an hour. Waived hours will be included in the accumulated overtime hours listed for those employees who waived the particular overtime assignment.

4) All overtime, worked and waived, will be accumulated on an hour per hour basis. Hours of compensated overtime plus hours of waived overtime will be combined and will reflect the total overtime hours for each employee on the overtime listing(s).

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5) When it is determined that additional personnel are needed to work overtime for routine work, employees in the work area (North, South, or Central) where the overtime is needed will be offered the opportunity to work the overtime, beginning with the lowest overtime, qualified, available employee and continuing down the list, in low overtime order, until the required number of employees are obtained. Please note that if the overtime is necessary to fill a shift vacated due to illness or other unplanned absence of an employee, the back filling of that shift will be offered to USW personnel within the work area of the vacated shift. For example, the USW employee who is assigned to cover the City area on 2nd shift calls in sick and the Dispatcher determines that the work load is sufficiently heavy enough to warrant filling that vacancy. In this case, the overtime to fill this vacancy must come from within the USW personnel in the Central work area.

6) When it is determined that additional personnel are needed to work overtime for gas trouble, only employees in the work area (North, South, or Central) who are qualified to work that type of gas trouble will be offered the opportunity to work the overtime. The overtime will be offered in low overtime order, until the required number of employees is obtained.

7) If the Dispatcher or other person contacting employees to work overtime is unable to obtain the required number of employees after going through the entire overtime list for that Work Area (North, South, or Central), employees in the next logical geographic work area will be offered the overtime, in low overtime order, until the required number of employees is obtained, based on the following chart:

   a) Overtime list in North exhausted; contact employees in Central, then South.
   b) Overtime list in South exhausted, contact employees in Central, then North.
   c) Overtime list in Central exhausted; contact employees in South, then North.

8) Qualified, available employees may work or be waived overtime seven days per week. A sincere effort will be made, however, to avoid working an employee more than 16 hours on any given day. As agreed with the USW, a sincere effort will also be made to avoid working any USW employee "back-to-back" 16-hour days.

9) If it is determined by management that the need exists for all employees at a headquarters to work a day of overtime in a particular week, all employees at that headquarters will be provided the opportunity to work on their first scheduled day off.

10) Employees who may be absent from work for extended periods of time will have no adjustment made to their hours on the overtime listing. The only exception to this would be if the employee's absence occurred during the beginning of the year, when the uniform reduction in overtime hours shown for all employees would occur.

11) With the implementation of the Mobile Work Management System (MWMS)/Service Suite and Home Based Reporting in each Work Area, additional "start-of-shift" and "end-of-shift" overtime guidelines are necessary. Employees who are contacted prior to the start of, or after their shift has ended, for communication purposes only will be compensated as follows:

a) If they have not yet left home, or are traveling toward their geo-grid prior to the start of their shift and are contacted momentarily by supervision, but are not required to begin working at that time, overtime pay at the appropriate rate for the amount of time such contact is made will be paid. This amount of time will also be added to the employees "worked overtime" accumulation for that day.

b) Employees who are on their way home and are contacted after their normal shift has ended for communication purposes only, but are not required to resume working will receive overtime pay at the appropriate rate for the amount of time such contact is made. This amount of time will also be added to the employees "worked overtime" accumulation for that day.

c) Employees who are contacted by supervision and given a job assignment within fifteen minutes of their scheduled start time will be paid overtime at the appropriate rate for the amount of time preceding their start of shift. Employees contacted by supervision and given a job assignment prior to fifteen minutes before the start of their scheduled shift will be paid overtime at the appropriate call-out rate.

d) Employees who are contacted by supervision and given a job assignment after they have confirmed their 10-7 with the dispatch office and after the end of their scheduled shift will be paid overtime at the appropriate call-out rate.

12) Overtime hours worked for "call-out" overtime for employees who home Base Report will be considered the total hours (minimum of 4 hours) elapsed from the time the employee leaves his or her home until his or her return home from that assignment when those hours are not contiguous with their normally scheduled shift

Company: _____ 6/2/16
Jay Alvaro
Director, Labor Relations
Date

Union: _____ 6-2-16
Steve Bowermaster
President, USW Local 5541--06
Date

Union: _____ 6-2-16
John Waits
President, USW Local 12049
Date

Duke Energy

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

August 1, 2007

Mr. Dave McLean
Sub District 5 Director
Mr. Tim Bray
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

RE: Inclement Weather – Service Delivery

Dear Gentlemen:

During the 2007 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed issues with unusually harsh weather conditions and the need of the Service Delivery Department to meet customer service expectations.

It is understood that the July 5, 1979 negotiations letter pertaining to inclement weather is applicable solely to the working forces in the Construction & Maintenance Division of Gas Operations. However, the Union expressed concern about work assigned to the Service Delivery employees during periods of extremely frigid temperatures. The Union wanted assurance from the Company that employees in Service Delivery would not be assigned work that would require them to endure extended periods of exposure to such weather conditions.

The Union was assured that management of Service Delivery has no intention of requiring employees to remain outdoors in frigid temperatures for prolonged periods to complete work that is not necessary to conform to law or applicable regulations, to protect life, property, or to guarantee service to the customers. However, some of the work performed routinely at customers' residences may require employees to be outdoors for short periods of time. Fortunately, under normal circumstances, employees are able to warm themselves in their vehicles or in the customers' residences as needed to avoid any risk of overexposure.

Of concern to the Company is the fact that much of the customer work routinely performed at customers' residences is on the basis of pre-arranged appointments. Customers often make special arrangements themselves in order to be home at the times of those appointments. Therefore, the Company must sometimes make reasonable strides, even under some adverse conditions, to avoid missing or cancelling its promised appointments with little or no notice.

The Company gave assurance to the Union that Service Delivery will continue its efforts to anticipate extreme weather events and to make adjustments as circumstances may allow for minimizing the need for employees to work outdoors for extended periods in extremely cold weather.

Very truly yours,

Jay R. Alvaro
Managing Director
Labor Relations

cc: M. McAlpin, USW, Local 12049
T. Caudill, USW, Local 5541-06

LISA A GREGORY
Director Labor Relations

Duke Energy
EMM80 / 139 East Fourth St.
Cincinnati, OH 45202

513-287-3934

June 3, 2011

Mr. Ronnie Wardrup
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

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

Mr. Mike McAlpin
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

RE: Union Employees' Annual Incentive Program (UEIP)

Dear Gentlemen:

During the 2011 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed that the payout for the incentive bonuses for employees will be modified to incorporate goals relative to Safety and the Company's financial results.

Beginning with the goals established by the Company for 2012, the UEIP payout (payable beginning in 2013) will be administered as follows:

Annual Incentive Plan Summary for those who participate in the New Retirement Program:

In conjunction with the New Retirement Program, under the Pension Plan, all participants will be eligible for up to a 5% maximum (1.75% minimum, 3% target, 5% maximum) annual incentive opportunity. Beginning in 2012 through 2013, 20% of the annual incentive opportunity will be based on safety goals as determined and established by the Company (i.e., number of recordables, preventable vehicular accidents, etc.) and 80% will be based on the Company's financial goals (i.e., earnings per share, net income, etc.) as determined and established by the Company. Beginning in 2014, 33% of the annual incentive opportunity will be based on safety goals as determined and established by the Company (i.e., number of recordables, preventable vehicular accidents, etc.) and 67% will be based on the Company's financial goals (i.e., earnings per share, net income, etc.) as determined and established by the Company.

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Annual Incentive Plan Summary for those who participate in the Traditional Retirement Program:

Employees who remain in the Traditional Program, under the Pension Plan, which provides benefits under the current final average pay formula, will be eligible for up to a 2% maximum (.75% minimum, 1.25% target, 2% maximum) annual incentive opportunity. Beginning in 2012 through 2013, 20% of the annual incentive opportunity will be based on safety goals as determined and established by the Company (i.e., number of recordables, preventable vehicular accidents, etc.) and 80% will be based on the Company's financial goals (i.e., earnings per share, net income, etc.) as determined and established by the Company. Beginning in 2014, 33% of the annual incentive opportunity will be based on safety goals as determined and established by the Company (i.e., number of recordables, preventable vehicular accidents, etc.) and 67% will be based on the Company's financial goals (i.e., earnings per share, net income, etc.) as determined and established by the Company.

Very truly yours,

Lisa A. Gregory

Lisa A. Gregory
Director, Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Amendment to A-67 Letter Regarding the Union Employee Annual Incentive Program (UEIP)

Dear Gentlemen:

During the 2016 contract negotiations, representatives of the Company and the USW, Locals 12049 and 5541-06 ("Union") discussed eligibility for the Union Employee Annual Incentive Program ("UEIP"). As a result of those discussions, the parties agreed to amend Letter A-67 dated June 3, 2011 as set forth below.

Beginning with the 2017 calendar year performance period under the UEIP, the Company will provide a prorated UEIP payment (calculated as set forth below) to any eligible Union employee who meets the following criteria during a performance period: (i) works for at least six complete calendar months, and (ii) retires (as defined below).

Such prorated UEIP payments shall be paid in the first quarter of the calendar year immediately following the applicable performance period at the same time and on the same basis as other UEIP payments are made to other eligible Union employees, and any such prorated UEIP payment shall be calculated based on the eligible earnings of the retired Union employee during the applicable performance period and actual achievement relative to the pre-established goals set forth in Letter A-67.

For purposes of clarity, in no event will a Union employee who does not meet the criteria set forth in this letter be eligible for a prorated UEIP payment for a performance period if he or she isn't employed on December 31st of the performance period. For purposes of this Letter, "retire" means separate from employment with the Company after having attained at least age 55 and 10 years of service (as determined for purposes of access to Company-sponsored retiree medical coverage).

A-67a

In other respects, Sidebar Letter A-67 shall continue in full force and effect herein for the duration of the 2016-2021 Agreement, unless changed by mutual agreement of the parties.

Sincerely,

Lisa A. Gregory
Human Resources Principal

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

August 1, 2007

Mr. Dave McLean
Sub District 5 Director
Mr. Tim Bray
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

RE: Employees with $9,000.00 Paid-Up Post-Retirement Life Insurance Coverage

Dear Gentlemen:

During the 2007 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the $9,000.00 paid-up post-retirement life insurance benefit that certain employees have available to them.

The Company assured the Union that it would provide the necessary updated contact information for the current carrier and administrator of those benefits to the active employees with those grandfathered policies.

Very truly yours,

Jay R. Alvaro
Managing Director
Labor Relations

cc: M. McAlpin, USW, Local 12049
T. Caudill, USW, Local 5541-06

Duke Energy.

DUKE ENERGY CORPORATION
139 East Fourth St.
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August 1, 2007

Mr. Dave McLean
Sub District 5 Director
Mr. Tim Bray
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

RE: Sabbatical Vacation Bank and Vacation Credit Programs

Dear Gentlemen:

During the 2007 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the phasing out of the Sabbatical Vacation Bank and the Vacation Credit Programs.

As agreed, these programs shall be phased out in accordance with the attached document, Attachment A, which outlines the specific revisions to the Sabbatical Vacation Bank and Vacation Credit Programs that will remain in effect through December 31, 2011.

The Company and the Union expressly understand and agreed that the phasing out of the Sabbatical Vacation Bank and the Vacation Credit Programs, as stated in the attached document, shall continue in full force until December 31, 2011, surviving the termination of the 2007 – 2011 Contract, and shall continue in force through succeeding contracts, or in the absence of succeeding contracts, unless changed by mutual agreement of the parties.

Very truly yours,

Jay R. Alvaro
Managing Director
Labor Relations

Attachment

cc: M. McAlpin, USW, Local 12049
T. Caudill, USW, Local 5541-06

Attachment A

REVISIONS TO THE SABBATICAL VACATION BANK AND VACATION CREDIT PROGRAMS FOR USW 12049 & 5541-06 LEGACY CINERGY EMPLOYEES

Effective January 1, 2008, the Vacation Bank and Service Credit programs will be phased out over a four year period for employees who are eligible for them as of December 31, 2011. As a reminder, employees are eligible to bank vacation if they are at least 47 years old, and are eligible to receive "vacation credits" if they are at least 51 years old.

The Changes:

Sabbatical Vacation Program:

- The sabbatical banking program will be eliminated for employees who are younger than 47 years old as of December 31, 2007.
- Employees who are 47 years old or older as of December 31, 2007 will be eligible to continue banking vacation until December 31, 2011, up to the limits described on the chart below.
- Employees who have already banked more than the maximum amount of vacation based on the schedule below (including any vacation credits) cannot bank more after January 1, 2008, but will be grandfathered with the amount they have banked.
- No additional banking will be permitted after January 1, 2012. Therefore, the last opportunity to bank vacation will be in December 2011 because banking is done at the end of the year.
- Banked vacation will be paid out at the final rate of pay at retirement.

Vacation Credit Program:

- The vacation credit program will be modified for employees who are younger than 51 years old as of December 31, 2011. For those employees hired prior to January 1, 1997 and who are age 50 or older at the time they leave the Company, they will continue to receive vacation credits up to the amount of vacation time they were eligible for as of January 1, 2006.
- Employees who are at least 51 years old as of December 31, 2011 will continue to receive vacation credits up to the lesser of their annual vacation entitlement or the schedule below.
- 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, 2011. Effective January 1, 2012, employees will be granted a 6th week of vacation time off during their 32nd year of employment in lieu of a week of service credit.

The Schedule:

Age as of 12/31/2007	Maximum Banked Vacation Weeks (including vacation and service credits)	Maximum Vacation Credits (not to exceed annual vacation eligibility)	Service Credits (granted at 32 and 33 years of service in lieu of time off)
47	10	up to 6	
48	10	up to 6	
49	10	up to 6	
50	12	up to 6	Up to 2
51	14	up to 6	Up to 2
52	16	up to 6	Up to 2
53	16	up to 6	Up to 2
54	18	up to 6	Up to 2
55	20	up to 6	Up to 2
56+	22	up to 6	Up to 2

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

June 3, 2011

Mr. Ronnie Wardrup
Staff Representative
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Mr. Steve Bowermaster
President
Local 5541-06
United Steelworkers
Todhunter Headquarters

Mr. Mike McAlpin
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

RE: Sale of Assets

Dear Gentlemen:

During the 2011 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed employment security for bargaining unit employees. The Company and the Union reached the following agreement:

I. Divestiture Issues

The utility industry is in the midst of major restructuring. It may become necessary or prudent, in the Company's sole judgment, to sell, divest, transfer or swap its gas assets or operations to a third party or to transfer gas assets or operations to a subsidiary, a joint venture, or other business combination. Employees who accept employment with the Buyer will be covered by the collective bargaining agreement with the Buyer. Employees who are offered employment by the Buyer will have their employment at the Company terminated on the transfer date and will have no future rights under the Labor Agreement between the Company and the Union. The Labor Agreement must be interpreted to require no other result.

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II. The Company and Union have conducted bargaining regarding potential divestiture, sale or transfer of assets.

A. As a condition of divestiture (e.g., sale, transfer or swap of assets as defined above), the Company will:

1. Require the Buyer to offer equivalent employment to any Union employee whose job is eliminated as a result of the Buyer's acquisition or purchase, including employees absent from active service due to illness or leave of absence, whether paid or unpaid but excluding employees on long-term disability as of the closing date. (However, employees who are on "own occupation" long-term disability and return to work within one year of the transfer of ownership of the asset, will be offered employment by the Buyer.) In the event that not all jobs of employees in a bidding area are eliminated, the Company will initially solicit volunteers, with the most senior employees getting the first opportunity to elect to stay at the Company or fill the vacant positions with the Buyer. If there are insufficient volunteers to fill all vacancies, the Buyer will offer the remaining positions to the least senior employees.

2. Subject to paragraph II B, require the Buyer to recognize the Union as the collective bargaining agent for bargaining unit employees the Buyer employs, and assume provisions identical to provisions of the Labor Agreement applicable to those bargaining unit employees.

3. Subject to paragraph II B, require the Buyer to provide employees with full credit for service with the Company, including retention of seniority under the provisions of the Labor Agreement.

4. Require the Buyer to agree that, prior to the expiration of the Labor Agreement, should Buyer transfer, sell or divest to any other business entity (regardless of relationship to the Buyer) the corporate gas assets or operations formerly owned by the Company, the Buyer will require the third party to assume the conditions set forth in paragraphs II A 1-3.

5. This Agreement satisfies any Company duty to bargain over the decision or effects of a transfer or sale of assets.

6. If any regulatory agency requires the Company to offer severance or other benefits to affected employees, the employees may accept those benefits or the benefits provided under this Agreement, but not both.

B. Employee Benefits

The Company will require the Buyer to provide to affected bargaining unit employees' benefits that are substantially equivalent to the Company's benefits under the Labor Agreement. In doing so, the Buyer may use

different providers and establish new benefit plans or use its existing plans. There will be no duplication of coverage. Subject to items 1 through 5 below, the Buyer must recognize service with the Company for calculating eligibility, vesting, and benefits in any benefit plan, program, or fringe-benefit arrangement, provided it does not result in duplication of benefits. The Buyer can substitute a different benefit package if the Union agrees.

1. With respect to the Cinergy Corp. Union Employees' Retirement Income Plan ("Pension Plan"), the Company will coordinate with the Buyer to enable the Buyer to provide employees no less than the pension benefit they would have received had they remained at the Company. The Company will require the Buyer to agree to credit all past service with the Company (subject to the Company's Pension Plan provisions) for eligibility for participation, vesting, early retirement subsidies, and benefit accrual service, provided it does not result in duplication of benefits. The Company will be responsible for its employees' benefits accrued through the date of closing. After the date of closing, the Buyer will be responsible for benefits accrued during the remainder of the Labor Agreement by its employees. The Buyer's plan may offset the benefit it pays by any benefit paid by the Company's plan.

2. For purposes of medical and dental coverage, the Company will require the Buyer to waive all limitations regarding pre-existing-condition exclusions, actively-at-work exclusions and waiting periods for employees who become employees of the Buyer. Further, for the calendar year in which closing occurs, all expenses incurred by bargaining unit employees that count towards any deductible or out-of-pocket limit under the Company's health plans shall also count towards any deductible or out-of-pocket limit under the Buyer's health plans.

3. The Buyer will be required to give affected bargaining unit employees full credit for all vacation, short-term disability, or FMLA benefits accrued but unused as of the transfer of ownership.

4. With respect to the Duke Energy Retirement Savings Plan for Legacy Cinergy Union Employees (Midwest), the Buyer must establish a 401(k) plan or add bargaining unit employees to its existing 401(k) plan provided that the employees' deferral options and employer match (except that matching contributions will not be made in Duke Energy stock) are no less favorable than those provided under the Company's plan. The Buyer must accept rollovers from other qualified plans. The Buyer may offer investment funds different than those offered under the Company's plan. Consistent with applicable law, employees hired by the Buyer will have the option of leaving their account balance in the Company's 401(k) plan, rolling the amount into the Buyer's plan or an individual retirement account, or cashing in the account balance subject to any tax withholding and penalties.

5. Employees offered employment by any Buyer shall not be eligible for severance pay or any other termination benefits from the Company, unless required by law.

C. Transfer of Assets

Bargaining unit employees offered employment by the Buyer will cease to be employees of the Company upon the transfer of ownership of the assets and will have no further bidding, recall or other rights for positions in the Company. Upon transfer of ownership, the Company is relieved of obligations and liabilities under the Labor Agreement or otherwise to all affected bargaining unit employees or employees of the Buyer.

D. Legal, Administrative or Legislative Proceedings

The Union will support and it will not oppose or in any way support or encourage opposition to the Company's position before regulatory or administrative agencies, in legislatures or in court, regarding any rate proceedings, plant or gas pipeline siting proceedings, mergers, acquisitions, divestitures or similar transactions announced or begun during the term of the Labor Agreement or the Company's effort to seek approval from any applicable regulatory agency for its recovery of stranded costs or asset swap or sale. In addition, the Union will support agreements (including settlements) between parties involved in the Company's stranded-cost determinations as reasonable and support the Company's position that the stranded costs it has identified are reasonable in amount and fully recoverable from customers. The Company will provide the Union as much timely information as is reasonably practicable about its regulatory and legislative proposals. The agreement set forth in this paragraph is not intended to limit legislative or regulatory actions on matters not reasonably related to the Company's restructuring and stranded-cost proposals.

E. Notwithstanding any provision of this letter to the contrary, the Company will satisfy all of its obligations under Sections II(A)(1)-(5) and II(B)(1)-(4) of this Letter so long as it uses reasonable efforts to require the Buyer to provide the items described therein.

III. Transition Assistance Plan

A. The Company will offer certain benefits to employees who lose employment as a result of a divestiture (e.g., sale, transfer or swap of assets) that results in a loss of employment for employees not located at the asset that was divested. Employees offered employment with the new owner will not be eligible. These benefits are contingent on the employee signing a waiver of all claims and release of liability for the Company and affiliates and will include:

1. Severance Benefit. A lump sum cash benefit for eligible employees equal to two weeks' base pay for each full year of service, with a minimum of eight weeks' and a maximum of one hundred four weeks' pay per eligible employee.

2. Deferred Pension Benefit. If over age 50 and would be eligible for unreduced pension benefits at age 55 (due to 85 points provision), may defer receipt of pension benefits until age 55 and receive unreduced pension benefits.

3. Medical and Dental Benefit. Union employees who voluntarily sever may elect to continue insurance coverage for a period of one month for each year of service up to a maximum of 18 months by paying premiums applicable to active employees. Coverage for medical and dental benefits under the Company's welfare benefits program generally ends on the last day of the month in which employment with the Company ends. Eligible employees generally can continue health coverage (i) if they are eligible for post-retirement health benefits or (ii) for 18 months under the Federal Law "COBRA" by paying 102% of the full premium.

4. Group Outplacement Assistance.

5. Educational Expense Reimbursement. The Company will reimburse eligible employees for up to $2,600 for educational expenses that they incur within two years of the date they terminate employment with the Company.

IV. Resolution of Disputes

A. Resolution of Disputes Between the Company and the Union

1. Any and all disputes between the Company and the Union regarding the Company's and the Union's interpretation or application of the terms of this Agreement shall be resolved exclusively through the grievance-arbitration procedures set forth in Articles IX and X of the Labor Agreement.

B. Resolution of Disputes Between Buyer and Union

1. Any and all disputes between the Buyer and the Union regarding the Buyer's and the Union's interpretation or application of the terms of this Agreement or regarding any other agreement between the Buyer and the Union, shall be resolved exclusively through whatever dispute resolution process and procedure to which the Buyer and the Union agree, if any.

This Agreement satisfies any obligations to bargain over the decision or effects of utility industry restructuring or divestiture of assets. This Agreement is hereby incorporated into the Labor Agreement and is made a part hereof, Unless otherwise expressly agreed in

writing by the Company and the Union, any extension or termination of the Labor Agreement also shall apply to the terms and provisions of this Agreement.

Very truly yours,



Jay R Alvaro
Vice President
Labor Relations

Duke Energy

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

August 1, 2007

Mr. Dave McLean
Sub District 5 Director
Mr. Tim Bray
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

RE: Retirement Plan and HRA Conversion Agreement

Dear Gentlemen:

During the 2007 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the Company's desire to migrate all employees to a common benefits program. The following outlines the agreement between the Company and the Union for providing the employees with options and protections for Retirement Plan participation and post-retirement health care benefit that will remain in effect beyond the 2007 – 2011 Contract.

Traditional Retirement Program Frozen:

Participation in the Cinergy Traditional Retirement Program will be frozen as of January 1, 2012 for certain employees. Active employees on January 1, 2012 who are younger than age 50 (as of December 31, 2011) and anyone who is older than 50 but has fewer than 25 years of service (as of December 31, 2011), will automatically begin participating in the New Duke Retirement Program.

Voluntary Conversion Opportunities:

Active employees in the Traditional Retirement Program will be offered a voluntary window in 2007 to elect to remain in the Traditional Pension Program or elect the New Retirement Program. In 2011, a second voluntary window will be offered only to those active employees who remain in the Traditional Program and who are age 50 with 25 years or more of service as of December 31, 2011.

Voluntary Conversion to the New Retirement Program:

Part A Benefit (Part A): The pension plan benefit 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 at retirement (not the date of conversion).

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 Duke Energy Retirement Cash Balance Plan.

The Company matching contributions for the 401(k) plan will be enhanced to mirror the Duke Energy 401(k) 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).

Employees will also begin participating in an annual incentive plan with greater award opportunities (up to 5%).

With Mandatory Conversion to the New Retirement Program:

1. Mandatory conversion will be effective January 1, 2012 for employees who are younger than 50 years old and anyone who is older than 50 but has fewer than 25 years of service, as of December 31, 2011. Other terms applicable to the mandatory conversion are as follows:

   a. The final average monthly pay for retirement will be frozen at the time of conversion (no pay run up).

   b. Employees will have no choice between annuity and lump sum on Part A; only the current traditional program annuitant options will be available for Part A.

   c. Can still grow in to the 85 points.

   d. Employees will receive the enhanced 401(k) and enhanced incentive pay as described above once they mandatorily convert.

Employees Currently in the Cash Balance Plans:

Employees who previously selected one of the Cinergy cash balance plans (Balance or Investor) will automatically transition to the New Retirement Program as soon as administratively possible, but no later than January 1, 2008, to include participation in a cash balance pension plan that mirrors the Duke Cash Balance Plan, an enhanced 401(k) plan to mirror the Duke Energy 401(k) Plan and enhanced annual incentive plan, as described below.

Annual Incentive Plan Summary Changes for those who elect or automatically move to the New Retirement Program:

In conjunction with the New Retirement Program, all participants who volunteer or upon mandatory conversion to the New Retirement Program will be eligible for up to a 5% maximum (1.25% minimum, 2.5% target, 5% maximum) annual incentive pay based solely on the Company's financial results (i.e., earnings per share, net income, etc.).

Annual Incentive Plan Summary Changes for those who do not elect the New Retirement Program:

Employees who elect to remain in the Cinergy Traditional Program, which provides benefits under the current final average pay formula, will not be eligible for the higher incentive payout, but will continue their eligibility for the current Cinergy 401(k) Plan formula and will begin participating in an annual incentive plan, with a maximum award of 2% (.5% minimum, 1% target, 2% maximum) based solely on the Company's financial results (i.e., earnings per share, net income, etc.).

Post-Retirement Health Care Subsidy Discontinued:

In 2007, the Company will offer employees enrolled in the Post-Retirement Health Care subsidy program a voluntary window to either stay in the current Post-Retirement subsidy program or to convert to the Post-Retirement Health Reimbursement Account (HRA) at $1,000/Year of Service. In 2011, any employee who is age 50 with 20 years or more of service as of December 31, 2011 will be offered another voluntary choice to convert to the HRA. Effective January 1, 2012, any employees remaining in the subsidy program younger than 50 years old or age 50 with less than 20 years of service, as of December 31, 2011, will be automatically converted to the Post-Retirement HRA.

The Retirement and HRA Conversion Agreement Survives the 2007-2011 Contract:

The Company and the Union expressly understand and agreed that the Retirement Program and HRA conversion agreement shall continue in full force through January 1, 2012, surviving the termination of the 2007 – 2011 Contract, and shall continue in force through succeeding contracts, or in the absence of succeeding contracts, unless changed by mutual agreement of the parties.

Very truly yours,

Jay R. Alvaro
Managing Director
Labor Relations

cc: M. McAlpin, USW, Local 12049
T. Caudill, USW, Local 5541-06

LISA A GREGORY
Director Labor Relations

Duke Energy
EMM80 / 139 East Fourth St.
Cincinnati, OH 45202

513-287-3934

June 3, 2011

Mr. Ronnie Wardrup
Staff Representative
United Steelworkers
Local Nos. 12049 and 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

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

Mr. Mike McAlpin
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

Re: Amendment to August 1, 2007 Sidebar Letter A-71

Dear Gentlemen:

During the 2011 contract negotiations, the Company and the Union discussed post-retirement health care. As a result of those discussions, the parties agreed to amend the Sidebar Letter A-71 dated August 1, 2007 entitled, "Retirement Plan and HRA Conversion Agreement."

Specifically, in consideration of the Union's agreement to modify Article VIII, Section 14(d) of the Contract to eliminate the post-retirement HRA Option for employees hired on or after January 1, 2012, the Company has agreed to amend the section titled "Post-Retirement Health Care Subsidy Discontinued" on page three of the August 1, 2007 letter effective as of the date of this letter, such that:

(i) Employees hired prior to January 1, 2006 will be offered a voluntary choice in 2011 to convert to an HRA if they are not already in the HRA Program, regardless of the employees' age or years of service (i.e., the provision requiring that an employee has attained age 50 with at least 20 years of service as of December 31, 2011 in order to participate in the second voluntary window has been deleted); and

(ii) Employees who choose to remain in the Traditional Program will not be forced into the HRA Program by the Company during the term of this Contract (i.e., the provision requiring that employees remaining in the subsidy program who have not

A-71a

attained age 50 with at least 20 years of service as of December 31, 2011 will be automatically converted to the Post-Retirement HRA has been deleted).

Except as provided above, the August 1, 2007 Sidebar Letter A-71 shall remain in full force and effect through the 2011-2016 Contract, and continue in force in any succeeding contracts unless changed by mutual agreement of the parties.

Very truly yours,

Lisa A. Gregory
Director Labor Relations

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

August 1, 2007

Mr. Dave McLean
Sub District 5 Director
Mr. Tim Bray
Staff Representative
United Steelworkers
Local Nos. 12049 & 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

RE: Discontinue Automatic Progression

Dear Gentlemen:

During the 2007 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the discontinuation of the automatic progression agreement for employees in the Meter Specialist, Mechanic Operator, Gas Systems Operations, Service Mechanic and Gas Plant Operator job progressions.

As agreed, all employees in a job classification within the Meter Specialist, Mechanic Operator, Gas Systems Operations, Service Mechanic or Gas Plant Operator job progression on May 14, 2007 shall be grandfathered for the automatic progression promotional agreement for the job classifications of Service Mechanic A, Meter Specialist I, Mechanic Operator I, Gas Systems Operations Mechanic I and Gas Plant Operator I within those direct promotional sequences in the future. In addition, employees in the job classifications of DNP Worker or Mechanic III and are members of the bargaining unit on May 14, 2007 shall also be grandfathered for the automatic progression, but only to the Service Mechanic B, Meter Specialist II, Mechanic Operator II, Gas Systems Operations Mechanic II and Gas Plant Operator II job classifications in each of the above referenced direct promotional job sequences.

Employees who are newly hired into the bargaining unit on or after May 15, 2007, shall not be eligible for the automatic progression.

Very truly yours,

Jay R. Alvaro
Managing Director
Labor Relations

cc: M. McAlpin, USW, Local 12049
T. Caudill, USW, Local 5541-06

A-72

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH. 45201-0960

April 4, 2005

CINERGY.
CG&E

Mr. Dave McLean
United Steelworkers of America
1329 East Kemper Road
Building 400, Suite 4214
Cincinnati, Ohio 45246

Re: Benefit Claims Disputes

Dear Mr. McLean:

During the benefits opener discussions for 2005, representatives of the Company and United Steelworkers of America and its Locals 12049 and 5541-06 (the "Union") discussed the process for employees to resolve disputes over claims or application of welfare and pension plan benefits.

With respect to any claim or dispute involving the application or interpretation of any employee welfare or pension plan, initially the employee and the Union will make a good faith effort to resolve those disputes in accordance with the terms and procedures set forth in the relevant plan document. Additionally, it is understood that, should the content of any communication relating to employee benefits conflict with the terms of the relevant plan document, the terms of the plan document shall govern. The plan documents will be modified to reflect changes agreed to during collective bargaining.

Disputes over any of the benefits provided in the Voluntary Benefits Program will not be subject to the grievance procedure.

Sincerely,

John E. Polley
General Manager
Labor Relations

Cc: M. McAlpin
T. Caudill

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

RE: Clothing Allowance

Dear Gentlemen:

During the 2016-2021 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the clothing allowance for eligible employees in Gas Operations – Field & Systems Operation and Customer Operation organizations.

The Company agreed that for calendar years 2016, 2017 and 2018 eligible employees will continue to receive the annual clothing allowance of $275.00. Effective January 1, 2019 and for the remainder of the 2016-2021 Contract, eligible employees will be eligible to receive an annual clothing allowance of $300.00.

It is the Company's expectation that this clothing allowance will provide employees with Duke Energy identified clothing to be worn daily on the job. Employees must continue to be in compliance with established appearance guidelines and dress policies.

Very truly yours,

Lisa A. Gregory
Human Resources Principal

Cinergy Corp.
139 East Fourth Street
P.O. Box 960
Cincinnati, OH 45201-0960

April 4, 2005

Mr. Mike McAlpin
President
Local Union 12049
United Steelworkers of America
Monfort Heights Headquarters

CINERGY.
CG&E

Mr. Tim Caudill
President
Local Union 5541-06
United Steelworkers of America
Todhunter Headquarters

Re: Post-Retirement Medical Benefits

Dear Mr. Gentlemen:

During the benefits opener discussion in 2005, representatives of the Company and the United Steelworkers of America and the Locals 12049 and 5541-06 ("the Union") discussed post-retirement healthcare benefits, including providing the Union members a post-retirement health reimbursement account ("HRA") option (the "HRA Option"). As a result of these discussions the parties agreed to the post-retirement Healthcare benefits set forth below.

I. OVERVIEW OF HRA OPTION

All current, full-time employees represented by USWA, Local 12049 and Local 5541-06 will be able to make a one-time choice during one of two windows between continuing in the current traditional post-retirement medical option (the "Traditional Option") or electing to participate in the new HRA Option described below. Employees will be required to make this election by a specified election date in 2005 or 2006. (Notwithstanding the foregoing, employees currently receiving long-term disability benefits or on a military leave of absence, will make this election when they return to active, full-time status. If they do not return to active, full-time status, they will default to the Traditional Option.) All employees hired or rehired on or after January 1, 2006 will participate in the HRA Option. Each employee who elects to participate in the HRA Option, and each employee hired on or after January 1, 2006, will be referred to as a "HRA Participant" herein.

Under the Traditional Option, eligible retirees (those who retire after attaining age 50 with five (5) years of Service, as defined in the applicable Pension Plan) are provided access to group medical coverage and a premium subsidy that varies based upon the retirees' service and classification (see detail regarding the subsidy levels attached hereto as Attachment A).

Subject to any collective bargaining obligation, the Company reserves the right to amend, modify or terminate the Traditional Option and/or the HRA Option at any time. However, amounts already credited to a HRA Participant's account will not be reduced by amendment, except to the extent necessary or appropriate to comply with changes in the law.

The benefit under the HRA Option is based on a bookkeeping account that can grow like a savings account with service and interest credits as described below. An employee who elects the HRA Option will start with an opening balance that is equal to 1/12th of $1,000 for each prior calendar month in which the HRA Participant worked at least one day for the Company. In the future, the Company will credit eligible HRA Participants with an additional 1/12th of $1,000 for each calendar month in which the HRA Participant works at least one day for the Company. The Company will also credit each eligible HRA Participant's bookkeeping account with an annual interest credit. Interest will be credited at the same interest rate as the cash balance updates as determined in August of each year, except that for the term of the current labor agreement, the interest rate will not be less than 3.5%; for 2005, the rate is 5.06%. Except as discussed below, only HRA Participants who are active, full-time employees and work at least one day in the month are eligible for the monthly service credit. Like retirees in the Traditional Option, HRA Participants will have access to group medical coverage only if they retire after attaining age 50 with five (5) years of Service (as defined in the applicable Pension Plan), however, there will be no subsidy. Please note the following regarding the HRA Option:

a. If a HRA Participant retires after attaining age 50 with five (5) years of Service (as defined in the applicable Pension Plan), the amounts credited to the HRAs generally can be used for the qualified medical expenses, as defined in Section 213(d) of the Internal Revenue Code, of the retiree and the retiree's spouse and eligible dependents See IRS publication 502 (Attachment B) for examples of qualified medical expenses. To the extent permitted by applicable law and as is otherwise practicable, the HRA option is intended to provide a tax-free benefit. Due to future law changes, however, there can be no assurance of favorable tax treatment.

b. Except as provided below, if the employment of a HRA Participant terminates prior to attaining age 50 with five (5) years of Service (as defined under the applicable Pension Plan), the HRA Participant forfeits all amounts credited to the HRA Account.

c. If a HRA Participant dies while actively employed prior to attaining age 50 with five (5) years of service (as defined in the applicable Pension Plan), the HRA Participant forfeits all amounts credited to the HRA Account.

d. If a HRA Participant dies while actively employed after attaining age 50 with five (5) years of Service, his/her spouse and eligible dependents will be entitled to use amounts credited to the HRA to pay qualified medical expenses immediately.

e. In the event of disability or leave, the Company will continue monthly service credits for the first 12 months. The Company will continue interest credits while the HRA Participant is disabled or on leave (and prior to recovery or retirement). For HRA Participants on a military leave, service credits and interest credits will continue for the full qualified leave period.

f. If the employment of a HRA Participant is involuntarily terminated in connection with an involuntary reduction in force and such termination is in no way related to performance deficiencies, the HRA Participant will be eligible to maintain his/her HRA balance as of termination. The HRA Participant will be able to use amounts held in his/her HRA Account immediately following the termination.

g. For the term of the current Collective Bargaining Agreement, the Company will agree not to amend, modify or terminate retiree health care benefits for any active employees covered by the CBA. Amounts credited to a HRA Participant's account will not be reduced by amendment, except to the extent necessary or appropriate to comply with changes in the law.

II. QUESTIONS

Set forth below are responses to some of the questions regarding the HRA Option raised in previous meetings.

1. Will the Company offer choice to all USWA employees?

A: Yes. The Company will allow all current, full-time employees to elect to stay in the Traditional Option or switch to the HRA Option. After January 1, 2006, new hires and rehires will automatically participate in the HRA Option.

2. Will an employee be able to elect the HRA Option upon retirement?

A: No. Employees will be able to make a one-time election in 2005 or 2006. Current employees will have one affirmative choice during one of two open windows, the first in 2005 with the choice to be effective 1/1/06 or one in 2006 to be effective 1/1/07.

3. Can a HRA Participant withdraw amounts credited to his/her HRA account in cash upon retirement? Can the Company pay the amount out in a lump sum?

A: Money may be withdrawn from the HRA account only for paying qualified medical expenses. The account will not be paid out in cash. Favorable tax treatment is available for a HRA only if the HRA reimburses medical expenses as defined in Section 213(d) of the Internal Revenue Code. As stated below from IRS Notice 2002-45, any right to receive cash will disqualify the HRA from receiving favorable tax treatment.

"An HRA does not qualify for the exclusion under § 105(b) if any person has the right to receive cash or any other taxable or non-taxable benefit under the arrangement other than the reimbursement of medical care expenses. If any person has such a right under an arrangement currently or for any future year, all distributions to all persons made from the arrangement in the current tax year are included in gross income, even amounts paid to reimburse medical care expenses. For example, if an arrangement pays a death benefit without regard to medical care expenses, no amounts paid under the arrangement to any person are reimbursements for medical care expenses excluded under § 105(b)... Arrangements formally outside the HRA that provide for the adjustment of an employee's compensation or an employee's receipt of any other benefit will be considered in determining whether the arrangement is an HRA and whether the benefits are eligible for the exclusions under §§ 106 and 105(b). If, for example, in the year an employee retires, the employee receives a bonus and the amount of the bonus is related to that employee's maximum reimbursement amount remaining in an HRA at the time of retirement, no amounts paid under the arrangement are reimbursements for medical care expenses for purposes of § 105(b)..."

4. **What happens to the HRA balance upon disability or extended leave from the Company?**

   A: See Section I(e).

5. **What happens to the HRA balance in the event of a termination of employment?**

   A: See Section I.

6. **What happens to the HRA balance if I die while actively employed?**

   A: See Sections I(c) and I(d). Currently, the spouse and eligible dependents of an employee who dies while actively employed with Cinergy can elect to become covered under the non-union medical plan and receive subsidized coverage at the active employee rate until death or a disqualifying event (for the spouse, this would include, but not be limited to, remarrying or becoming Medicare eligible; for an eligible dependent, it would include, but not be limited to, ceasing to qualify as an eligible dependent due to age).

7. **Will the Company contributions be indexed in future years (e.g., indexed to the trend line for health care costs)?**

A: No. At this time, we do not plan to align our service credit or interest credit to any index. However, the Company will continue to evaluate its crediting levels. Subject to any collective bargaining obligations, the Company reserves the right to make adjustments, including increasing, decreasing or discontinuing credits unilaterally.

8. **Will the opening HRA balances be calculated with retroactive interest crediting?**

A: No. Making retroactive interest credits would be cost prohibitive from the Company's perspective.

9. **What are other companies doing with regards to post-retirement healthcare?**

A: See Hewitt survey (Attachment C) (51% of survey respondents have a unionized workforce).

10. **How can HRA Participants use amounts credited to the HRA?**

A: Money credited to a HRA can be used to reimburse the HRA Participant for medical expenses as defined in Section 213(d) of the Internal Revenue Code. See IRS publication 502 for examples of qualified medical expenses.

11. **Who will administer the HRA account balances?**

A: Hewitt Associates will track the HRA credits while HRA Participants are actively employed. The Company is reviewing proposals from third party administrators for post-retirement administration, but this will likely be Hewitt Associates.

12. **Will the HRAs be protected/guaranteed?**

A: The benefit under the HRA option is based on a bookkeeping account and is not funded like a 401(k) plan. See Section I regarding the Company's ability to amend.

13. **If the Company decides to eliminate the Traditional Option at a later date, would employees be allowed to get in the HRA?**

A: The Company periodically evaluates its benefit programs and would determine the appropriate course of action at that time.

14. **Would interest on the HRA account continue to accrue after an employee retires?**

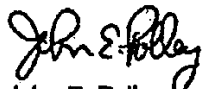
A: See Section I.

15. If two Cinergy employees are married, can they make different elections with respect to the HRA Option?

A: Yes, one could elect to remain in the Traditional Option, and the other could elect the HRA Option; if they remain married during retirement and so elect, they would receive subsidized coverage under the Traditional Option and have access to amounts credited to the HRA on behalf of the other spouse. Regardless, the elections are independent of each other.

Please note that the explanation set forth above merely summarizes the basic elements of the HRA Option. The Company has fully documented the Health Reimbursement Account Program in the "Cinergy Corp. Post-Retirement Health Reimbursement Account Program" which governs the terms of the Plan as adopted by the Company.

Very truly yours,



John E. Polley
General Manager
Labor Relations

cc: T. Verhagen
P. Gibson
K. Feld
C. Riggs

Attachment A

Summary of Post-Retirement Health Care Options

Current Post-Retirement Health Care Option

Employees hired before January 1, 2006, who elect the subsidy option and who retire from the company on or after age 50 with at least five years of service, may be entitled to a post-retirement health care subsidy from the company dependent on their years of service at retirement.

Subsidy Schedule:

Service at Retirement	(Pre-65 only)
30+	50%
29	45%
28	40%
27	35%
26	30%
25	25%
24	20%
23	15%
22	10%
21	5%
20	0%
19	0%
18	0%
17	0%
16	0%
15	0%
14	0%
13	0%
12	0%
11	0%
10	0%
9	0%
8	0%
7	0%
6	0%
5	0%

DUKE ENERGY®

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

RE: Special Union Wide Lump Sum Opportunity

Dear Gentlemen:

During the 2016 contract negotiations, the parties discussed a special union wide lump sum opportunity for the Union's participation in the Accelerated Service Replacement Program (ASRP). It was agreed that employees will be eligible for a 0.5% lump sum bonus based on achieving the ASRP completion targets established each year by the Company for 2017, 2018, 2019, 2020 and 2021, with the payout to be issued in the following calendar year.

The opportunity for this payout begins in 2018 for 2017 calendar year performance, continues in 2018, 2019, 2020 and concludes in 2022 for 2021 calendar year performance. The Company will determine any appropriate payout for each year. The payout amount will be calculated based on all straight time and overtime earnings for the applicable year, and will be paid as a lump sum, less applicable taxes.

In the event the ASRP does not receive utility commission approval or the Program is completed prior to 2021, the Company will continue to provide the special union wide lump sum opportunity for the remainder of the existing labor agreement, provided the Union participates in all Company sponsored programs.

Sincerely,

Lisa A. Gregory
Human Resources Principal

Duke Energy

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

June 3, 2011

Mr. Ronnie Wardrup
Staff Representative
United Steelworkers
Local Nos. 12049 and 5541-06
13 Triangle Park Drive
Building 13, Suite 1301
Cincinnati, Ohio 45246

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

Mr. Mike McAlpin
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

Re: Health Care Security

Dear Gentlemen:

During the 2011 contract negotiations, representatives of the Company and the USW and its Locals 12049 and 5541-06 (the "Union") discussed the issue of health care security for bargaining unit employees.

As a result of those discussions, the Company understands the Union's concerns over health care uncertainty, particularly given recent health care reform legislation and the potential impact of the Company's planned merger with Progress Energy. In turn, it is hoped that the Union recognizes the high value that the Company places on safety, wellness, and the overall well-being of all employees. We are making investments in educating and engaging our employees in improving and managing their health. The Union should be assured that providing quality health care coverage options for all employees aligns with our health and wellness strategy and promotes safety in the workplace. In addition to its value to safety and wellness, health care coverage also adds great value to our recruitment and retention of high quality employees.

Assuming the merger is completed with Progress Energy later this year, the combined company is expected to have more than 25,000 employees across the country. As a Fortune 500 company and the soon-to-be largest investor-owned utility in the United States,

the Company takes its responsibilities to its employees and their families very seriously. Given the level of importance of health care to the Company's priorities and brand, the Company intends to ensure that employees have access to comprehensive healthcare coverage options now and in the future.

The Company also plans to continue its annual review of health care options to determine if any revisions are appropriate given our demographics, legislative and regulatory developments, and any changes in the marketplace. Any material changes determined by the Company will be planned to take effect on January 1 of a calendar year. The Company recognizes that it would be administratively burdensome to increase the frequency of such reviews, and the Company has no current plans to make material changes to health care coverage options or benefit levels that are effective other than on January 1 of a calendar year.

It is unlikely that the Company would feel compelled to completely discontinue offering company-sponsored health care coverage options under the current laws. Because the impact of the planned government-sponsored health care exchanges and other possible legal developments are unknown at this time, in the unlikely event that the Company's current intent changes regarding the discontinuation of all company-sponsored health care coverage, the Company will notify the Union in advance and bargain over the complete elimination of company-sponsored health care coverage, even though the company-sponsored coverage likely would be replaced by government-sponsored coverage or USW-sponsored coverage. In that event, if the Union believes that the USW-sponsored plans are more competitive or would offer greater benefits desired by the membership, the Company would be willing to negotiate with the Union over a potential move for USW members to the USW-sponsored plans. The Company also will notify the Union in advance in the unlikely event that the Company changes its current intent to make material changes to health care coverage options effective on a date other than January 1 of a calendar year so that the parties can discuss the issue and any concerns. Again, the Company views health care coverage as vital to the success of its business due to its impact on safety, wellness, recruitment, retention, our image and reputation, and the overall well-being of our employees and their families.

The Company understands the Union's concerns with respect to health care coverage for its members. This letter shall apply for the duration of the 2011- 2016 collective bargaining agreement between the Company and the Union. It is the intent of this letter to demonstrate the Company's willingness to consider and discuss those concerns.

Very truly yours,



Jay R. Alvaro
Vice President, Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

Mr. Mike McAlpin
President
Local 12049
United Steelworkers
Monfort Heights Headquarters

Re: Gas Operations Promotional Sequences and New Position

Dear Gentlemen:

During the 2011 – 2016 Contract negotiations, representatives of the Company and United Steelworkers and its Locals 12049 and 5541-06 (the Union) discussed revisions to progression sequences with Gas Operations, and the creation of a new entry level job classification. As a result of these discussions, the revised "Gas Operations Promotional Chart" ("Chart") is attached.

Under the new Chart, the Mechanic III entry level position will have direct bidding rights to three different lines of progression: Meter Specialist III (Local 12049 only), Gas Systems Operations Mechanic III, and/or Gas Plant Operator III. Mechanic IIIs may apply for other positions in the Company, but shall not have direct bidding rights to any position other than as set forth in this Letter.

Similarly, DNP Workers will have direct bidding rights to the Premise Mechanic progression or the Meter Specialist III progression (Local 12049 only). In the event that the Company is unable to fill Premise Mechanic or Meter Specialist III positions with DNP Workers, the Company reserves the right to fill those positions as entry level positions. DNP Workers may bid on other positions in the Company, but will not have direct bidding rights to any other position other than as set forth in this Letter.

For the Mechanic Operator III progression, the Company will create a new entry level position for "Apprentice Mechanic Operator III (AMO3)". The Company and the Union

will negotiate a special wage rate for the newly created AMO3 position. In the event agreement cannot be reached, the AMO3 will be evaluated pursuant to Article V, Section 1, (h)-(m) of the Contract. The newly created AMO3 position will have direct bidding rights to the Mechanic Operator III progression exclusively.

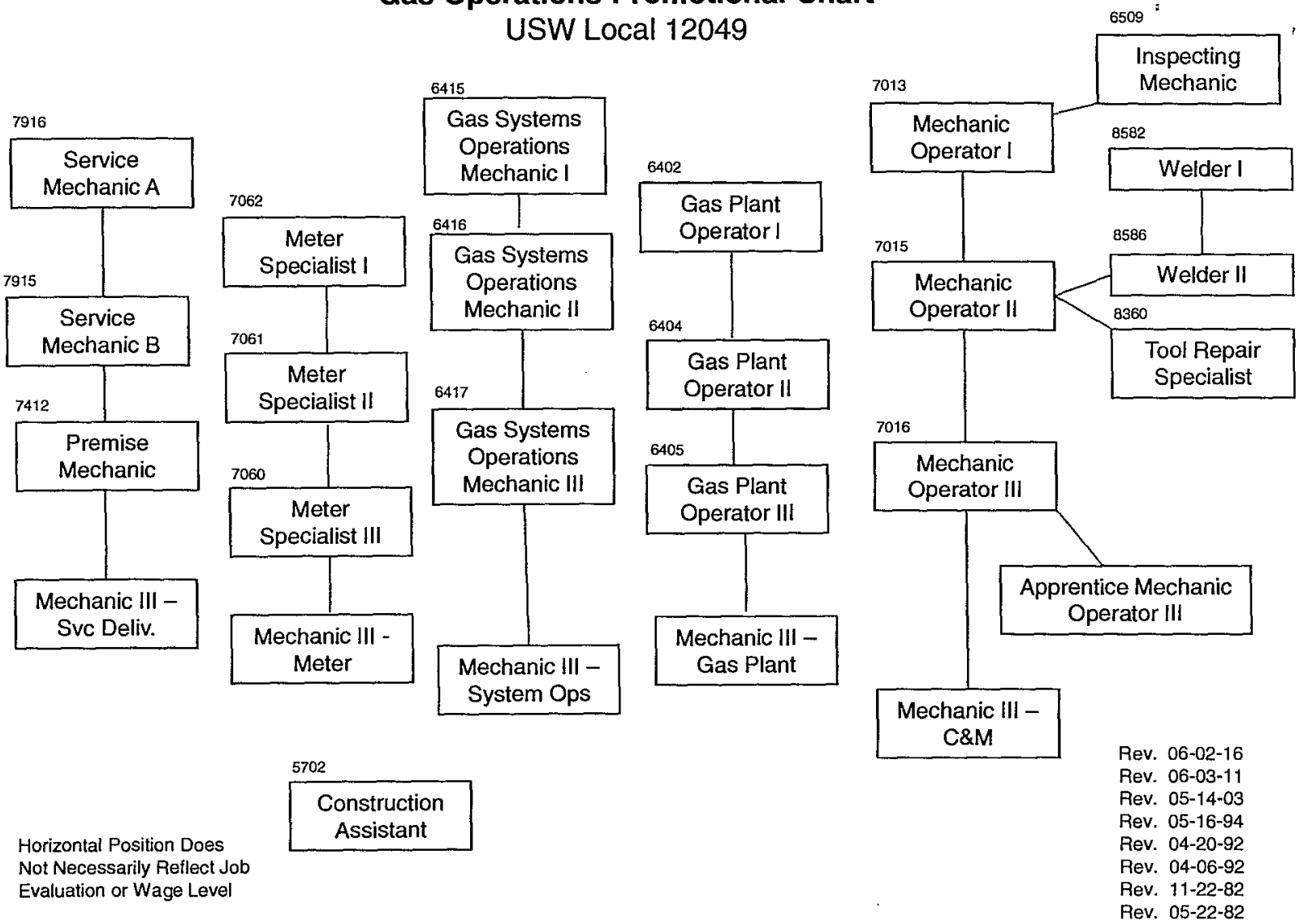
The parties recognize and acknowledge that the former positions for Mechanic (6931) and Senior Mechanic (7890) are no longer in use and therefore eliminated from the Chart.

Very truly yours,

Lisa A. Gregory
Human Resources Principal

Gas Operations Promotional Chart

USW Local 12049

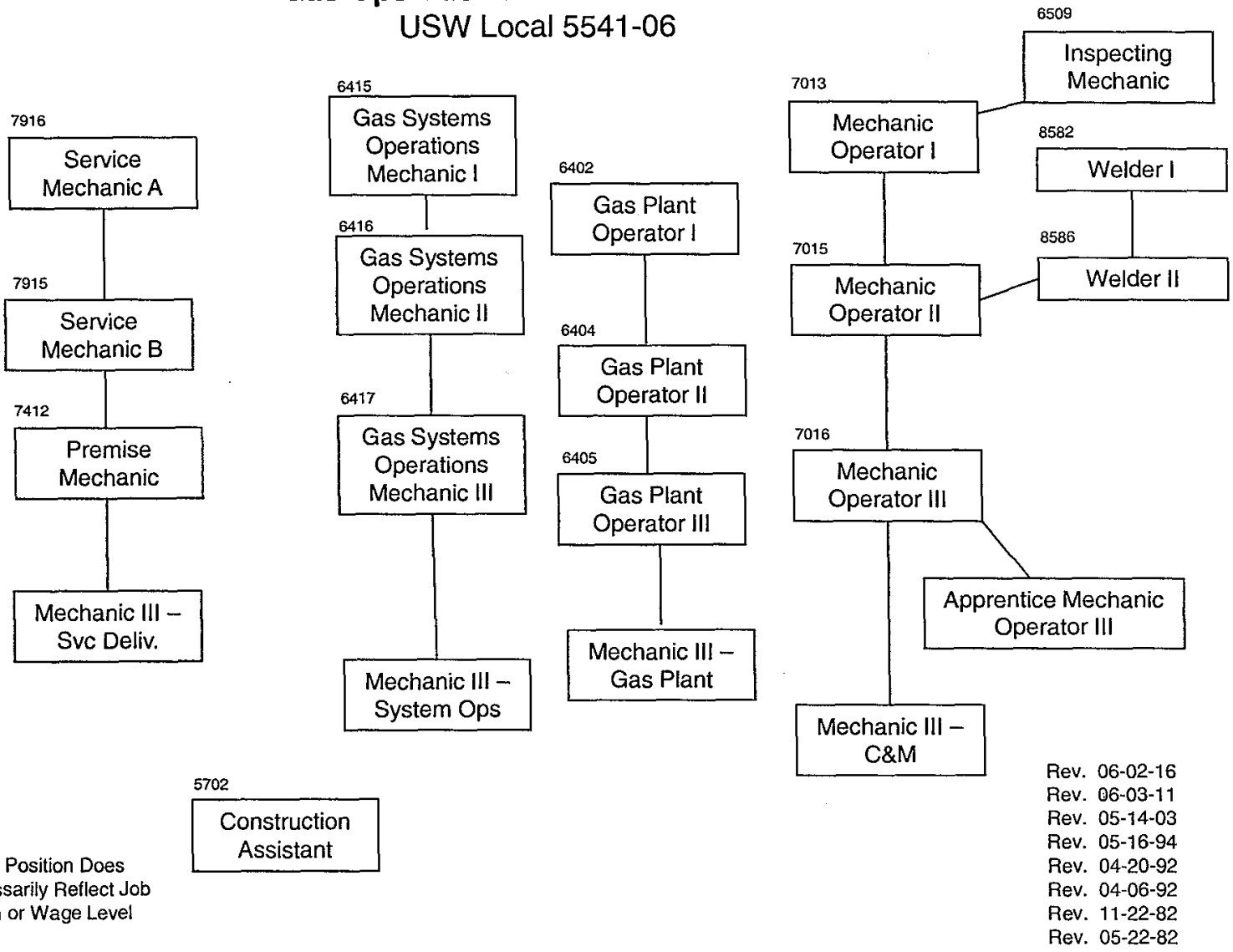


Horizontal Position Does Not Necessarily Reflect Job Evaluation or Wage Level

Rev. 06-02-16
Rev. 06-03-11
Rev. 05-14-03
Rev. 05-16-94
Rev. 04-20-92
Rev. 04-06-92
Rev. 11-22-82
Rev. 05-22-82

Gas Operations Promotional Chart

USW Local 5541-06



Horizontal Position Does Not Necessarily Reflect Job Evaluation or Wage Level

Rev. 06-02-16
Rev. 06-03-11
Rev. 05-14-03
Rev. 05-16-94
Rev. 04-20-92
Rev. 04-06-92
Rev. 11-22-82
Rev. 05-22-82

Schedule Replacement Guidelines

(Applies to USW Local 12049)

When a temporary vacancy occurs in the schedule, the following replacement procedure will be used to fill the vacancy.

The person selected to fill the vacancy will be determined by counting over five on the appropriate crew leader or helper schedule list.

Upon return, the individual will fulfill the next schedule of the affected member at their option, barring any extenuating circumstances.

Members electing to trade schedules shall be held responsible for the schedule after the proper paperwork is completed.

(Applies to USW Local 5541-06)

When a temporary vacancy occurs in the schedule, the following replacement procedure will be used to fill the vacancy.

A Crew Leader vacancy is to be filled with the junior qualified Mechanic Operator I regardless of placement on schedule listing.

A Helper vacancy is to be filled with the junior qualified Helper regardless of placement on schedule listing.

The person causing the vacancy in the shift will be required to work the shift of the person assigned to their shift.

(Applies to USW Local 12049 and 5541-06)

When a permanent vacancy occurs in the schedule, the following replacement procedure will be used to fill the vacancy.

A Crew Leader vacancy is to be filled with the junior qualified Mechanic Operator I regardless of placement on schedule listing.

A Helper vacancy is to be filled with the junior qualified Helper regardless of placement on schedule listing.

In the event a vacancy cannot be filled by the process described above, the Union and the Company will meet to discuss and resolve.

Home Site Reporting Guidelines
June 2, 2016

(Field Operations, Gas Measurement Center, Contractor Construction, Corrosion, System Operations, Gas Production and Service Delivery)

Company Vehicles:

Effective January 1, 2017, employees who home site report and are assigned a Company vehicle, will be required to live within 40 air miles of their assigned headquarters. In this case, vehicles can be parked at the employee's residence. If an employee lives beyond 40 air miles of their assigned headquarters, they will be required to leave the vehicle at the closest Headquarters or agreed upon location for pick-up each day. (Example: Headquarters closer to the residence than reporting headquarters)

Reporting Time:

When reporting within the area of the assigned headquarters, start time is on the job site at the start of the shift.

When reporting outside of the area of the assigned headquarters, start time is on the job site no longer than 30 minutes after the start of the shift.

Quitting Time:

When quitting from the job site within the area of the assigned headquarters, it is permissible to leave the site no earlier than 15 minutes prior to the end of the shift.

When quitting from the job site outside the area of the assigned headquarters, it is permissible to leave the site no earlier than 30 minutes prior to the end of the shift.

Employees are expected to be available until the end of their shift.

Meetings:

For training or Company meetings , employees shall report to the headquarters directed by the Supervisor at the start of the shift.

Inclement Weather

During periods of inclement weather employees with an assigned route or geo-grid will typically remain in the field within their assigned area unless directed by their Supervisor to report to a different work location.

Employees who do not have an assigned area or geo-grid nor any work to perform, should report to the District at the start of their shift unless directed otherwise by Management.

When on Vacation or other leave:

The vehicle shall be left at the regular parking location or brought to the headquarters as determined by the Company. The assigned driver shall notify the Supervisor and provide access to the vehicle. The assigned driver shall also arrange with the Supervisor when he/she will pick up the vehicle upon or prior to returning to duty.

When on Schedule (excludes Service Delivery):

The vehicle shall be left at the regular parking location or brought to the headquarters as determined by the Company.

Duke Energy.

February 25, 2013

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

Mr. John Waits
President
Local 12049
United Steelworkers
Eastern Avenue Headquarters

Re: Apprentice Mechanic Operator III

Dear Gentlemen:

Reference is made to the committee efforts and discussions between the parties pertaining to the new Apprentice Mechanic Operator III position.

As agreed to in the 2011-2016 negotiations, this newly created position is the starting position for the Mechanic Operator line of progression. The attached job description outlines the duties and qualifications of the position. The parties have agreed that the job will be set at a wage level VI in lieu of using the formal job evaluation process as is outlined in the contract (Article V, Section 1, (h)-(m).

All employees entering into the Apprentice Mechanic Operator III position will be employed with the understanding that they must successfully promote to the Mechanic Operator II position within the timeframes outlined. Specifically, it is expected that employees entering into the Apprentice Mechanic Operator III position, will have successfully completed all the training and received the necessary licenses and/or certifications to be able to qualify to promote to the Mechanic Operator III position within a period of 12 months. At a minimum, failure to qualify for this purpose would include situations where two successive written examinations or two successive practical demonstrations were not passed. Employees will be allowed a maximum time period of three months between the two successive examinations and/or demonstrations.

In addition, it is expected that employees entering into the Mechanic Operator III position, will have successfully completed all the training and received the necessary licenses and/or certifications to be able to qualify to promote to the Mechanic Operator II position within a period of 24 months. At a minimum, failure to qualify in this case would include situations where two successive written examinations or two successive practical demonstrations were not passed. Employees will be allowed a maximum time period of three months between the two successive examinations and/or demonstrations.

If an employee is not able to complete the required training within the timeframes outlined above due to the Company not being able to schedule the appropriate classes, the Company will accommodate those delays by extending the time period to promote by the time the start of the class was delayed.

The employment of any individual who does not successfully meet the requirements to promote to the Mechanic Operator III or Mechanic Operator II position will be terminated.

Very truly yours,

Lisa A. Gregory
Director, Labor Relations

cc: G. Hebbeler
S. Farley
D. Smiley

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.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

Mr. Steve Bowermaster
President, Local No. 5541-06
United Steelworkers
Todhunter Headquarters

Mr. John Waits
President, Local No. 12049
United Steelworkers
Valley View Headquarters

Re: Safety Shoe Policy

Dear Gentlemen:

During the 2016 negotiations, the Company and the Union agreed to memorialize the Safety Shoe Policy rolled out in 2014 for eligible employees in the Gas Operations – Field & Systems Operation and Customer Operation organizations describing appropriate footwear to be worn by employees and an annual reimbursement amount.

Eligible employees, as determined by the Company, will be reimbursed up to $150.00 for the purchase of one pair of safety shoes per year that comply with the Company standards. Newly hired employees into one of the above referenced organizations also will be eligible for this reimbursement. Employees will not be eligible for this reimbursement if they were previously provided reimbursement by the Company for safety shoes under this or another program to ensure that there is no duplication or stacking of benefits for this purpose.

Employees will be expected to purchase and wear footwear that meets the requirements for the type of work they are required to perform. The protective footwear must comply with the following standards: over the ankle foot support, a reinforced toe cap (when performing certain job duties) and a well-defined heel. Footwear must meet an impact resistance rating of 75 pounds and have a compression resistance rating of 75 or 2,500 pounds. Shoes can be purchased at a vendor of the employee's choosing. Prior to reimbursement, the employee is required to provide a copy of the receipt and also proof that the boots meet the safety standards. Employees who damage their boots during normal work activities, should contact their Supervisor immediately, to discuss boot replacement options. Violations of this footwear policy could result in corrective action up to and including discharge.

Sincerely,

Jay R. Alvaro
Director, Labor Relations

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Global Positioning Satellite (GPS) Technology

Dear Gentlemen:

This letter documents our discussions and agreement concerning the use of Global Positioning Satellite (GPS) system and other similar types of technology being contemplated for use within Gas Operations.

The primary purpose of the GPS and similar technology is to allow the Company the ability to more efficiently manage and assign work and to enhance safety by allowing us to locate a vehicle in the event we have lost contact with someone or a vehicle has been stolen. As discussed, it is not the Company's intent to constantly monitor employee's whereabouts using the GPS or other technology for purposes of issuing corrective action.

Although its primary use is for managing work, the Company may review and rely on technology and/or the information obtained through its use to aid in an investigation where there is reason to believe an employee may have violated a Company policy or work rule, and the violation may be substantiated or disproven by such a review. To the extent the Company does rely on such information, the Company will treat similarly-situated employees in the same manner. Any such information, upon which the Company relies for purposes of imposing corrective action, will be provided upon request by the Union in accordance with applicable law.

The Company will endeavor to limit the history used in these systems to a maximum of 90 days for any type of disciplinary action.

This letter will be interpreted and applied to comply with all laws. To the extent that this letter conflicts with any applicable law, the law will prevail.

Sincerely,

Gary J. Hebbeler
GM, Gas and Field Systems

cc: L. Gregory
C. Lange

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Seniority Departments

Dear Gentlemen:

During the 2016 – 2021 Contract negotiations, representatives of the Company and the United Steelworkers and it's Locals 12049 and 5541-06 (the Union) discussed changes to certain seniority Departments, Divisions and Sections. This letter documents our discussions and agreements.

As was agreed, effective June 1, 2016, the Departments, Divisions and Sections for Local Union 12049 will be modified such that Field Operations will consist of a combined Ohio/Kentucky Seniority District. Similarly Service Delivery will be modified to consist of a combined Ohio/Kentucky Seniority District.

As of the date of this letter, employees currently in the Field Operations Kentucky seniority district or the Service Delivery Kentucky seniority district in the Mechanic Operator II, Mechanic Operator I, Inspecting Mechanic, Service Mechanic B, or Service Mechanic A job classification, will remain in the respective Kentucky seniority district (see attached list). In addition, the employees in the Service Delivery Kentucky seniority district, will continue to maintain seniority for the purpose of assigning work (i.e. bidding routes) over employees in the newly combined Service Delivery Ohio/Kentucky seniority district.

Employees in the Mechanic Operator II and Service Mechanic B job classifications, will have exclusive rights to the next promotional bid in the Kentucky district within their job hierarchy. For example, a Mechanic Operator II in the Kentucky seniority district, will have seniority for the next Mechanic Operator I opportunity in the Kentucky seniority district.

Should those employees remaining in the Kentucky seniority district within Field Operations or Service Delivery elect to change their current job (i.e. downbid) they will be placed in the appropriate combined department and seniority list.

Any employees bidding or downbidding into Kentucky, in Field Operations or Service Delivery, after June 1, 2016, will be placed in the combined Field Operations (Ohio/Kentucky) or Service Delivery (Ohio/Kentucky) department and seniority unit.

Any future job openings within the Inspecting Mechanic job classification in Kentucky will be filled based on the combined seniority list of all qualified employees in the Field Operations (Ohio/Kentucky) seniority unit.

Effective June 1, 2016, one seniority list will be maintained within Local 12049 for the Field Operations (Ohio/Kentucky) Department and one list for the Service Delivery (Ohio/Kentucky) Department for all future job opportunities.

In the event of a surplus in Kentucky, Denny Caple, Hans Butsch and Craig Rittinger will retain their original classified seniority date as indicated below:

Denny Caple 4/01/2002
Hans Butsch 5/27/2002
Craig Rittinger 5/22/2008

It is believed that this letter properly describes the agreement reached between the parties concerning this matter.

Sincerely,

Lisa A. Gregory

Lisa A. Gregory
Human Resources Principal

cc: Chuck Allen
Terri Barnes
Gary Hebbeler

Current Field Operations Kentucky District Employees

Name	Job Title	Classified Seniority Date
Kevin Anthony Hall (031970)	Inspecting Mechanic	5/13/2002
James McDermott Jr. (054120)	Inspecting Mechanic	2/18/2008 (02)
Robert Allen Cooper (018361)	Inspecting Mechanic	1/4/2016
Patrick Glenn (028445)	Mechanic Operator I	10/10/1988 (03)
Walter Kevin Montgomery (058180)	Mechanic Operator I	3/13/1989 (01)
Michael J. Highhouse (037512)	Mechanic Operator I	7/29/2002 (02)
Russell D. Routt (070160)	Mechanic Operator I	8/26/2002 (03)
Glenn D. Poston (064863)	Mechanic Operator I	11/25/2002
Michael D. Allen (017446)	Mechanic Operator I	9/5/2006 (02)
Denny J. Caple (018163)	Mechanic Operator I	11/17/2014 (01)
Hans J. Butsch (018116)	Mechanic Operator I	09/28/2015 (02)
Craig A. Rittinger (096798)	Mechanic Operator I	04/11/2016 (02)
Christopher M. Thomas (095389)	Mechanic Operator II	7/20/2011 (03)
Brian Waters (087845)	Welder I	11/28/2011

Current Service Delivery Kentucky District Employees

Jeffrey Paul Bucher (018023)	Service Mechanic A	5/9/1994 (01)
Michael E. Johnson (042203)	Service Mechanic A	4/29/1996
Douglas Duryea (021750)	Service Mechanic A	4/5/2015
Robert L Gebhardt (026857)	Service Mechanic B	9/26/2011 (02)
David A. Harms (033300)	Service Mechanic B	9/26/2011 (03)
Eric A. Leedy (048630)	Service Mechanic B	06/10/2013
Gerald Joseph Schack (071853)	Service Mechanic B	08/04/2014 (01)
Jerry William Harris (033635)	Service Mechanic B	08/04/2014 (02)
Michael J. Hertzenberg (036884)	Service Mechanic B	08/04/2014 (03)
Marc D. King (044792)	Service Mechanic B	08/04/2014 (04)
Michael Anthony Baynum (017662)	Service Mechanic B	12/10/2014 (01)
Robert W. Winterman (091847)	Service Mechanic B	12/10/2014 (02)
Jeff Berkemeier (017723)	Service Mechanic B	01/25/2016 (01)
Ryan Moore (096039)	Service Mechanic B	01/25/2016 (02)

DUKE ENERGY®

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Work Hours Beyond Normal Scheduled Shift

Dear Gentlemen:

This letter documents our discussions related to rest periods allowed by employees after they have worked extended hours due to Company needs.

Pursuant to previous Company Protocol Group guidelines, as revised in 1999, the Company will continue to follow the guideline stating that any employee required to work as a result of an emergency callout, will be permitted six (6) hours rest, which includes travel time, before being required to report to their next scheduled shift. This guideline does not establish start or release times or limit managements right to hold employees over during emergency situations.

It is believed that this letter properly describes the agreement reached between the parties concerning this matter.

Sincerely,

Lisa A. Gregory

Lisa A. Gregory
Human Resources Principal

cc: Chuck Allen
Gary Hebbeler

DUKE ENERGY®

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Emergency Work Outside of Ohio/Kentucky Service Territory

Dear Gentlemen:

This letter documents our discussions and agreement concerning emergency work performed outside of the Ohio/Kentucky service territory. The following guidelines will apply when employees represented by USW 12049 or 5541-06, are called upon to work outside of the Ohio/Kentucky service territory in emergency situations.

For continuous emergency work performed at any location or facility owned and/or operated by the Company, or its parent and related subsidiaries/affiliates, that requires a lodging stay away from home, on the first day of the assignment the straight time rate will be paid during regular working hours and the time and one-half rate will be paid for hours of continuous work over the regularly scheduled hours. Beginning with the second day of such an assignment, the rate of time and one-half will be paid for all hours worked.

Time and one-half shall be paid for all emergency time worked for other utilities at their respective operating locations.

Compensation Guidelines:

- Compensation when traveling begins when the employee begins driving toward their destination and ends when the employee arrives at the final destination of the day.

- When employees reach their destination and are to begin work, compensation will begin when the employee leaves the host Company staging area. If the staging area is away from the place of lodging and crews have to be transported to the staging area, then time begins when the employee leaves the place of lodging.
- Compensation ends for the work day when the employee returns to the host Company's staging area. If the staging area is away from the place of lodging and crews have to be transported, then the time will stop when the employee returns to the place of lodging.
- Employees required to work ten consecutive hours or more, shall be furnished a meal or compensation in lieu thereof (in accordance with the Contract), and an additional meal or compensation in lieu thereof, for each contiguous five hour interval worked thereafter until released from duty.
- Employees are not eligible to receive a daily per diem allowance.
- After 16 consecutive hours of work, Article VII, Section 1(i) will continue to apply.

Crew Assignments:

- The duration of the each employee's deployment will be for no longer than two weeks. It is the intention of the Company to rotate crews in and out of deployments. Employees deployed for an initial time period may become eligible for a second deployment after serving at least one rotation back at their regularly assigned location or if there are no other volunteers.
- Management will determine which Districts will be eligible to participate in a deployment, and the number of employees and crews from each of the Districts. Management will post a sign-up sheet, if time allows, at each eligible District for employees to volunteer no later than the deadline communicated or attempt to contact employees by low overtime to solicit volunteers, if time does not allow. Management will determine the appropriate make-up of the crew.
- If there are excess volunteers, the Company will select employees to be deployed based on low overtime. In the event of an insufficient number of volunteers, the Company will assign employees to the deployment based on low overtime but will consider extenuating circumstances.
- If an employee is on a rotating shift schedule, as determined by the Company, at the start of a deployment period, the employee will not be eligible to participate in the deployment, either voluntarily or by assignment.
- An employee will not be eligible for this opportunity if there are disciplinary issues.
- During their deployment, employees are expected to comply with the Duke Energy Code of Business Ethics and related policies and procedures.

This letter will be interpreted and applied to comply with all laws. To the extent that this letter conflicts with any applicable law, the law will prevail. The current Contract will remain in effect for issues not addressed herein.

Sincerely,

Gary J. Hebbeler
GM, Gas and Field Systems

cc: L. Gregory
C. Lange

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

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

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

Re: Welders Returning to C&M

Dear Gentlemen:

This letter documents our discussions and agreements related to employees in the Welder job classification who are returned to Construction & Maintenance.

If the Company determines that it is necessary for a Welder to return to Construction and Maintenance, that person will return to the Mechanic Operator position that they vacated at the District from which they were promoted/down bid or its replacement. Welders will maintain all of their current accrued seniority as a Welder, if they are returned to a Mechanic Operator position.

In addition, Welders being returned to a Mechanic Operator position, will return at their current rate of pay. If the employee's current rate of pay exceeds the maximum for the job classification they are returning to, the employee will have their pay redlined, until the Mechanic Operator I or II wage rate increases to the point of surpassing the Welder pay. At that time, the person would again be eligible to receive a wage increase up to the maximum rate of pay for the Mechanic Operator I or II.

It is believed that the procedures outlined in this letter properly describe the agreement reached between the parties concerning this issue.

Sincerely,

Lisa A. Gregory
Human Resources Principal

A-90

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

Mr. Steve Bowermaster
President, Local No. 5541-06
United Steelworkers
Todhunter Headquarters

Mr. John Waits
President, Local No. 12049
United Steelworkers
Valley View Headquarters

RE: 2016-2021 Post Retirement Healthcare Letter

Dear Gentlemen:

During the 2016 negotiations, the parties discussed post-retirement healthcare benefits. This letter amends the Retirement Plan and HRA Conversion Sidebar Letter A-71 dated August 1, 2007, as amended by Sidebar Letter A-71a dated June 3, 2011, and the Post Retirement Medical Benefit Sidebar Letter A-76 dated April 4, 2005, and confirms these discussions and the resulting agreement.

Access to Post-Retirement Health Benefits

Employees who terminate on or after November 1, 2016 after attaining at least age 50 with at least 5 years of service will have unsubsidized access (i.e., no Company contributions) to post-retirement medical, dental, and vision coverage. Coverage for retirees age 65 and older will be provided on an unsubsidized basis through a Medicare Coordinator. The Company shall provide a subsidy/contribution towards the cost of post-retirement health coverage only as provided below in this letter.

Subsidies/Company Contributions - Traditional Option

For employees who terminate on or after November 1, 2016, the "Traditional Option" is hereby amended to provide contributions towards the cost of post-retirement healthcare coverage, in the form of credits to a newly established Subsidy Health Reimbursement Account ("Subsidy HRA") only for individuals who are under age 65 and who are:

- In a group eligible for a medical subsidy under the rules in effect prior to November 1, 2016, which is limited to those hired prior to January 1, 2012; and
- At least age 55 with at least 10 years of service at termination of employment.

The amount of the contributions will vary as follows:

- Eligible employees age 50 or older by November 1, 2016 will receive (during retirement) a pre-65 contribution of $350 per month, plus $175 per month for their spouse/domestic partner, if any; and

- Eligible employees younger than age 50 as of November 1, 2016 will receive (during retirement) a pre-65 contribution of $250 per month, plus $125 per month for their spouse/domestic partner, if any.

Subsidies/Company Contributions - HRA Option

Effective November 1, 2016, the "HRA Option" is hereby amended such that:

- The Company will discontinue crediting 1/12 of $1,000 each month to the health reimbursement accounts for those employees who have a health reimbursement account under the HRA Option, with interest credits continuing; and

- The Company will offer a choice window in 2016 to employees who have a health reimbursement account under the HRA Option to elect whether to continue in the HRA Option (modified as described in the above bullet) or to forego their rights to their modified health reimbursement accounts under the HRA Option in exchange for participation in the Traditional Option (modified to provide credits to a Subsidy HRA as described above).

Miscellaneous

The post-retirement health benefits described above will replace the post-retirement medical coverage options in effect prior to November 1, 2016, for employees who terminate on or after November 1, 2016, including those described in Sidebar Letters A-71, 71a, and 76. These benefits will be governed by and construed in accordance with the applicable plan documents.

In all other respects, Sidebar Letters A-71,71a, and 76 shall continue in accordance with their terms.

Sincerely,

Lisa A. Gregory
Human Resources Principal

DUKE ENERGY.

Duke Energy
139 East Fourth Street
Cincinnati, OH 45202

June 2, 2016

Mr. Steve Bowermaster
President, Local No. 5541-06
United Steelworkers
Todhunter Headquarters

Mr. John Waits
President, Local No. 12049
United Steelworkers
Valley View Headquarters

RE: Amendment to A-71 "Retirement Plan and HRA Conversion Agreement"

Dear Gentlemen:

During the 2016 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 and Rehires

For employees hired or rehired on or after January 1, 2017, the Company will provide an annual Employer Retirement 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 compensation in accordance with the RSP plan documents on the same basis as employees hired or rehired prior to January 1, 2017 who are eligible for that matching contribution formula. Employees hired or rehired on or after January 1, 2017 will not be eligible to participate in the Cinergy Corp. Union Employees' Retirement Income Plan (the "Retirement Income Plan").

Cash Balance Interest Credit

The cash balance interest credit rate under the Retirement Income Plan for pay credits made on and after January 1, 2017 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.

Retirement Income Benefit for Long-Term Disability

A participant who starts receiving long-term disability benefits on or after July 1, 2017 will receive interest credits under the Retirement Income Plan's cash balance formula while disabled, but will not receive pay credits while long-term disabled, in accordance with the Retirement Income Plan documents. This change will not apply for any individual who starts receiving long-term disability benefits before July 1, 2017, or participants 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.

For purposes of clarity, as previously agreed, the Company may in its discretion merge the Retirement Income Plan into the Duke Energy Retirement Cash Balance Plan or other defined benefit plan maintained by the Company. In accordance with applicable law, any such merger will not reduce participants' accrued benefits.

The complete provisions of the Company's retirement plans are set forth in the plan documents, as amended to make administrative changes, legally-required changes and/or technical changes that do not reduce the benefits formula. 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-71 relating to retirement plan agreements.

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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-036

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 STAFF-DR-01-036 Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell
Claire C. Hudson

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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

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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
Jan-21	Union					623,978	4,929	628,907	488,838	45,651	534,489			
Jan-21	Non-Union					635,822	30,757	666,579	621,088	3,233	624,321			
			162		0	1,259,800	35,687	1,295,486	1,109,926	48,884	1,158,809	-11.9%	37.0%	-10.6%
Feb-21	Union					523,908	5,015	528,922	425,600	67,361	492,960			
Feb-21	Non-Union					640,314	31,228	671,543	631,485	3,497	634,983			
			166		0	1,164,222	36,243	1,200,465	1,057,085	70,858	1,127,943	-9.2%	95.5%	-6.0%
Mar-21	Union					507,492	6,123	513,614	430,795	64,272	495,067			
Mar-21	Non-Union					654,839	38,492	693,331	578,574	2,743	581,317			
			166		0	1,162,331	44,614	1,206,946	1,009,369	67,015	1,076,384	-13.2%	50.2%	-10.8%
Apr-21	Union					526,509	3,695	530,204	413,804	67,502	481,306			
Apr-21	Non-Union					658,557	18,864	677,421	597,720	2,450	600,170			
			162		0	1,185,066	22,559	1,207,625	1,011,524	69,952	1,081,476	-14.6%	210.1%	-10.4%
May-21	Union					531,897	3,470	535,367	389,147	87,729	476,876			
May-21	Non-Union					653,258	17,831	671,089	610,709	1,825	612,533			
			160		0	1,185,155	21,302	1,206,457	999,855	89,554	1,089,409	-15.6%	320.4%	-9.7%
Jun-21	Union					517,209	4,516	521,724	426,866	96,301	523,167			
Jun-21	Non-Union					653,744	24,296	678,040	624,146	2,203	626,348			
			162		0	1,170,953	28,812	1,199,765	1,051,012	98,504	1,149,516	-10.2%	241.9%	-4.2%
Jul-21	Union					801,544	7,715	809,259	641,417	181,974	823,391			
Jul-21	Non-Union					665,624	18,036	683,661	633,249	4,844	638,093			
			160		0	1,467,168	25,752	1,492,920	1,274,666	186,818	1,461,484	-13.1%	625.5%	-2.1%

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Aug-21	Union					535,618	5,293	540,911	435,434	105,752	541,186			
Aug-21	Non-Union					643,563	23,387	666,951	605,295	2,673	607,968			
			156		0	1,179,181	28,680	1,207,861	1,040,729	108,425	1,149,154	-11.7%	278.0%	-4.9%
Sep-21	Union					516,619	5,034	521,654	431,090	93,399	524,489			
Sep-21	Non-Union					642,279	24,240	666,519	616,617	2,286	618,903			
			152		0	1,158,898	29,275	1,188,173	1,047,707	95,685	1,143,392	-9.6%	226.9%	-3.8%
Oct-21	Union					535,864	8,254	544,118	425,203	80,554	505,757			
Oct-21	Non-Union					651,503	18,477	669,980	605,440	2,160	607,601			
			155		0	1,187,367	26,731	1,214,098	1,030,644	82,714	1,113,358	-13.2%	209.4%	-8.3%
Nov-21	Union					535,434	9,498	544,932	425,246	91,835	517,081			
Nov-21	Non-Union					677,186	30,660	707,846	601,680	2,255	603,934			
			158		0	1,212,620	40,158	1,252,777	1,026,926	94,089	1,121,015	-15.3%	134.3%	-10.5%
Dec-21	Union					785,882	8,919	794,801	589,115	129,466	718,581			
Dec-21	Non-Union					706,278	32,334	738,612	605,365	4,973	610,339			
			163		0	1,492,160	41,253	1,533,413	1,194,480	134,439	1,328,919	-19.9%	225.9%	-13.3%
YTD - 21	Union					6,941,953	72,461	7,014,414	5,522,555	1,111,795	6,634,350			
YTD - 21	Non-Union					7,882,967	308,605	8,191,572	7,331,367	35,141	7,366,508			
						14,824,921	381,065	15,205,986	12,853,922	1,146,936	14,000,858	-13.3%	201.0%	-7.9%

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jan-22	Union					538,978	53,043	592,021	497,544	63,219	560,763			
Jan-22	Non-Union					623,071	1,972	625,043	635,301	2,731	638,031			
			165		0	1,162,049	55,015	1,217,064	1,132,844	65,950	1,198,794	-2.5%	19.9%	-1.5%
Feb-22	Union					449,565	34,631	484,195	443,282	72,696	515,978			
Feb-22	Non-Union					700,548	1,972	702,520	652,729	2,615	655,344			
			165		0	1,150,113	36,603	1,186,716	1,096,011	75,311	1,171,322	-4.7%	105.8%	-1.3%
Mar-22	Union					435,791	35,147	470,938	437,243	64,232	501,475			
Mar-22	Non-Union					718,456	2,145	720,601	675,862	3,957	679,818			
			160		0	1,154,246	37,292	1,191,538	1,113,104	68,189	1,181,293	-3.6%	82.9%	-0.9%
Apr-22	Union					451,793	16,086	467,879	399,131	47,079	446,211			
Apr-22	Non-Union					733,496	1,977	735,474	709,404	5,159	714,564			
			157		0	1,185,289	18,063	1,203,352	1,108,536	52,238	1,160,774	-6.5%	189.2%	-3.5%
May-22	Union					456,464	14,355	470,819	390,983	56,800	447,783			
May-22	Non-Union					694,365	1,977	696,342	690,953	4,968	695,920			
			157		0	1,150,828	16,332	1,167,161	1,081,936	61,768	1,143,703	-6.0%	278.2%	-2.0%
Jun-22	Union					442,381	19,458	461,839	371,548	60,359	431,907			
Jun-22	Non-Union					688,136	2,508	690,644	689,286	5,689	694,975			
			157		0	1,130,517	21,966	1,152,483	1,060,834	66,048	1,126,882	-6.2%	200.7%	-2.2%
Jul-22	Union					689,494	20,513	710,007	604,925	115,631	720,556			
Jul-22	Non-Union					641,806	2,077	643,883	684,456	4,362	688,818			
			154		0	1,331,299	22,591	1,353,890	1,289,380	119,993	1,409,374	-3.1%	431.2%	4.1%
Aug-22	Union					459,951	35,954	495,904	434,769	101,637	536,406			
Aug-22	Non-Union					615,292	1,964	617,256	662,921	2,405	665,326			

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
			158		0	1,075,242	37,918	1,113,160	1,097,690	104,042	1,201,732	2.1%	174.4%	8.0%
Sep-22	Union					445,059	28,920	473,980	427,735	85,863	513,599			
Sep-22	Non-Union					613,900	2,272	616,172	645,772	3,107	648,879			
			160		0	1,058,959	31,193	1,090,152	1,073,507	88,970	1,162,478	1.4%	185.2%	6.6%
Oct-22	Union					459,834	28,193	488,027	447,104	95,195	542,300			
Oct-22	Non-Union					613,205	1,963	615,168	646,475	2,609	649,085			
			159		0	1,073,040	30,156	1,103,195	1,093,580	97,805	1,191,384	1.9%	224.3%	8.0%
Nov-22	Union					460,067	25,250	485,317	428,975	108,489	537,464			
Nov-22	Non-Union					613,432	1,963	615,394	635,176	1,627	636,803			
			161		0	1,073,499	27,212	1,100,711	1,064,151	110,116	1,174,267	-0.9%	304.7%	6.7%
Dec-22	Union					678,009	43,906	721,914	678,136	128,633	806,769			
Dec-22	Non-Union					636,765	2,394	639,159	694,446	3,757	698,202			
			159		0	1,314,774	46,299	1,361,073	1,372,582	132,389	1,504,971	4.4%	185.9%	10.6%
YTD - 22	Union					5,967,386	355,455	6,322,840	5,561,374	999,835	6,561,209			
YTD - 22	Non-Union					7,892,471	25,185	7,917,656	8,022,780	42,986	8,065,766			
						13,859,857	380,640	14,240,496	13,584,154	1,042,821	14,626,975	-2.0%	174.0%	2.7%

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jan-23	Union					420,378	36,416	456,794	527,965	47,463	575,428			
Jan-23	Non-Union					623,202	2,521	625,723	630,834	1,877	632,711			
			157		0	1,043,580	38,937	1,082,517	1,158,799	49,340	1,208,138	11.0%	26.7%	11.6%
Feb-23	Union					356,051	29,141	385,192	450,996	72,741	523,737			
Feb-23	Non-Union					637,414	2,521	639,935	630,859	1,833	632,692			
			156		0	993,465	31,662	1,025,127	1,081,854	74,574	1,156,428	8.9%	135.5%	12.8%
Mar-23	Union					356,051	29,141	385,192	436,564	118,366	554,930			
Mar-23	Non-Union					656,283	2,522	658,805	650,152	2,868	653,020			
			151		0	1,012,333	31,664	1,043,997	1,086,715	121,234	1,207,949	7.3%	282.9%	15.7%
Apr-23	Union					359,113	29,141	388,255	477,849	138,993	616,843			
Apr-23	Non-Union					657,923	2,522	660,446	649,937	2,139	652,076			
			149		0	1,017,036	31,664	1,048,700	1,127,786	141,132	1,268,919	10.9%	345.7%	21.0%
May-23	Union					362,302	29,476	391,779	471,989	129,001	600,991			
May-23	Non-Union					661,505	2,523	664,028	667,468	2,324	669,792			
			151		0	1,023,808	31,999	1,055,807	1,139,457	131,325	1,270,782	11.3%	310.4%	20.4%
Jun-23	Union					548,231	44,681	592,912	725,189	111,181	836,370			
Jun-23	Non-Union					672,782	2,547	675,329	684,772	2,889	687,661			
			150		0	1,221,013	47,228	1,268,241	1,409,961	114,069	1,524,030	15.5%	141.5%	20.2%
Jul-23	Union					367,854	29,804	397,658	471,087	61,262	532,349			
Jul-23	Non-Union					661,497	2,498	663,995	681,616	3,100	684,716			
			149		0	1,029,351	32,302	1,061,653	1,152,703	64,362	1,217,064	12.0%	99.2%	14.6%
Aug-23	Union					367,854	29,804	397,658	452,643	79,864	532,506			

Duke Energy Kentucky - Gas
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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Aug-23	Non-Union					662,492	2,497	664,989	664,913	2,692	667,605			
		151		0		1,030,346	32,301	1,062,647	1,117,555	82,556	1,200,112	8.5%	155.6%	12.9%
Sep-23	Union					367,854	29,800	397,654	441,947	51,985	493,932			
Sep-23	Non-Union					659,095	2,497	661,592	662,357	2,616	664,974			
		151		0		1,026,949	32,297	1,059,246	1,104,304	54,601	1,158,906	7.5%	69.1%	9.4%
Oct-23	Union					367,854	29,801	397,655	437,722	55,562	493,283			
Oct-23	Non-Union					662,251	2,509	664,761	784,449	1,949	786,398			
		149		0		1,030,106	32,310	1,062,416	1,222,171	57,511	1,279,682	18.6%	78.0%	20.5%
Nov-23	Union					367,854	29,808	397,662	438,215	68,646	506,861			
Nov-23	Non-Union					660,510	2,497	663,007	649,866	2,533	652,399			
		147		0		1,028,364	32,305	1,060,669	1,088,081	71,179	1,159,260	5.8%	120.3%	9.3%
Dec-23	Union					551,794	44,684	596,478	677,441	88,092	765,532			
Dec-23	Non-Union					668,193	2,503	670,696	620,179	4,390	624,569			
		150		0		1,219,987	47,187	1,267,174	1,297,620	92,481	1,390,101	6.4%	96.0%	9.7%
YTD - 23	Union					4,793,191	391,698	5,184,889	6,009,606	1,023,155	7,032,762			
YTD - 23	Non-Union					7,883,148	30,157	7,913,306	7,977,401	31,210	8,008,611			
						12,676,339	421,855	13,098,194	13,987,008	1,054,365	15,041,373	10.3%	149.9%	14.8%

Duke Energy Kentucky - Gas
Case No. 2025-00125
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Month	Employee Group	Budgeted	Actual	Budgeted	Actual	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Base Period														
Sep-24	Union					501,158	32,279	533,438	450,772	65,484	516,256			
Sep-24	Non-Union					615,731	2,775	618,506	677,544	2,075	679,619			
			141		0	1,116,889	35,054	1,151,943	1,128,316	67,559	1,195,875	1.0%	92.7%	3.8%
Oct-24	Union					501,158	32,268	533,426	441,790	80,070	521,860			
Oct-24	Non-Union					621,244	2,775	624,019	700,212	1,347	701,559			
			139		0	1,122,403	35,043	1,157,445	1,142,002	81,417	1,223,419	1.7%	132.3%	5.7%
Nov-24	Union					752,642	48,370	801,012	710,976	176,789	887,765			
Nov-24	Non-Union					624,764	2,810	627,573	731,548	4,299	735,847			
			141		0	1,377,406	51,180	1,428,586	1,442,524	181,088	1,623,612	4.7%	253.8%	13.7%
Dec-24	Union					501,179	32,260	533,440	448,329	90,968	539,297			
Dec-24	Non-Union					617,958	2,775	620,733	671,889	583	672,472			
			141		0	1,119,137	35,036	1,154,173	1,120,218	91,551	1,211,769	0.1%	161.3%	5.0%
Jan-25	Union					538,192	41,148	579,340	521,165	50,538	571,704			
Jan-25	Non-Union					662,633	1,748	664,380	708,634	2,684	711,318			
			151		0	1,200,825	42,896	1,243,720	1,229,799	53,222	1,283,022	2.4%	24.1%	3.2%
Feb-25	Union					455,581	33,006	488,588	460,418	67,998	528,416			
Feb-25	Non-Union					660,256	1,583	661,839	703,273	1,922	705,196			
			154		0	1,115,837	34,589	1,150,426	1,163,692	69,920	1,233,612	4.3%	102.1%	7.2%
Mar-25	Union					455,581	33,013	488,595						
Mar-25	Non-Union					679,799	1,535	681,334						
						1,135,380	34,548	1,169,929						
Apr-25	Union					459,372	33,028	492,400						

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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

YTD 2021 had a variance of -7.9% as a result of lower labor in the Natural Gas Business Unit. YTD 2023 had a variance of 14.8% for increased labor charges to capital projects.

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
Apr-25	Non-Union					683,435	1,523	684,958						
						1,142,807	34,551	1,177,358						
May-25	Union					695,251	50,096	745,347						
May-25	Non-Union					707,804	1,616	709,421						
						1,403,055	51,712	1,454,767						
Jun-25	Union					467,633	33,793	501,426						
Jun-25	Non-Union					682,069	1,849	683,918						
						1,149,702	35,643	1,185,345						
Jul-25	Union					467,633	33,805	501,438						
Jul-25	Non-Union					683,985	1,752	685,738						
						1,151,618	35,557	1,187,175						
Aug-25	Union					467,633	33,805	501,438						
Aug-25	Non-Union					683,910	1,715	685,625						
						1,151,543	35,520	1,187,063						
Base Period	Union					6,263,014	436,872	6,699,886						
Base Period	Non-Union					7,923,588	24,456	7,948,044						
						14,186,602	461,328	14,647,930						

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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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
Forecast Period														
Jan-26	Union					467,633	33,782	501,415						
Jan-26	Non-Union					682,025	1,513	683,538						
						1,149,658	35,295	1,184,953						
Feb-26	Union					467,633	33,782	501,415						
Feb-26	Non-Union					682,025	1,513	683,538						
						1,149,658	35,295	1,184,953						
Mar-26	Union					484,000	34,964	518,964						
Mar-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Apr-26	Union					484,000	34,964	518,964						
Apr-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
May-26	Union					725,997	52,434	778,431						
May-26	Non-Union					732,412	1,577	733,989						
						1,458,409	54,011	1,512,419						
Jun-26	Union					484,000	34,964	518,964						
Jun-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Jul-26	Union					484,000	34,964	518,964						
Jul-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Aug-26	Union					484,000	34,964	518,964						

Duke Energy Kentucky - Gas
Case No. 2025-00125
Monthly Payroll Variance Analysis

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

YTD 2021 had a variance of -7.9% as a result of lower labor in the Natural Gas Business Unit. YTD 2023 had a variance of 14.8% for increased labor charges to capital projects.

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-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Sep-26	Union					484,000	34,964	518,964						
Sep-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Oct-26	Union					725,997	52,434	778,431						
Oct-26	Non-Union					732,412	1,577	733,989						
						1,458,409	54,011	1,512,419						
Nov-26	Union					484,000	34,964	518,964						
Nov-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Dec-26	Union					484,000	34,964	518,964						
Dec-26	Non-Union					705,896	1,566	707,462						
						1,189,896	36,530	1,226,426						
Forecast Period	Union					6,259,261	452,145	6,711,405						
Forecast Period	Non-Union					8,476,045	18,705	8,494,750						
						14,735,306	470,850	15,206,155						

CONFIDENTIAL STAFF-DR-01-037
(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 surveys utilized by Duke Energy as compared to Duke Energy's historical overall wage increase budgets for the corresponding years. The full 2024/2025 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-01-037 Confidential Attachments 1 and 2. Duke Energy's actual salary increase for 2025 is included below; however, survey data reflecting 2025 actual data from industry peers is not yet available. Likewise, 2026 survey data is not yet available.

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%
2025[Δ]		4.0%		4.0%		4.0%		4.0%
*Industry data based on surveys utilized by Duke Energy [Δ]2025 industry results are not yet available								

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.

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 United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW) Local 12049 & 5541-06 entered into a CBA effective on May 15, 2021, that expires on May 15, 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 May 15. The wage increase that impacts the forecasted test period will be determined with the next contract:

PERSON RESPONSIBLE: Shannon A. Caldwell

CONFIDENTIAL PROPRIETARY TRADE SECRET

STAFF-DR-01-037 CONFIDENTIAL ATTACHMENTS 1 & 2

FILED UNDER SEAL

CONFIDENTIAL STAFF-DR-01-038
(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-01-038 Confidential Attachment 1 for schedules showing salary information and employee counts for current executives.

Please see STAFF-DR-01-038 Attachment 2 for responsibilities by executive officer.

Please see STAFF-DR-01-038 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
4/1/2025	[redacted]		$700,000	85%	200%	9,479	Sideris, Harry K
3/1/2025		30.84%	$700,000	85%	200%	9,530	Sideris, Harry K
2/28/2025			$535,000	70%	150%	9,563	Sideris, Harry K
1/1/2025			$535,000	70%	150%	9,509	Sideris, Harry K
9/1/2024			$535,000	70%	150%	9,522	Sideris, Harry K
3/1/2024		8.26%	$535,000	70%	135%	9,519	Sideris, Harry K
1/1/2024			$494,173	60%	115%	6,414	Sideris, Harry K
3/1/2023		3.00%	$494,173	60%	115%	6,376	Sideris, Harry K
1/1/2023			$479,780	60%	115%	6,359	Sideris, Harry K
3/1/2022		3.50%	$479,780	60%	115%	6,086	Sideris, Harry K
1/1/2022			$463,555	60%	115%	6,015	Sideris, Harry K
3/1/2021		2.00%	$463,555	60%	115%	6,110	Sideris, Harry K
1/1/2021			$454,466	60%	115%	6,079	Sideris, Harry K

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
2/28/2025	[redacted]		$380,000	50%	85%	16	Savoy, Brian D
1/1/2025			$380,000	50%	85%	14	Savoy, Brian D
11/1/2024		7.74%	$380,000	50%	85%	14	Savoy, Brian D
9/1/2024			$352,715	45%	75%	25	Janson, Julie
4/1/2024			$352,715	45%	75%	25	Janson, Julie
3/1/2024		3.50%	$352,715	45%	75%	25	Janson, Julie
1/1/2024			$340,787	45%	75%	25	Janson, Julie
3/1/2023		4.02%	$340,787	45%	75%	24	Janson, Julie
1/1/2023			$327,625	45%	75%	21	Janson, Julie
3/1/2022		10.75%	$327,625	45%	75%	17	Janson, Julie
1/1/2022			$295,837	45%	75%	16	Janson, Julie
3/1/2021		2.00%	$295,837	45%	75%	15	Janson, Julie
1/1/2021			$290,037	45%	75%	15	Janson, Julie

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
2/28/2025	[redacted]		$756,000	100%	350%	828	Good, Lynn J
1/1/2025			$756,000	100%	350%	834	Good, Lynn J
9/1/2024		8.00%	$756,000	100%	350%	849	Good, Lynn J
3/1/2024		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
2/28/2025	[redacted]		$772,967	95%	275%	7,575	Sideris, Harry K
1/1/2025			$772,967	95%	275%	7,551	Sideris, Harry K
9/1/2024			$772,967	95%	275%	7,531	Sideris, Harry K
4/1/2024			$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

Executive Officer Job History

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
2/28/2025	[redacted]		$562,913	85%	300%	123	Sideris, Harry K
1/1/2025			$562,913	85%	300%	121	Sideris, Harry K
9/1/2024		4.00%	$562,913	85%	300%	121	Sideris, Harry K
4/1/2024			$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
2/28/2025	[redacted]		$1,500,000	200%	1067%	27,007	
1/1/2025			$1,500,000	200%	1067%	27,007	
4/1/2024			$1,500,000	200%	1067%	27,556	
9/1/2024			$1,500,000	200%	1067%	27,596	
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	

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
2/28/2025	[redacted]		$900,000	115%	350%	2,143	Sideris, Harry K
1/1/2025			$900,000	115%	350%	2,135	Sideris, Harry K
9/1/2024			$900,000	115%	350%	2,124	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

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
2/28/2025	[redacted]		$346,913	50%	90%	97	Savoy, Brian D
1/1/2025			$346,913	50%	90%	95	Savoy, Brian D
9/1/2024			$346,913	50%	90%	88	Savoy, Brian D
3/1/2024		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

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
2/28/2025	[redacted]		$579,726	95%	325%	123	Good, Lynn J
1/1/2025			$579,726	95%	325%	122	Good, Lynn J
9/1/2024			$579,726	95%	325%	121	Good, Lynn J
3/1/2024		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
2/28/2025	[redacted]		$696,613	100%	350%	373	Good, Lynn J
1/1/2025			$696,613	100%	350%	368	Good, Lynn J
9/1/2024			$696,613	100%	350%	368	Good, Lynn J
3/1/2024		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

Executive Officer Job History

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
2/28/2025	[redacted]		$900,000	115%	475%	22,653	Good, Lynn J
1/1/2025			$900,000	115%	475%	22,524	Good, Lynn J
9/1/2024			$900,000	115%	475%	22,579	Good, Lynn J
4/1/2024		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
2/28/2025	[redacted]		$343,218	45%	75%	32	Glenn, Alex
1/1/2025			$343,218	45%	75%	30	Glenn, Alex
9/1/2024			$343,218	45%	75%	31	Glenn, Alex
3/1/2024		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

Executive Officer Job History

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
4/1/2025	[redacted]		$625,000	95%	300%	2,991	Sideris, Harry K
3/1/2025		7.05%	$625,000	95%	300%	2,997	Good, Lynn J
2/28/2025			$583,818	85%	250%	3,004	Good, Lynn J
1/1/2025			$583,818	85%	250%	2,991	Good, Lynn J
9/1/2024		9.00%	$583,818	85%	250%	3,014	Good, Lynn J
3/1/2024		3.50%	$535,613	70%	160%	1,965	Young, Steve K
1/1/2024			$517,500	70%	160%	1,976	Young, Steve K
3/1/2023		3.50%	$517,500	70%	160%	2,052	Young, Steve K
1/1/2023			$500,000	70%	160%	2,090	Young, Steve K
7/1/2022		15.02%	$500,000	70%	160%	2,146	Young, Steve K
3/1/2022		8.68%	$434,700	60%	120%	1,900	Birmingham, Melody
1/1/2022		11.69%	$400,000	55%	110%	1,897	Birmingham, Melody
3/1/2021		2.00%	$358,142	50%	95%	1,575	Savoy, Brian D
1/1/2021			$351,120	45%	95%	1,582	Savoy, Brian D

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
2/28/2025	[redacted]		$472,213	70%	150%	3,243	Sideris, Harry K
1/1/2025			$472,213	70%	150%	3,202	Sideris, Harry K
9/1/2024			$472,213	70%	150%	3,275	Sideris, Harry K
4/1/2024		8.00%	$472,213	70%	150%	3,392	Sideris, Harry K
3/1/2024		3.50%	$437,235	50%	95%	2,018	Young, Steve K
1/1/2024			$422,449	50%	95%	2,032	Young, Steve K
3/1/2023		3.50%	$422,449	50%	95%	1,974	Young, Steve K
1/1/2023			$408,163	50%	95%	1,978	Young, Steve K
3/1/2022		3.77%	$408,163	50%	95%	1,992	Savoy, Brian D
1/1/2022			$393,352	50%	95%	1,982	Savoy, Brian D
3/1/2021		2.00%	$393,352	50%	95%	1,932	Esamann, Doug
1/1/2021			$385,639	50%	95%	1,935	Esamann, Doug

[redacted]

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	Total # Employee Reports	Reports To
2/28/2025	[redacted]		$350,000	50%	95%	2,030	Janson, Julie
1/1/2025			$350,000	50%	95%	2,027	Janson, Julie
9/1/2024			$350,000	50%	95%	2,018	Janson, Julie
4/1/2024		8.12%	$350,000	50%	95%	2,018	Janson, Julie
3/1/2024		3.25%	$323,729	50%	95%	2,018	Janson, Julie
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

Scott Batson serves as senior vice president and chief power grid officer for Duke Energy. He oversees the safe, reliable and efficient operation of Duke Energy's electric system for the company's six-state service area, which includes more than 360,000 miles of transmission and distribution lines and approximately 3,000 substations. His responsibilities also include fleet services, lighting, vegetation management and the execution of Duke Energy's grid improvement initiatives.

Having served as Duke Energy's chief distribution officer since November 2019, Batson assumed added responsibility for the electric transmission system in March 2024. He has served as regional senior vice president of customer delivery in the Carolinas, where he led operations for the company's electric distribution system in North Carolina and South Carolina, including construction, maintenance, engineering, and resource and project management.

Prior to that, he served as senior vice president of nuclear operations for Duke Energy, where he provided oversight for the safe and reliable operation of the company's nuclear plants in South Carolina. He assumed lead responsibilities for the Catawba, Oconee and Robinson plants in September 2016.

Batson has more than 40 years of experience in the energy field. He joined the company in January 1985 as a junior engineer at Oconee Nuclear Station. He held various leadership positions at Oconee, including operations shift manager, maintenance instrument and electrical section manager, mechanical and civil engineering manager, operations manager, site engineering manager and plant manager. He was named plant manager of Catawba Nuclear Station in 2012 and site vice president of Oconee Nuclear Station in 2013. As site vice president, he directed station and facilities management, operations, maintenance, chemistry and radiation protection, engineering, nuclear and industrial safety, and business operations.

The Pickens, S.C., native earned a Bachelor of Science degree in mechanical engineering from Clemson University. He is a registered professional engineer in South Carolina.

In January 2018, Batson was appointed to the South Carolina Governor's Nuclear Advisory Council. He received a senior reactor operator license from the U.S. Nuclear Regulatory Commission and a senior nuclear plant management certification from the Institute of Nuclear Power Operations. He has also completed the Duke Energy Advanced Leadership Program.

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Michael Callahan serves as senior vice president and treasurer for Duke Energy. 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 major credit rating agencies.

Callahan has 25 years of experience in the finance and energy industries. Before assuming his current position in November 2024, he led Duke Energy's utility operations in South Carolina as state president for five years. In this role, he was responsible for the financial performance of Duke Energy's 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.

Prior to that, Callahan served as Duke Energy's vice president of investor relations, overseeing the company's investor relations and shareholder services organizations. He was responsible for managing the company's key relationships with investors and analysts, monitoring trends in the investment markets and developing investor communication materials.

Callahan joined Duke Energy in 2002 as a senior consultant in the audit services group. He went on to hold positions of increasing responsibility in treasury, investor relations, and financial planning and analysis. He served as Duke Energy's director of regulated utilities forecasting, where he was responsible for preparing and consolidating regulated utility forecasts to support financial planning and strategic decision-making activities. He also served as finance director of grid solutions for Duke Energy's Midwest and Florida regions.

Prior to joining Duke Energy, Callahan was a senior consultant at PricewaterhouseCoopers.

A native of Fulton, N.Y., Callahan earned a Bachelor of Science in accounting and a Master of Business Administration from the State University of New York at Buffalo. He is also a certified public accountant in both North Carolina and New York.

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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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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.

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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 and chief executive officer of Duke Energy, one of the nation's largest energy holding companies. Under Sideris' leadership, Duke Energy is focused on critical infrastructure investments that meet historic load growth, provide superior service to customers and communities, and maintain safety and operational excellence.

Sideris oversees one of the largest regulated capital plans in the industry, supporting energy modernization that delivers value for Duke Energy's customers and shareholders, advances the nation's growth and economic development aspirations and makes progress on the company's climate goals. Duke Energy is executing a diverse generation strategy, adding natural gas assets to its portfolio, extending the life of its nuclear plants, modernizing the energy grid, advocating for new dispatchable technologies, and adding new renewables and energy storage while collaborating with stakeholders and policymakers to advance supportive energy policy.

Duke Energy has paid a quarterly cash dividend on its common stock for 99 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 April 2025, Sideris served as president of Duke Energy, leading the company's electric and natural gas utilities, including all aspects of operations, customer service and delivery, economic development, regulatory and legislative affairs, and grid and generation strategy. A 29-year veteran of the company, Sideris is a long-standing member of Duke Energy's senior management committee. His prior leadership roles include executive vice president of customer experience, solutions and services; president of Duke Energy's utility operations in Florida; and vice president of environmental, health and safety. He began his career at Progress Energy (formerly Carolina Power & Light), prior to the merger with Duke Energy in 2012.

Sideris currently serves on the boards of directors for the Edison Electric Institute, the Institute of Nuclear Power Operations and the World Association of Nuclear Operators. He is also a member of the Business Roundtable and Charlotte Executive Leadership Council.

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. Sideris grew up in Asheville, N.C., and now lives in Charlotte. 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 8.6 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.

Bonnie Titone serves as Duke Energy's senior vice president and chief administrative officer. She leads the company's information technology operations, infrastructure and telecom, cybersecurity and physical security functions, product delivery and support for various business areas, and the expanding digital transformation and data optimization strategy. In April 2024, she assumed added responsibility for the supply chain and facilities, and real estate functions. Her team enables the company's broader efforts to transform and deliver a smarter, cleaner energy future and coordinates with peer utilities to ensure that our country's critical infrastructure, information and energy grid remain well protected.

Titone joined Duke Energy in June 2019 from Pacific Gas and Electric (PG&E) in San Francisco, Calif., where she served as vice president of information business technology. In this role, she led technology delivery for all core business functions, including natural gas, electric, nuclear, energy supply, human resources, finance, supply chain, safety and environmental, security, risk management, legal and fleet operations. Titone was responsible for digital transformation, application and software delivery and operations.

Titone has a deep history in information technology with more than 27 years in positions ranging from project management, operations and application delivery to portfolio management across the hospitality, financial services and automotive industries.

Prior to her work at PG&E, Titone served in leadership roles at Volkswagen and Toyota, where she focused on software and project delivery, as well as strategic direction and alignment across multiple brands and countries.

Titone serves on the board of directors for Young Black Leadership Alliance and is passionate about access to education for diverse populations, expanding STEM programs and mentoring women in technology. She serves as host chief information officer for Apparo, a nonprofit in Charlotte that assists local nonprofits with leveraging technology to improve business processes to expand their social change in the community. In addition, Titone serves on the governing body for Evanta, a Gartner Company that aims to create communities for chief information officers and chief information security officers across industries to share innovation, validate strategies and solve leadership challenges.

Titone holds a Bachelor of Science degree from the Pennsylvania State University.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 8.6 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.

Sasha Weintraub serves as senior vice president and chief customer officer for Duke Energy. In addition to focusing on enhancing the customer experience, he is responsible for the development of new products and services, customer pricing, rate design, economic development and wholesale customers. Additionally, he has responsibility for the company's electrification efforts, including continued development of long-term grid strategies and solutions.

Weintraub has more than 25 years of experience with the company. Before assuming his current position in April 2024, Weintraub served as senior vice president and president of Duke Energy's natural gas business, where he was responsible for the company's regulated natural gas operations in the Carolinas, Ohio, Kentucky and Tennessee. In addition, 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 has served as senior vice president of both customer and market solutions. In these roles, he aligned customer-focused products and services to deliver a personalized end-to-end customer experience to position Duke Energy for long-term growth. His duties included retail programs, enhanced basic services, rate design and analysis, customer regulatory strategy and analytics, and data analytics. Additionally, he had responsibility for economic development, large business customers and wholesale power sales. He also served as vice president of fuels and systems optimization. He joined the company in 1999 as a senior analyst with Progress Energy.

A native of New York City, Weintraub earned a bachelor's degree in engineering from Rensselaer Polytechnic Institute, a master's degree in engineering from Columbia University and a doctorate degree in engineering from North Carolina State University. He is also a lecturer at the Kenan-Flagler Business School at the University of North Carolina at Chapel Hill.

Weintraub currently serves on the board of trustees for UNC Charlotte and the boards of directors for TerraGo and the Charlotte Hearing and Speech Center. Weintraub has attended several Advanced Management courses at the University of North Carolina at Chapel Hill and Duke University. He also completed an executive nuclear technology course at the Massachusetts Institute of Technology. Weintraub and his wife, Nichelle, have three daughters. They both served on the board of directors for the Cleft Palate Foundation.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 8.6 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.

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.

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.

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
Scott Batson	SVP, Chief Power Grid Officer	4/1/2024	See Note 1		
[redacted]	[redacted]	11/1/2024	[redacted]	11/12024	$ 565,488.64
Bonnie Titone	SVP and Chief Administrative Officer	4/1/2024	See Note 2		
Sasha Weintraub	SVP & Chief Customer Officer	4/1/2024	See Note 3		

Note 1: Scott Batson was promoted to the senior management committee effective 4/1/24. His role partially replaced Harry Sideris' former role of EVP, Customer Experience, Solutions & Services.

Note 2: Bonnie Titone was promoted to the senior management committee effective 4/1/24. She retained her prior responsibilities for Information Technology and Cybersecurity, while adding Supply Chain responsibilities from Harry Sideris and Admin Services from Kodwo Ghartey-Tagoe.

Note 3: Sasha Weintraub was promoted to the senior management committee effective 4/1/24. His role partially replaced Harry Sideris' former role of EVP, Customer Experience, Solutions & Services.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

CONFIDENTIAL STAFF-DR-01-039
(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 NonUnion 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-01-039 Confidential Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2025-00125
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																								
Total Amount			$ 8,606,141	$ -	$ -	$ 28,396,780	$ 3,383,839	$ 40,386,761																
[redacted]		thru 4/30/21	$ 236,250			$ 2,216,122	$ 179,739	$ 2,632,111																
		eff 5/1/21 (termed 7/31/21)	$ 177,188				$ 94,560	$ 271,747																
			$ 1,390,500	$ -	$ -	$ 14,308,054	$ 1,498,311	$ 17,196,866																
			$ 873,055	$ -	$ -	$ 3,335,385	$ 335,064	$ 4,543,504																
		thru 4/30/21	$ 250,250			$ 2,287,760	$ 184,193	$ 2,722,203																
		eff 5/1/21	$ 500,500				$ 45,128	$ 545,628																
			$ 775,675	$ -	$ -	$ 2,496,110	$ 252,336	$ 3,524,121																
			$ 288,386	$ -	$ -	$ 151,034	$ 12,050	$ 451,470																
		thru 5/15/21	$ 131,594			$ 422,829	$ 29,744	$ 584,168																
		eff 5/16/21	$ 187,500				$ 4,045	$ 191,545																
			$ 522,129	$ -	$ -	$ 676,606	$ 56,794	$ 1,255,528																
			$ 595,833	$ -	$ -	$ 648,787	$ 264,213	$ 1,508,833																
		thru 4/30/21	$ 168,333			$ 581,742	$ 33,339	$ 783,414																
		eff 5/1/21	$ 357,000			$ 86	$ 19,855	$ 376,941																
		thru 4/30/21	$ 168,709			$ 714,656	$ 48,002	$ 931,366																
		eff 5/1/21	$ 178,898				$ 9,049	$ 187,948																
		eff 5/1/21	$ 178,898				$ 20,049	$ 198,947																
		eff 5/1/21	$ 316,710			$ 55,544	$ 21,502	$ 393,756																
		eff 5/1/21	$ 300,000				$ 8,717	$ 308,717																
		eff 5/1/21	$ 296,875				$ 7,570	$ 304,445																
		eff 5/1/21	$ 19,792				$ 3,318	$ 23,110																
			$ 392,066			$ 501,980	$ 47,905	$ 941,951																
		eff 5/1/21	$ 300,000			$ 86	$ 208,356	$ 508,442																
$ Allocated to Kentucky																								
[redacted]		thru 4/30/21	$ 254	$ -	$ -	$ 2,382	$ 193	$ 2,830																
		eff 5/1/21 (termed 7/31/21)	$ 190	$ -	$ -	$ -	$ 102	$ 292																
			$ 5,979	$ -	$ -	$ 61,525	$ 6,443	$ 73,947																
			$ 7,596	$ -	$ -	$ 29,018	$ 2,915	$ 39,528																
		thru 4/30/21	$ 538	$ -	$ -	$ 4,919	$ 396	$ 5,853																
		eff 5/1/21	$ 538	$ -	$ -	$ -	$ 49	$ 587																
			$ 3,335	$ -	$ -	$ 10,733	$ 1,085	$ 15,154																
			$ 231	$ -	$ -	$ 121	$ 10	$ 361																
		thru 5/15/21	$ 566	$ -	$ -	$ 1,818	$ 128	$ 2,512																
		eff 5/16/21	$ 806	$ -	$ -	$ -	$ 17	$ 824																
			$ 2,245	$ -	$ -	$ 2,909	$ 244	$ 5,399																
			$ 2,562	$ -	$ -	$ 2,790	$ 1,136	$ 6,488																
		thru 4/30/21	$ 724	$ -	$ -	$ 2,501	$ 143	$ 3,369																
		eff 5/1/21	$ 1,535	$ -	$ -	$ 0	$ 85	$ 1,621																
		thru 4/30/21	$ 725	$ -	$ -	$ 3,073	$ 206	$ 4,005																
		eff 5/1/21	$ 769	$ -	$ -	$ -	$ 39	$ 808																
		eff 5/1/21	$ 192	$ -	$ -	$ -	$ 22	$ 214																
		eff 5/1/21	$ 443	$ -	$ -	$ 78	$ 30	$ 551																
		eff 5/1/21	$ 1,290	$ -	$ -	$ -	$ 37	$ 1,327																
		eff 5/1/21	$ 5,881	$ -	$ -	$ -	$ 150	$ 6,031																
		eff 5/1/21	$ 392	$ -	$ -	$ -	$ 66	$ 457																
			$ -	$ -	$ -	$ -	$ -	$ -																
		eff 5/1/21	$ 1,290	$ -	$ -	$ 0	$ 896	$ 2,186																
KY Jurisdictional Retail Amount			$ 38,083	$ -	$ -	$ 121,868	$ 14,392	$ 174,343																
Managers																								
Total Amount			$ 17,734	$ -	$ -	$ 1,250	$ -	$ 18,984																
KY Jurisdictional Retail Amount			$ 17,734	$ -	$ -	$ 1,250	$ -	$ 18,984																
Supervisors																								
Total Amount			$ 406,902	$ -	$ -	$ 39,042	$ -	$ 445,944																
KY Jurisdictional Retail Amount			$ 406,902	$ -	$ -	$ 39,042	$ -	$ 445,944																
Exempt																								
Total Amount			$ 378,523	$ -	$ 3,338	$ 29,078	$ 149	$ 411,087																
KY Jurisdictional Retail Amount			$ 378,523	$ -	$ 3,338	$ 29,078	$ 149	$ 411,087																
Non-Union Non-Exempt																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Union																								
Total Amount			$ 12,614,519	$ 3,419,633	$ 64,909	$ 382,390	$ 235,426	$ 16,716,877																
KY Jurisdictional Retail Amount			$ 12,614,519	$ 3,419,633	$ 64,909	$ 382,390	$ 235,426	$ 16,716,877																
Total Amount			$ 22,023,820	$ 3,419,633	$ 68,247	$ 28,848,540	$ 3,619,414	$ 57,979,653	$ 2,626,112	$ 802,007	$ 103,804	$ 65,683	$ -	$ 23,249	$ 23,613	$ 97,197	$ 1,974	$ 16,660	$ 1,176,091	$ 1,992,833	$ 93,387	$ 38,120	$ 4,024,981	$ 3,035,749
KY Jurisdictional Retail Amount			$ 13,455,761	$ 3,419,633	$ 68,247	$ 573,627	$ 249,967	$ 17,767,234	$ 2,626,112	$ 802,007	$ 103,804	$ 65,683	$ -	$ 23,249	$ 23,613	$ 97,197	$ 1,974	$ 16,660	$ 1,176,091	$ 1,992,833	$ 93,387	$ 38,120	$ 4,024,981	$ 3,035,749

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2025-00125
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

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.

Benefit Costs:
(1) Employer costs for benefits are not recorded by employee or group of employee. All employees are eligible to enroll in the same plan options and tiers.
(2) Amounts above represent costs for active employees of Duke Energy Kentucky (DEK - electric and gas). Certain officers, who are service company employees, will have benefit costs that are allocated to Kentucky. Because of the items noted in (1), these costs are not represented in the table above.
(3) Other benefits include long-term disability coverage, commuter benefits, tuition reimbursement, Employee Assistance Program, service and retirement awards.
(4) Employee costs noted above, specifically for medical, do not account for out-of-pocket costs to the employee related to meeting deductible.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2025-00125
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																							
Total Amount			$ 8,826,487	$ -	$ -	$ 38,486,774	$ 2,692,590	$ 49,705,571																
[redacted]			$ 1,481,750			$ 17,112,592	$ 1,384,062	$ 19,978,404																
			$ 898,519			$ 4,441,333	$ 326,408	$ 5,666,260																
			$ 772,647			$ 3,769,760	$ 251,321	$ 4,793,727																
		1/1/22 - 8/31/22	$ 530,691			$ 3,523,581	$ 220,553	$ 4,274,825																
		9/1/22 - 12/31/22	$ 267,608				$ 32,673																	
			$ 317,819			$ 410,872	$ 28,567	$ 757,257																
			$ 316,513			$ 206,629	$ 6,240	$ 529,382																
			$ 536,937			$ 1,045,326	$ 60,191	$ 1,642,454																
			$ 651,867			$ 1,273,378	$ 69,478	$ 1,994,723																
		1/1/22 - 4/30/22	$ 185,640			$ 1,719,849	$ 43,534	$ 1,949,024																
		5/1/22 - 12/31/22	$ 395,199				$ 27,659	$ 422,858																
		1/1/22 - 8/31/22	$ 379,264			$ 1,516,358	$ 56,114	$ 1,951,736																
		9/1/22 - 12/31/22	$ 208,667				$ 18,605	$ 227,271																
			$ 494,860			$ 578,633	$ 13,658	$ 1,087,151																
			$ 478,125			$ 814,612	$ 54,501	$ 1,347,238																
			$ 504,688			$ 1,366,906	$ 53,982	$ 1,925,576																
			$ 405,695			$ 706,944	$ 45,046	$ 1,157,685																
$ Allocated to Kentucky																								
[redacted]			$ 6,372	$ -	$ -	$ 73,584	$ 5,951	$ 85,907																
			$ 7,907	$ -	$ -	$ 39,084	$ 2,872	$ 49,863																
			$ 831	$ -	$ -	$ 4,052	$ 270	$ 5,153																
		1/1/22 - 8/31/22	$ 2,282	$ -	$ -	$ 15,151	$ 948	$ 18,382																
		9/1/22 - 12/31/22	$ 1,151	$ -	$ -	$ -	$ 140	$ 1,291																
			$ 254	$ -	$ -	$ 329	$ 23	$ 606																
			$ 1,361	$ -	$ -	$ 889	$ 27	$ 2,276																
			$ 2,309	$ -	$ -	$ 4,495	$ 259	$ 7,063																
			$ 2,803	$ -	$ -	$ 5,476	$ 299	$ 8,577																
		1/1/22 - 4/30/22	$ 798	$ -	$ -	$ 7,395	$ 187	$ 8,381																
		5/1/22 - 12/31/22	$ 3,478	$ -	$ -	$ -	$ 243	$ 3,721																
		1/1/22 - 8/31/22	$ 408	$ -	$ -	$ 1,630	$ 60	$ 2,098																
		9/1/22 - 12/31/22	$ 897	$ -	$ -	$ -	$ 80	$ 977																
			$ 643	$ -	$ -	$ 752	$ 18	$ 1,413																
			$ 2,056	$ -	$ -	$ 3,503	$ 234	$ 5,793																
			$ 9,856	$ -	$ -	$ 26,694	$ 1,054	$ 37,605																
			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ 43,405	$ -	$ -	$ 183,034	$ 12,667	$ 239,107																
	Managers																							
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
	Supervisors																							
Total Amount			$ 347,346			$ 66,059		$ 413,405																
KY Jurisdictional Retail Amount			$ 347,346			$ 66,059		$ 413,405																
	Exempt																							
Total Amount			$ 406,281			$ 59,545	$ 6,000	$ 471,826																
KY Jurisdictional Retail Amount			$ 406,281			$ 59,545	$ 6,000	$ 471,826																
	Non-Union Non-Exempt																							
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
	Union																							
Total Amount			$ 12,910,759	$ 3,723,986	$ 47,333	$ 691,454	$ 455,820	$ 17,829,353																
KY Jurisdictional Retail Amount			$ 12,910,759	$ 3,723,986	$ 47,333	$ 691,454	$ 455,820	$ 17,829,353																
Total Amount			$ 22,490,872	$ 3,723,986	$ 47,333	$ 39,303,833	$ 3,154,411	$ 68,720,435	$ 2,981,019	$ 779,993	$ 99,390	$ 66,841	$ -	$ 23,890	$ 41,446	$ 87,764	$ 3,577	$ 16,233	$ 1,305,950	$ 2,154,600	$ 75,529	$ 33,948	$ 4,506,911	$ 3,163,270
KY Jurisdictional Retail Amount			$ 13,707,791	$ 3,723,986	$ 47,333	$ 1,000,093	$ 474,488	$ 18,953,690	$ 2,981,019	$ 779,993	$ 99,390	$ 66,841	$ -	$ 23,890	$ 41,446	$ 87,764	$ 3,577	$ 16,233	$ 1,305,950	$ 2,154,600	$ 75,529	$ 33,948	$ 4,506,911	$ 3,163,270

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.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2025-00125
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																							
Total Amount			$ 9,499,521	$ -	$ 44,312	$ 42,520,656	$ 3,397,982	$ 55,462,470																
[redacted]			$ 1,500,000			$ 17,028,490	$ 1,473,096	$ 20,001,586																
		termed 6/30/23	$ 451,806		$ 44,312	$ 4,510,590	$ 338,888	$ 5,345,596																
			$ 796,452			$ 3,657,392	$ 292,618	$ 4,746,461																
		termed 6/30/24	$ 822,894			$ 3,745,328	$ 302,601	$ 4,870,823																
			$ 331,604			$ 400,582	$ 39,232	$ 771,418																
			$ 334,660			$ 217,896	$ 6,398	$ 558,954																
			$ 550,797			$ 932,849	$ 64,601	$ 1,548,247																
			$ 695,500			$ 2,418,457	$ 187,500	$ 3,301,457																
			$ 632,560			$ 1,882,893	$ 142,951	$ 2,658,404																
			$ 646,867			$ 1,882,314	$ 149,018	$ 2,678,199																
		termed 3/31/24	$ 515,446			$ 1,048,737	$ 69,891	$ 1,634,074																
			$ 532,125			$ 1,292,461	$ 71,218	$ 1,895,804																
			$ 536,156			$ 954,561	$ 64,670	$ 1,555,387																
			$ 420,068			$ 655,021	$ 53,315	$ 1,128,404																
		SMC 1/1/23	$ 732,586			$ 1,893,086	$ 141,983	$ 2,767,655																
$ Allocated to Kentucky																								
[redacted]			$ 6,600	$ -	$ -	$ 74,925	$ 6,482	$ 88,007																
		termed 6/30/23	$ 4,021	$ -	$ 394	$ 40,144	$ 3,016	$ 47,576																
			$ 876	$ -	$ -	$ 4,023	$ 322	$ 5,221																
		termed 6/30/24	$ 3,621	$ -	$ -	$ 16,479	$ 1,331	$ 21,432																
			$ 265	$ -	$ -	$ 320	$ 31	$ 617																
			$ 1,473	$ -	$ -	$ 959	$ 28	$ 2,459																
			$ 2,424	$ -	$ -	$ 4,105	$ 284	$ 6,812																
			$ 3,060	$ -	$ -	$ 10,641	$ 825	$ 14,526																
			$ 5,630	$ -	$ -	$ 16,758	$ 1,272	$ 23,660																
			$ 2,846	$ -	$ -	$ 8,282	$ 656	$ 11,784																
		termed 3/31/24	$ 722	$ -	$ -	$ 1,468	$ 98	$ 2,288																
			$ 2,341	$ -	$ -	$ 5,687	$ 313	$ 8,342																
			$ 10,648	$ -	$ -	$ 18,958	$ 1,284	$ 30,890																
			$ -	$ -	$ -	$ -	$ -	$ -																
		SMC 1/1/23	$ 6,520	$ -	$ -	$ 16,848	$ 1,264	$ 24,632																
KY Jurisdictional Retail Amount			$ 51,046	$ -	$ 394	$ 219,598	$ 17,207	$ 288,246																
	Managers																							
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
	Supervisors																							
Total Amount			$ 282,895			$ 30,562		$ 313,457																
KY Jurisdictional Retail Amount			$ 282,895			$ 30,562		$ 313,457																
	Exempt																							
Total Amount			$ 417,142			$ 43,102		$ 460,244																
KY Jurisdictional Retail Amount			$ 417,142			$ 43,102		$ 460,244																
	Non-Union Non-Exempt																							
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
	Union																							
Total Amount			$ 12,733,693	$ 3,636,254	$ 19,745	$ 652,239	$ 201,342	$ 17,243,274																
KY Jurisdictional Retail Amount			$ 12,733,693	$ 3,636,254	$ 19,745	$ 652,239	$ 201,342	$ 17,243,274																
Total Amount			$ 22,933,251	$ 3,636,254	$ 64,057	$ 43,246,559	$ 3,599,324	$ 73,479,445	$ 1,549,881	$ 677,729	$ 129,402	$ 57,120	$ -	$ 21,048	$ 30,233	$ 69,342	$ 1,984	$ 14,890	$ 1,290,148	$ 2,012,935	$ 98,341	$ 28,476	$ 3,099,989	$ 2,881,541
KY Jurisdictional Retail Amount			$ 13,484,777	$ 3,636,254	$ 20,140	$ 945,501	$ 218,549	$ 18,305,221	$ 1,549,881	$ 677,729	$ 129,402	$ 57,120	$ -	$ 21,048	$ 30,233	$ 69,342	$ 1,984	$ 14,890	$ 1,290,148	$ 2,012,935	$ 98,341	$ 28,476	$ 3,099,989	$ 2,881,541

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.

CONFIDENTIAL PROPRIETARY TRADE SECRET

Duke Energy Kentucky, Inc.
Case No: 2025-00125
Salary & Benefit Data by Employee

Base Period 9/1/2024 - 8/31/2025

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																								
Total Amount			$ 4,776,358	$ -	$ -	$ 41,797,010	$ 496,419	$ 47,069,787																
[redacted]		termed 3/31/25	$ 750,000			$ 21,864,866	$ 218,667	$ 22,833,532																
			$ 450,000			$ 3,611,864	$ 42,055	$ 4,103,919																
			$ 171,609			$ 339,085	$ 7,074	$ 517,767																
			$ 173,457			$ 349,267	$ 3,944	$ 526,668																
			$ 378,000			$ 2,840,728	$ 32,658	$ 3,251,386																
			$ 450,000			$ 2,227,587	$ 45,614	$ 2,723,201																
			$ 348,306			$ 2,543,019	$ 30,090	$ 2,921,415																
			$ 289,863			$ 1,721,262	$ 29,442	$ 2,040,566																
			$ 281,457			$ 1,538,771	$ 20,183	$ 1,840,410																
			$ 175,000			$ 253,193	$ 3,565	$ 431,758																
			$ 267,500			$ 788,188	$ 9,829	$ 1,065,517																
			$ 291,909			$ 801,511	$ 15,986	$ 1,109,405																
			$ 236,107			$ 542,653	$ 11,124	$ 789,884																
			$ 126,667			$ 360,820	$ 1,712	$ 489,199																
			$ 386,484			$ 2,014,197	$ 24,478	$ 2,425,159																
$ Allocated to Kentucky																								
[redacted]		termed 3/31/25	$ 3,525	$ -	$ -	$ 102,765	$ 1,028	$ 107,318																
			$ 529	$ -	$ -	$ 4,244	$ 49	$ 4,822																
			$ 137	$ -	$ -	$ 271	$ 6	$ 414																
			$ 815	$ -	$ -	$ 1,642	$ 19	$ 2,475																
			$ 1,777	$ -	$ -	$ 13,351	$ 153	$ 15,282																
			$ 4,230	$ -	$ -	$ 20,939	$ 429	$ 25,598																
			$ 1,637	$ -	$ -	$ 11,952	$ 141	$ 13,731																
			$ 1,362	$ -	$ -	$ 8,090	$ 138	$ 9,591																
			$ 5,953	$ -	$ -	$ 32,546	$ 427	$ 38,926																
			$ 88	$ -	$ -	$ 127	$ 2	$ 216																
			$ -	$ -	$ -	$ -	$ -	$ -																
			$ 1,372	$ -	$ -	$ 3,767	$ 75	$ 5,214																
			$ 1,485	$ -	$ -	$ 3,414	$ 70	$ 4,969																
		eff 11/1/24	$ 595	$ -	$ -	$ 1,696	$ 8	$ 2,299																
			$ 3,633	$ -	$ -	$ 18,933	$ 230	$ 22,797																
KY Jurisdictional Retail Amount			$ 27,138	$ -	$ -	$ 223,738	$ 2,775	$ 253,652																
Managers																								
Total Amount			$ 90,419					$ 90,419																
KY Jurisdictional Retail Amount			$ 90,419					$ 90,419																
Supervisors																								
Total Amount			$ 528,018				$ 30	$ 528,049																
KY Jurisdictional Retail Amount			$ 528,018				$ 30	$ 528,049																
Exempt																								
Total Amount			$ 159,703			$ 500	$ 35	$ 160,238																
KY Jurisdictional Retail Amount			$ 159,703			$ 500	$ 35	$ 160,238																
Non-Union Non-Exempt																								
Total Amount			$ -	$ -	$ -	$ -	$ -	$ -																
KY Jurisdictional Retail Amount			$ -	$ -	$ -	$ -	$ -	$ -																
Union																								
Total Amount			$ 6,198,052	$ 2,159,996	$ 11,894	$ 1,900	$ 57,589	$ 8,429,431																
KY Jurisdictional Retail Amount			$ 6,198,052	$ 2,159,996	$ 11,894	$ 1,900	$ 57,589	$ 8,429,431																
Total Amount			$ 11,752,551	$ 2,159,996	$ 11,894	$ 41,799,410	$ 554,073	$ 56,277,924	$ 1,955,879	$ 695,440	$ 101,630	$ 57,807	$ -	$ 19,147	$ 21,061	$ 67,987	$ 1,859	$ 14,293	$ 1,404,402	$ 2,043,889	$ 92,077	$ 29,642	$ 3,576,907	$ 2,928,206
KY Jurisdictional Retail Amount			$ 7,003,332	$ 2,159,996	$ 11,894	$ 226,138	$ 60,430	$ 9,461,788	$ 1,955,879	$ 695,440	$ 101,630	$ 57,807	$ -	$ 19,147	$ 21,061	$ 67,987	$ 1,859	$ 14,293	$ 1,404,402	$ 2,043,889	$ 92,077	$ 29,642	$ 3,576,907	$ 2,928,206

* Former 'Chair and CEO' retired on 3/31/2025 and the 'President, Duke Energy' was promoted to 'President & CEO' effective 4/1/2025

Labor Dollars (Regular though Other):
(1) Includes actuals for 9/1/24 - 2/28/25. Forecasted labor dollars are not included for the remainder of the base period (3/1/25 - 8/31/25).
(2) Bonus/Incentive includes 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) For employer cost, includes actuals for 9/1/24 - 2/28/25 and budgeted dollars for 3/1/2025 - 8/31/2025; Employee cost are not budgeted and includes forecasted dollars for 9/1/2024 - 8/31/2025.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-040

REQUEST:

For each benefit listed in Item 39 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 Shannon A. Caldwell's direct testimony beginning on page 34 under "What Portion of the Health and Insurance Costs of Benefits Do Employees Pay?"

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-041

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-01-041 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	$129.00	$314.50	$162.00	$339.50	$583.00	$1,395.50	$1,050.00	$1,514.50
Health Savings Plan 2 - Deductible $1,600 Individual / $3,200 Family	$184.00	$562.50	$348.00	$604.50	$612.00	$1,349.50	$1,006.00	$1,466.50
PPO - Deductible $600 Individual / $1,200 Family	$335.00	$945.50	$630.00	$1,031.50	$575.00	$1,240.50	$920.00	$1,337.50

	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	$34.00	$36.00	$61.00	$30.00	$57.00	$62.00	$95.00
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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-042

REQUEST:

Provide a copy of 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-01-042 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)

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, 2025 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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 (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 WellPower Rewards biometric screening during an applicable year's program cycle, or if your spouse/domestic partner completes a WellPower Rewards Health Assessment 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 WellPower Rewards and redeeming any rewards you earn is included in the WellPower Rewards materials sent to you 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 WellPower Rewards materials sent to you 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 WellPower Rewards are generally available to all eligible employees. If you think you might be unable to meet a standard for a reward under 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 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

[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.

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.

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.**

[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.

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, changes to your contribution amounts will be made as soon as administratively practicable after the Company learns that you (and/or your spouse/domestic partner) did not complete the Tobacco Cessation Program by the applicable deadline.

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, 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.

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

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

When 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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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, 2025, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2026, 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, 2028; or

- 18 months following your termination of employment – July 1, 2027

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2028 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.

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Benefit Booklet

Duke Energy Active Medical Plan
Health Savings Plan 1 Option

Effective: January 1, 2025
Group Number: 729784

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

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

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer and can provide, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease and can provide education and guidance with chronic kidney disease (CKD) stage 4/5 or end stage renal disease (ESRD) throughout your care path.

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] 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
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	80% after you meet the Annual Deductible Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensi

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
■ Virtual Behavioral Health Therapy & Coaching.	Outpatient Treatment 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%	ve Outpatient Treatment 60% after you meet the Annual Deductible Non-Network Benefits are not available
Neonatal Services	See Section 6, *Clinical Programs & Resources*, for Program Details.	
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient	80% after you meet the Annual Deductible Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	Intensive Behavioral Therapy 80% after you meet the Annual Deductible	Intensive Behavioral Therapy 60% after you meet the Annual Deductible
Nutritional Counseling	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 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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
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
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		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
■ 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 Use of a Network program for Partial Hospitalization/Day Treatment/High Intensity Outpatient, and Residential Treatment 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 <u>Office visit</u> 80% after you meet the Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u>	60% after you meet the Annual Deductible <u>Office visit</u> 60% after you meet the Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u>

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	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	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	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**
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 fail to obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 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 (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 *U.S. Food and Drug Administration (FDA)* approved 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 a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

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 from the Claims Administrator 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.

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 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.

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/High Intensity Outpatient.
- 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
For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from 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/High Intensity Outpatient.
- 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 Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization from 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).

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 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 you do not obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 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 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 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 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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from 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 from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions Programs & Services.
- Disease Management Services.
- Wellness Programs.

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

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.

Second Opinion Service

2nd.MD is a second opinion education service for individuals with one or more eligible conditions who are looking for a second opinion from a medical expert. This program is covered by Plan at $0 added cost. You can download the 2nd.MD app or visit www.2nd.md/dukeenergy. You can call the 2nd.MD Care Team directly at 866-269-3534 or get more information about the program by calling the number on your ID card..

Medical Conditions Included: Consultations available on the 2nd.MD platform include a range of medical conditions, currently covering all adult and pediatric subspecialties. To obtain a Consultation, a Participant must have received a diagnosis and/or treatment plan from a licensed specialist. Live support is provided during regular business days. The secure website and secure mobile application shall be available 24 hours a day, seven (7) days a week, excluding limited periods of maintenance, or periods of emergency maintenance, internet-wide disruptions, force majeure events, or attributable to Participant's software or hardware used to attempt access.

Maven

Maven is an app-based virtual program that provides you with pregnancy, postpartum and newborn support. It also gives you and your partner 24/7 access to resources — all included in the Plan at $0 added cost. Maven is here to help—get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health
- and more.

Visit mavenclinic.com/join/dukeenergy for more information.

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;
- 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**.

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.

Transplant Resource Services (TRS) Program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about the Transplant Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-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.

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.

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 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.

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 or visit www.myuhc.com 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 (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care, 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 it is the primary source of nutrition and is 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.

13. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

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 or Domestic Partners 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 Medicare's Allowable Expense or Medicare's limiting charge 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, administrative 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 adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally 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 or as required by law 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 its discretion, following evaluation and validation of all provider billings generally 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-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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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.

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ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on 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

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 (including pregnancy, sexual orientation, and gender identity). 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 help you communicate 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

We also provide reasonable modifications for persons with disabilities.

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 send a complaint to the Civil Rights Coordinator identified below.

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 complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

ATTACHMENT IV – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUXILIARY AIDS AND SERVICES

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	لطلب ذلك، اتصل برقم الهاتف الموجود على بطاقة خطة التأمين الصحي الخاصة بك واضغط على 0.)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	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

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

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी 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'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	နအိဉ်ဒီးတါဖဲးတါယာ်လၢနကဘီးနူဉ်ဘဉ်တါမၤစၢးဒီးတါဂ့ါတါကျိုလၢနကျိဉ်ဘဉ်နဲဝဲလၢတဂလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါကယ့နူ်ပူၤကတီၤကျိုးထံတါတဂၤအဂီၢ်ကိုးဘဉ်လီတဲစိအကျိုလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချုအတၢ်ရဉ်တၢ်ကဲ့ အကးအလိၤဒီးဆိဉ်လီၤနိၢ်ဂ့ၢ် 0 တကွ့ၢ်.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	تۆخ یارمە بەتسووپێیاراڵان و هقمارە،مەهامەبێهکەی هەموئیەفام ئونۆفەلەتمارمژمە بەهکبدیونیەپەیکواز یکیوژگیوە ئیئرکواد ۆبب.تیوگیوە هرگ 0 ناشاپ تۆخ یتسوردفتیئالاپیەیساپێیتاکید ایئواڤلواروسون .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 yíníkeedgo, 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 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.دهای تفاوی رایگان زبان خود را به طور کامل و کامل در اختیار دارید. برای درخواست مترجم شفاهی با شماره تلفن رایگان ذکر شده در کارت شناسایی برنامه خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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	ܫܝܫ ܠܟ ܙܟܘܬܐ ܕܬܓܒܝܬܐ ܘܝܕܥܢܐ ܒܠܫܢܟ ܕܝܠܝ ܒܠܐ ܡܚܐܪ. ܐܢ ܨܒܝܬ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܣܦܪ ܕܛܠܦܘܢ ܕܚܒܪܐ ܕܟܬܘܒ ܥܠ ܟܪܛܝܣ ܕܗܘܝܬܟ ܕܒܝܛܘܚ ܕܐܝܟ ܕܐܬ ܒܪܝܐ ܘܠܚܘ 0 ܕܡܣܬ ܠܡܠܦܢ. 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 مفت فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Prescription Drug Program Guide for the Duke Energy Active Medical Plan

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SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 65,000 participating retail pharmacies.
- Your long-term (maintenance) prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy. Maintenance medications also can now be filled at Costco® and Kroger® affiliated pharmacies.
- 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 65,000 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 or Costco or Kroger affiliated 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 or Costco or Kroger affiliated pharmacy at the

applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy, a CVS retail pharmacy or a Costco or Kroger affiliated 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 automated 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 or Costco or Kroger affiliated 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 Flexible Spending Account

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

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, 2025, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2026 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, 2025 would have 45 days (until February 14, 2025) 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.*

UnitedHealthcare® is a registered mark of United Health Group, Inc.
GoodRx® is a registered mark of GoodRx Holdings, Inc.
Costco® is a registered mark of Costco Wholesale Corporation.
Kroger® is a registered mark of The Kroger Co.

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

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

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)

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, 2025 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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 (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 WellPower Rewards biometric screening during an applicable year's program cycle, or if your spouse/domestic partner completes a WellPower Rewards Health Assessment 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 WellPower Rewards and redeeming any rewards you earn is included in the WellPower Rewards materials sent to you 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 WellPower Rewards materials sent to you 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 WellPower Rewards are generally available to all eligible employees. If you think you might be unable to meet a standard for a reward under 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 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

[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.

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.

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.**

[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.

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, changes to your contribution amounts will be made as soon as administratively practicable after the Company learns that you (and/or your spouse/domestic partner) did not complete the Tobacco Cessation Program by the applicable deadline.

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, 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.

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

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

When 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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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, 2025, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2026, 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, 2028; or

- 18 months following your termination of employment – July 1, 2027

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2028 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.

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Benefit Booklet

Duke Energy Active Medical Plan
Health Savings Plan 2 Option

Effective: January 1, 2025
Group Number: 729784

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

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

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer and can provide education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease and can provide education and guidance with chronic kidney disease (CKD) stage 4/5 or end stage renal disease (ESRD) throughout your care path.

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	$1,650	$3,300
■ Family (cumulative Annual Deductible[2])	$3,300	$6,600
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
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	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. ■ Outpatient	80% after you meet the Annual Deductible Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensiv	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensiv

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
■ Virtual Behavioral Health Therapy & Coaching.	e Outpatient Treatment 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%.	e Outpatient Treatment 60% after you meet the Annual Deductible Non-Network Benefits are not available.
Neonatal Services	See Section 6, *Clinical Programs & Resources,* for program information.	
Neurobiological Disorders – Autism Spectrum Disorder Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	Intensive Behavioral Therapy 80% after you meet the Annual Deductible	Intensive Behavioral Therapy 60% after you meet the Annual Deductible
Nutritional Counseling	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 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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Physician's Office Services – Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
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
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 Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	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 Use of a Network program for Partial Hospitalization/Day Treatment/High Intensity Outpatient, and Residential Treatment 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 Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
	Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	Intensity Outpatient/Intensive Outpatient Treatment 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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 *U.S. Food and Drug Administration (FDA)* approved 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 a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

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 from the Claims Administrator 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, 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 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 from the Claims Administrator 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/High Intensity Outpatient.
- 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
For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from 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/High Intensity Outpatient.
- 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 Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization from 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).

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 you do not obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 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 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 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 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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from 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 from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions Programs & Services.
- Disease Management Services.
- Wellness Programs.

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

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.

Second Opinion Service

2nd.MD is a second opinion education service for individuals with one or more eligible conditions who are looking for a second opinion from a medical expert. This program is covered by the Plan at $0 added cost. You can download the 2nd.MD app or visit www.2nd.md/dukeenergy. You can call the 2nd.MD Care Team directly at 866-269-3534 or get more information about the program by calling the number on your ID card.

Medical Conditions Included: Consultations available on the 2nd.MD platform include a range of medical conditions, currently covering all adult and pediatric subspecialties. To obtain a Consultation, a Participant must have received a diagnosis and/or treatment plan from a licensed specialist. Live support is provided during regular business days. The secure website and secure mobile application shall be available 24 hours a day, seven (7) days a week, excluding limited periods of maintenance, or periods of emergency maintenance, internet-wide disruptions, force majeure events, or attributable to Participant's software or hardware used to attempt access.

Maven

Maven is an app-based virtual program that provides you with pregnancy, postpartum and newborn support. It also gives you and your partner 24/7 access to resources — all included in the Plan at $0 added cost. Maven is here to help—get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health
- and more.

Visit mavenclinic.com/join/dukeenergy for more information.

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;
- 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**.

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.

Transplant Resource Services (TRS) Program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about the Transplant Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-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.

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.

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 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.

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 or visit www.myuhc.com 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 (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care, 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 it is the primary source of nutrition and is 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.

13. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

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 or Domestic Partners 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 Medicare's Allowable Expense or Medicare's limiting charge 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, administrative 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 adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally 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 or as required by law 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 its discretion, following evaluation and validation of all provider billings generally 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-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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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.

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ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on 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

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 (including pregnancy, sexual orientation, and gender identity). 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 help you communicate 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.

We also provide reasonable modifications for persons with disabilities.

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 send a complaint to the Civil Rights Coordinator identified below.

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 complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

ATTACHMENT IV – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUXILIARY AIDS AND SERVICES

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 ከፊለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لطلب المساعدة المجانية بلغتك، اتصل برقم الهاتف الموجود على بطاقة هويتك الصحية، واضغط على 0. (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	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ D4Ꭴ ᏏᎵ ᎯCZᏢᎯ Ꭰ4ᏫᎯ ᏂAᏯᎳW ᎥᏐ GᏙᎵ VᎯ ᏏR ᎯJAVᎯ ACᏫVᎯ ᎢᎾᏂᏫᎯT, ᎣᏎ0ᏍᏫᏓ 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 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'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	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးနူဉ်ဘဉ်တါ်မၤစၢဒီးတါ်ဂ့ါတါ်ကျိုလၢနကျိုဘဉ်နဝဲလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါ်ကယ့နူ်ပူၤကတိၤကျိုးထံတါ်တက၊အဂီၢ်ကိုးဘဉ်လီတဲဖိအကျိုလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချုအတၢ်ရဲဉ်တၢ်ကဲ အကးအလိၤဒီးဆိဉ်လီၤနိုၢ်ဂ့ၢ် 0 တကွ့ၢ်.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	تۆخ یارمە بەتسووچپیاریاڵی و یقەمارە،مەهامرەهبچەکەیە تەموئیەفام ینۆفهاتەمارتۆمە بەبکیدنوەیپەیکواز یکیوچگرەو ینیرکواد بۆبتیوگرەو هرگن 0 ناشاپ تۆخ یتسوردقتیئالپەیساپچیتاکید ایئواقلواروسون .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 yíníkeedgo, 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 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.ش‌ما حق دارید که به طور رایگان و به زبان خود راجع به اطلاعات درخواست ترجمه شفاهی را با تماس رایگان با شماره تلفن درج شده در کارت شناسایی .برای درخواست یک مترجم شفاهی، با شماره تلفن درج شده در کارت شناسایی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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	Dum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܫܝܫ ܠܟ ܙܟܘܬܐ ܕܬܓܒܝܬܐ ܘܝܕܥܢܐ ܒܠܫܢܟ ܕܠܐ ܡܨܪܝܐ. ܠܡܒܥܐ ܠܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܢܝܢ ܕܛܠܦܘܢ ܕܒܟܪܛܝܣ ܕܚܒܪܘܬܟ ܕܒܝܛܘܚ ܘܠܚܘ ܥܠ ܡܢܝܢ ܕܬܪܓܡܢܐ ܕܡܬܟܬܒ ܒܟܪܛܝܣ ܕܫܡܐ ܕܒܝܛܘܚ ܐܝ ܕܒܝܬܟ. 0 ܢܩܘܠ ܠܡܢܝܢ ܕܛܠܦܘܢ ܕܡܬܟܬܒ ܒܟܪܛܝܣ ܕܫܡܐ ܕܒܝܛܘܚ ܐܝ ܕܒܝܬܟ. 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 مفت فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Prescription Drug Program Guide for the Duke Energy Active Medical Plan

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SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 65,000 participating retail pharmacies.
- Your long-term (maintenance) prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy. Maintenance medications also can now be filled at Costco® and Kroger® affiliated pharmacies.
- 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 65,000 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 or Costco or Kroger affiliated 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 or Costco or Kroger affiliated pharmacy at the

applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy, a CVS retail pharmacy or a Costco or Kroger affiliated 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 automated 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 or Costco or Kroger affiliated 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 Flexible Spending Account

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

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, 2025, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2026 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, 2025 would have 45 days (until February 14, 2025) 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.*

UnitedHealthcare® is a registered mark of United Health Group, Inc.
GoodRx® is a registered mark of GoodRx Holdings, Inc.
Costco® is a registered mark of Costco Wholesale Corporation.
Kroger® is a registered mark of The Kroger Co.

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.	$1,650 per year for individual coverage / $3,300* 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 $3,300 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.

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

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)

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, 2025 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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 (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 WellPower Rewards biometric screening during an applicable year's program cycle, or if your spouse/domestic partner completes a WellPower Rewards Health Assessment 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 WellPower Rewards and redeeming any rewards you earn is included in the WellPower Rewards materials sent to you 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 WellPower Rewards materials sent to you 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 WellPower Rewards are generally available to all eligible employees. If you think you might be unable to meet a standard for a reward under 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 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

[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.

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.

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.**

[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.

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, changes to your contribution amounts will be made as soon as administratively practicable after the Company learns that you (and/or your spouse/domestic partner) did not complete the Tobacco Cessation Program by the applicable deadline.

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, 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.

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

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

When 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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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, 2025, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2026, 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, 2028; or

- 18 months following your termination of employment – July 1, 2027

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2028 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.

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Benefit Booklet

Duke Energy Active Medical Plan
PPO Option

Effective: January 1, 2025
Group Number: 729784

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

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

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer and can provide education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease and can provide education and guidance with chronic kidney disease (CKD) stage 4/5 or end state renal disease (ESRD) throughout your care path.

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	80% after you meet the Annual Deductible Office visit 100% after you pay a $25 Copay All Other Outpatient Services, including Partial Hospitalization/Day	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ Virtual Behavioral Health Therapy & Coaching.	Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible **Designated Network (AbleTo Therapy 360)** 100%	Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible Non-Network Benefits are not available
Neonatal Services	See Section 6, *Clinical Programs & Resources,* for Program Details.	
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient	80% after you meet the Annual Deductible Office visit 100% after you pay a $25 Copay (ABA) Intensive Behavioral Therapy 80% (No Deductible) All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment/ Intensive Behavioral Therapies 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible (ABA) Intensive Behavioral Therapy 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment/ Intensive Behavioral Therapies

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
		60% after you meet the Annual Deductible
Nutritional Counseling	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
Physician Fees for Surgical and Medical Services	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**
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*.		
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. ■ Colonoscopy	 100% 100% 100% 100%	 60% after you meet the Annual Deductible 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**
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 Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
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 Use of a Network program for Partial Hospitalization/Day Treatment/High Intensity Outpatient, and Residential Treatment 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% Office visit 100% after you pay a $25 Copay All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% 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	Office Visit: PCP: $25 then 100% Specialist: $40 then 100%	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Therapeutic Treatments - Outpatient	Office Visit: PCP $25 then 100% Specialist: $40 then 100% All other places of service: 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 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:*	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
■ 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 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 (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 *U.S. Food and Drug Administration (FDA)* approved 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 a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

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 from the Claims Administrator 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, 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 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 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.

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/High Intensity Outpatient.
- 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
For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from 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/High Intensity Outpatient.
- 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 Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization from 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).

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 you do not obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 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 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 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 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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient/programs; Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from 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 from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions Programs & Services.
- Disease Management Services.
- Wellness Programs.

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

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.

Second Opinion Service

2nd.MD is a second opinion education service for individuals with one or more eligible conditions who are looking for a second opinion from a medical expert. This program is covered by the Plan at $0 added cost. You can download the 2nd.MD app or visit www.2nd.md/dukeenergy. You can call the 2nd.MD Care Team directly at 866-269-3534 or get more information about the program by calling the number on your ID card.

Medical Conditions Included: Consultations available on the 2nd.MD platform include a range of medical conditions, currently covering all adult and pediatric subspecialties. To obtain a Consultation, a Participant must have received a diagnosis and/or treatment plan from a licensed specialist. Live support is provided during regular business days. The secure website and secure mobile application shall be available 24 hours a day, seven (7) days a week, excluding limited periods of maintenance, or periods of emergency maintenance, internet-wide disruptions, force majeure events, or attributable to Participant's software or hardware used to attempt access.

Maven

Maven is an app-based virtual program that provides you with pregnancy, postpartum and newborn support. It also gives you and your partner 24/7 access to resources — all included in the Plan at $0 added cost. Maven is here to help—get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health
- and more.

Visit mavenclinic.com/join/dukeenergy for more information.

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;
- 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**.

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.

Transplant Resource Services (TRS) Program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about the Transplant Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-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.

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.

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 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.

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 or visit www.myuhc.com 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 (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care, 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 it is the primary source of nutrition and is 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.

13. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

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 or Domestic Partners 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 Medicare's Allowable Expense or Medicare's limiting charge 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, administrative 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 adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally 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 or as required by law 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 its discretion, following evaluation and validation of

all provider billings generally 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-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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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.

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ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on 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

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 (including pregnancy, sexual orientation, and gender identity). 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 help you communicate 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

We also provide reasonable modifications for persons with disabilities.

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 send a complaint to the Civil Rights Coordinator identified below.

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 complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

ATTACHMENT IV – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUXILIARY AIDS AND SERVICES

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 فإن ،مجانًا وبلغتك المساعدة على الحصول في الحق لديك (TTY 711) 0 على اضغط ثم، الصحة خطة بطاقة على الموجود الهاتف رقم على اتصل، ذلك
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների 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 তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ D4Ꮷ ᏏᏢ ᎫCZᏬᎫ Ꭻ4ᏫᎠᎫ ᏂᎪᏯᏭW ᎥᏊ GᏙᏢ VᎯ ᏏR ᎫJAVᎫ ACᏫᎠVᎫ ᎢᎾᏲᏫᎠᎫT, ᎺᏐ0ᏰᎠᏓ 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 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'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	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဘီးန့ၣ်ဘဉ်တါ်မၤစၢးဒီးတါ်ဂ့ၢ်တါ်ကျိုၤလၢနကျိုဘဉ်နတဲလၢတဂၤလိဉ်ဟုဉ်အ ပူၤဘဉ်နှဉ်လီၤ.လၢတါ်ကယ့နှ်ပူၤကတိၤကျိုးထံတါ်တဂၤအဂီၢ်ကိုးဘဉ်လီတဲဖိအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချုအတၢ်ရဲဉ်တါကဲ့ အကးအလိၤဒီးဆီဉ်လီၤနီၢ်ဂ့ၢ် 0 တက့ၢ်.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	تۆخ یارمەتی زمان و هەمەجۆرەکانی پەیوەندیکردن بە تەلەفۆنی ئەرمانجی ژمارە بکە بۆ ئەندامانی پلانەکەت لەسەر کارتی ناسنامەکەت. تەلەفۆنی گوێگرانی قسەکردن بۆ کەسانی کەمئەندام یان کەسانی لێوشاوە 0 بگرە. 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 yíníkeedgo, 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 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.دهید تماس افتنی رایگان شماره از طریق به راحتی و به زبان خود را انتخاب کنید. برای درخواست مترجم شفاهی با شماره رایگان ذکر شده در کارت شناسایی برنامه خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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	ܫܝܐ ܕܙܒܢ ܠܡܐ ܕܡܬܝ ܠܗ ܠܡܐ ܕܡܬܝ ܠܗ ܠܡܐ ܕܡܬܝ ܠܗ

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 مفت فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Prescription Drug Program Guide for the Duke Energy Active Medical Plan

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SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 65,000 participating retail pharmacies.
- Your long-term (maintenance) prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy. Maintenance medications also can now be filled at Costco® and Kroger® affiliated pharmacies.
- 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 65,000 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 or Costco or Kroger affiliated 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 or Costco or Kroger affiliated pharmacy at the applicable 90-day supply co-pay or coinsurance amount. If you do not use the CVS Caremark

Mail Service Pharmacy, a CVS retail pharmacy or a Costco or Kroger affiliated 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 automated 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 or Costco or Kroger affiliated 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 Flexible 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 Flexible Spending Account (HCFSA) and are eligible to access HCFSA funds, you may pay any prescription drug co-pays and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCFSA or using your HCFSA 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®

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, 2025, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2026 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, 2025 would have 45 days (until February 14, 2025) 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.*

UnitedHealthcare® is a registered mark of United Health Group, Inc.
GoodRx® is a registered mark of GoodRx Holdings, Inc.
Costco® is a registered mark of Costco Wholesale Corporation.
Kroger® is a registered mark of The Kroger Co.

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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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, 2025 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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, 2025, 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, 2025, 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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage:

- 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

Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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 may 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, 2025 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, 2025, 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 enrolled 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 Plan. 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.

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Benefit Booklet

Duke Energy Retiree Medical Plan Catastrophic Option

Effective: January 1, 2025
Group Number: 729784

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

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

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Retiree Medical Plan's 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer and can provide education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease and can provide education and guidance with chronic kidney disease (CKD) stage 4/5 or end stage renal disease (ESRD) throughout your care path.

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*. ■ 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 *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	100% after you meet the Annual Deductible <u>Office visit</u> 100% after you meet the Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u>

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
■ Virtual Behavioral Health Therapy & Coaching	100% after you meet the Annual Deductible **Designated Network** **(AbleTo Therapy 360)** 100%
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient ■ Outpatient	100% after you meet the Annual Deductible Office visit 100% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 100% after you meet the Annual Deductible Intensive Behavioral Therapy 100%
Nutritional Counseling	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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
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
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.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible 100% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	100% after you meet the Annual Deductible
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 Use of a Network program for Partial Hospitalization/Day Treatment/High Intensity Outpatient, and Residential Treatment 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% <u>Office visit</u> 100% after you meet the Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u> 100% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
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 Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you meet the Annual Deductible Non-Network Benefits are not available
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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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.

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 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
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 from the Claims Administrator 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, 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 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 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 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 from the Claims Administrator 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/High Intensity Outpatient.
- 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 a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from 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/High Intensity Outpatient.
- 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 a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization from 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).

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 from the Claims Administrator as soon as the possibility of obesity 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.

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 you do not obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 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 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 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 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/High Intensity Outpatient.
- 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 a scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from 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 from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator 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:

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions Programs & Services.
- Disease Management Services.
- Wellness Programs.

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

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.

Maven

Maven is an app-based virtual program that provides you with pregnancy, postpartum and newborn support. It also gives you and your partner 24/7 access to resources — all included in the Plan at $0 added cost. Maven is here to help—get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health
- and more.

Visit mavenclinic.com/join/dukeenergy for more information.

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;
- 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**.

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.

Transplant Resource Services (TRS) Program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about the Transplant Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-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.

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.

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

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.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com 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 (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care, 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 it is the primary source of nutrition and is 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.

13. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

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 or Domestic Partners 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 Medicare's Allowable Expense or Medicare's limiting charge 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, administrative 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 adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally 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 or as required by law 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 its discretion, following evaluation and validation of all provider billings generally 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.

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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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

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 (including pregnancy, sexual orientation, and gender identity). 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 help you communicate 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

We also provide reasonable modifications for persons with disabilities.

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 send a complaint to the Civil Rights Coordinator identified below..

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 complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

ATTACHMENT III – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUXILIARY AIDS AND SERVICES

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 ከፊለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لطلب المساعدة مجانًا بلغتك، اتصل برقم العضو المدرج على بطاقة هويتك الصحية، واضغط 0. (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	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ D4Ꮷ ᏏᏢ ᎫCZᏬᎫ Ꭻ4ᏫᎫ ᏂᎪᏯᏭW ᎥᏊ GᏙᏢ VᎯ ᏏR ᎫJAVᎫ ACᏫᎠVᎫ ᎢᎾᏂᏫᎠᎫT, ᎣᏎ0ᏮᏫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी 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'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	နအိဉ်ဒီးတါခွဲးတါယာ်လၢနကဒီးနူဉ်ဘဉ်တါမၤစၢဒီးတါဂ့ၢ်တါကျိုလၢနကျိုဘဉ်နတဲလၢတဃိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါကဃုနူဉ်ပူၤကတိၤကျိုးထံတါတဘၤအဂီၢ်ကိုးဘဉ်လီတဲဖိအကျိုလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချုအတၢ်ရဲဉ်တါကဲ အကးအလိၤဒီးဆိဉ်လီၤနိၢ်ဂ့ၢ် 0 တကွ့ၢ်.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	تۆخ یان زمە بەتسووپێیاریاڵی و هقمارەی،مرەهامرەهبێمکەیە تەموئیەفام ونۆفەلەتمارەی زمە بەمکیدیەوپێ،یکاوی زاکیوگرگەوە ونیرلکداوا بۆ.تیوگەوە هرگ 0 ناشاپ تۆخ یتیوردفتیڵاپیەیساپێیتاکیدی ایوناڤیقاولراوسون .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 bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit ‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77

Language	Translated Taglines
	bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.دهید تماس افتنی رایگان شماره طور به زبان خود را با انتخاب و کلمک حق دارید .برای درخواست یک مترجم شفاهی با شماره رایگان درج شده در کارت شناسایی .برنامه خود تماس حاصل نمودهٔ و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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	ܙܝܢ ܠܟ ܕܬܬܚܕ ܥܕܪܐ ܘܝܕܥܬܐ ܒܠܫܢܟ ܕܠܐ ܡܫܠܡ ܐܢ ܒܥܝܬ ܠܟ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܣܦܪ ܕܛܠܦܘܢ ܕܒܪܫܝܡܬ ܐܝܕܝ ܕܥܠ ܟܪܛܝܣ ܕܚܒܪܘܬܟ ܘܠܚܘ 0 ܕܝ ܒܟܪܟ ܕܐܝܬ ܠܟ ܬܘܡܟ ܕܫܘܬܦ ܒܬܘ ܐܝܬ ܠܟ ܒܝܬ ܫܘܟܠܐ ܕܐܝܬ ܒܗ ܡܫܟܚ ܐܢ ܠܐ ܐܝܬ ܠܟ

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 مفت فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Prescription Drug Program Guide for the Duke Energy Retiree Medical Plan

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SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 65,000 participating retail pharmacies.
- Your long-term (maintenance) prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy. Maintenance medications also can now be filled at Costco® and Kroger® affiliated pharmacies.
- 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 65,000 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 or Costco or Kroger affiliated 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 or Costco or Kroger affiliated pharmacy at the applicable 90-day supply co-pay or coinsurance amount. If you do not use the CVS Caremark

Mail Service Pharmacy, a CVS retail pharmacy or a Costco or Kroger affiliated 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 automated 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 or Costco or Kroger affiliated 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®

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, 2025, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2026 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, 2025 would have 45 days (until February 14, 2025) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

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

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

Reviews & Appeals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances.

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

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

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

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

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

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

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

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

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

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

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final adverse benefit determination and any applicable time limits for bringing such a civil action;
- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge; and
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances.

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

Second Level Appeal Process for Pre-Service Claims
If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal

will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

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

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

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

UnitedHealthcare® is a registered mark of United Health Group, Inc.
GoodRx® is a registered mark of GoodRx Holdings, Inc.
Costco® is a registered mark of Costco Wholesale Corporation.
Kroger® is a registered mark of The Kroger Co.

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, 2025 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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, 2025, 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, 2025, 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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage:

- 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

Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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 may 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, 2025 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, 2025, 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 enrolled 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 Plan. 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.

myHR™ is a trademark of Alight Solutions LLC.

Benefit Booklet

Duke Energy Retiree Medical Plan
Health Savings Plan 1 Option

Effective: January 1, 2025
Group Number: 729784

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

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

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

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

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

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

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Retiree Medical Plan's Health Savings Plan 1 Option works. If you have questions call the number on 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 <u>not</u>:

- 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer and can provide education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease and can provide education and guidance with chronic kidney disease (CKD) stage 4/5 or end stage renal disease (ESRD) throughout your care path.

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*. ■ 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* 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 *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.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	Office visit 80% after you meet the Annual Deductible	Office visit 60% after you meet the Annual Deductible
	All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible
■ Virtual Behavioral Health Therapy & Coaching	**Designated Network (AbleTo Therapy 360)** 100% after you meet the Annual Deductible; Benefits for the Initial Consultation will be paid at 100%	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient	80% after you meet the Annual Deductible Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible Intensive Behavioral Therapy 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible Intensive Behavioral Therapy 60% after you meet the Annual Deductible
Nutritional Counseling	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.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
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		
■ 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	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.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
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 Use of a Network program for Partial Hospitalization/Day Treatment/High Intensity Outpatient, and Residential Treatment 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.	Office visit 80% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
		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 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

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Wigs Up to a $500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1] 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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, 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 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 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.

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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from 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/High Intensity Outpatient.
- 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 Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you do not obtain prior authorization from 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).

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 you do not obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 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 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 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 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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from 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 from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions Programs & Services.
- Disease Management Services.
- Wellness Programs.

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

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.

Maven

Maven is an app-based virtual program that provides you with pregnancy, postpartum and newborn support. It also gives you and your partner 24/7 access to resources — all included in the Plan at $0 added cost. Maven is here to help—get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health
- and more.

Visit mavenclinic.com/join/dukeenergy for more information.

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;
- 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**.

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.

Transplant Resource Services (TRS) Program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about the Transplant Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-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.

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.

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

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.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com 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 (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care, 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 it is the primary source of nutrition and is 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.

13. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

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 or Domestic Partners 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 Medicare's Allowable Expense or Medicare's limiting charge 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, administrative 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 adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally 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 or as required by law 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 its discretion, following evaluation and validation of all provider billings generally 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-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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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.

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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

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 (including pregnancy, sexual orientation, and gender identity). 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 help you communicate 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

We also provide reasonable modifications for persons with disabilities.

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 send a complaint to the Civil Rights Coordinator identified below.

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 complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

ATTACHMENT III – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUXILIARY AIDS AND SERVICES

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 ከፊለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لطلب ف أتّصل لمجانًا دون كلفة بلغتك وللحصول على مساعدة ،ترجمة فوريّة ،يرجى الاتصال برقم الهاتف المدوّن على بطاقة عضويتك الصحيّة، وللضغط على 0.)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	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ D4Ꮻ ᏏᏢ ᎫCZᏬᎫ Ꭻ4ᏫᎠᎫ ᏂᎪᎯᏭW ᎥᏊ GᏙᏢ VᎯ ᏏR ᎫJAVᎫ ACᏫᎠVᎫ ᎢᎾᏲᏫᎠᎫT, ᎺᏐ0ᏰᎠᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी 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'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	နအိဉ်ဒီးတါဒွဲးတါယာ်လၢနကဒီးနူဉ်ဘဉ်တါမၤစၢးဒီးတါဂ့ါတါကျိုလၢနကျိဉ်ဘဉ်နဝဲလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါကယ့နူ်ပူၤကတိၤကျိုးထံတါတက၊အဂီၢ်ကိုးဘဉ်လီတဲဖိအကျိုလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချုအတၢ်ရဲဉ်တါကဲ့ အကးအလိၤဒီးဆိဉ်လီၤနိ်ါဂ့ါ 0 တကုၢ်.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	تۆخ یارمە بەتایبەتیی و زانیاری وەربگرێت. هەروەها مافی هەیە بە خۆڕایی وەرگێڕاوی زمانەکەی خۆت وەربگرێت. تکایە بۆ بەکارهێنانی خزمەتگوزاری وەرگێڕانی زمان پەیوەندی بکە بە ژمارەی پشتەوەی کارتی ئەندامێتی تەندروستیی خۆت 0 بنێرە. 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 yíníkeedgo, 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 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.دهید تماس افتنی رایگان شماره تلفن اعضا روی کارت شناسایی خود را بخوانید و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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	ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܫܡܫ̈ܬܐ ܘܝܕܥܢܐ ܒܠܫܢܟ ܒܚܠܐ ܕܠܐ ܡܨܪܐ. ܒܥܝܢ ܕܬܬܪܓܡܢܐ ܐܬܪ ܠܡܣܦܪ ܕܛܠܦܘܢ ܕܒܟܪܛܝܣ ܕܚܒܪܘܬܟ ܕܒܚܒܪ ܐܢ ܐܬ ܒܥܝܢ ܕܬܫܡܫ̈ܬܐ ܕܒܪ ܡܢ

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 مفت فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Prescription Drug Program Guide for the Duke Energy Retiree Medical Plan

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SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 65,000 participating retail pharmacies.
- Your long-term (maintenance) prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy. Maintenance medications also can now be filled at Costco® and Kroger® affiliated pharmacies.
- 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 65,000 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 or Costco or Kroger affiliated 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 or Costco or Kroger affiliated pharmacy at the

applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy, a CVS retail pharmacy or a Costco or Kroger affiliated 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 automated 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 or Costco or Kroger affiliated 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®

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, 2025, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2026 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, 2025 would have 45 days (until February 14, 2025) 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.*

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SECTION 7 – PRESCRIPTION DRUG BENEFIT SUMMARY

	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 30-day supply) you pay:	**Maintenance Choice® CVS Caremark Mail Service Pharmacy or CVS Retail Pharmacy** For long-term medications (up to a 90-day supply) you pay:
Preventive Medications 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.

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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, 2025 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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Medical Coverage Availability

Duke Energy Corporation (Duke Energy) offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (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, 2025, 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, 2025, 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: Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage:

- 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

Under the enrollment requirements for Duke Energy-sponsored pre-65 retiree health coverage, 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 may 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, 2025 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, 2025, 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 enrolled 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 Plan. 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.

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Benefit Booklet

Duke Energy Retiree Medical Plan
Standard PPO Option

Effective: January 1, 2025
Group Number: 729784

UnitedHealthcare®

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SECTION 1 - WELCOME

Quick Reference Box

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

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

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

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

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

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Retiree Medical Plan's Standard PPO Option works. If you have questions call the number on 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.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer and can provide education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease and can provide education and guidance with chronic kidney disease (CKD) stage 4/5 or end stage renal disease (ESRD) throughout your care path.

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	80% after you meet the Annual Deductible Office visit 100% after you pay a $40 Copay All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensiv	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/ Day

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
	e Outpatient Treatment 80% after you meet the Annual Deductible	Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 60% after you meet the Annual Deductible
■ Virtual Behavioral Health Therapy & Coaching	**Designated Network (AbleTo Therapy 360)** 100%	Not Covered
Neurobiological Disorders – Autism Spectrum Disorder Services		
■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	Office visit 100% after you pay a $40 Copay (ABA) Intensive Behavioral Therapy 80% (No Deductible) All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment/Intensive Behavioral Therapies 80% after you meet the Annual Deductible	Office visit 60% after you meet the Annual Deductible (ABA) Intensive Behavioral Therapy 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/ Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment/Inten

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
		sive Behavioral Therapies 60% after you meet the Annual Deductible
Nutritional Counseling (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
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. ■ Outpatient Use of a Network program for Partial Hospitalization/Day Treatment/High Intensity Outpatient, and Residential Treatment 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% Office visit 100% after you pay a $40 Copay All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Office visit 60% after you meet the Annual Deductible All Other Outpatient Services, including Partial Hospitalization/ Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment 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	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**
(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		
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 (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*	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
	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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 from the Claims Administrator 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 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.

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 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.

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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you do not obtain prior authorization from 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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received:. Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization from 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).

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 you do not obtain prior authorization from the Claims Administrator 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 from the Claims Administrator 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 you do not obtain prior authorization from the Claims Administrator 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 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 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 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 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/High Intensity Outpatient.
- 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 an admission for services at a Residential Treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient programs; Intensive Outpatient Treatment programs; psychological testing.

If you do not obtain prior authorization from 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 from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

- Consumer Solutions and Self-Service Tools.
- Complex Medical Conditions Programs & Services.
- Disease Management Services.
- Wellness Programs.

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

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.

Maven

Maven is an app-based virtual program that provides you with pregnancy, postpartum and newborn support. It also gives you and your partner 24/7 access to resources — all included in the Plan at $0 added cost. Maven is here to help—get the app for support with:

- Creating your birth plan
- Breastfeeding and bottle-feeding
- Navigating infant sleep
- Returning to work
- Managing your mental health
- and more.

Visit mavenclinic.com/join/dukeenergy for more information.

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;
- 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**.

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.

Transplant Resource Services (TRS) Program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about the Transplant Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-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.

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.

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 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

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.

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com 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 (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care, 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 it is the primary source of nutrition and is 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.

13. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

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 or Domestic Partners 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 Medicare's Allowable Expense or Medicare's limiting charge 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, administrative 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 adjudicates claims consistent with industry standards. UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, generally 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 or as required by law 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 its discretion, following evaluation and validation of all provider billings generally 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-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/High Intensity Outpatient - a structured ambulatory program that may be a freestanding 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.

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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

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 (including pregnancy, sexual orientation, and gender identity). 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 help you communicate 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

We also provide reasonable modifications for persons with disabilities.

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 send a complaint to the Civil Rights Coordinator identified below.

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 complaint, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

ATTACHMENT III – NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE AND AUXILIARY AIDS AND SERVICES

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 ከፊለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ።** TTY 711
3. Arabic	لطلب ذلك، اتصل برقم الهاتف الموجود على بطاقة هويتك الصحية، واضغط على 0. (TTY: 711)
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների 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 তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ D4Ꮷ ᏏᏢ ᎫCZᏬᎫ Ꭻ4ᏫᎠᎫ ᏂᎪᎯᏭW ᎥᏊ GᏙᏢ VᎯ ᏏR ᎫJAVᎫ ACᏫᎠVᎫ ᎢᎾᏲᏫᎠᎫT, ᎺᏐ0ᏰᎠᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी 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'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	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနုကဘီးနူဉ်ဘဉ်တါ်မၤစၢးဒီးတါ်ဂ့ါတါ်ကျိုလၢနုကျိဉ်ဒဉ်နဲဝလၢတဂလိဉ်ဟုဉ်အ ပူၤဘဉ်နူဉ်လီၤ.လၢတါ်ကယ့နူ်ပူၤကတိၤကျိုးထံတါ်တဂၤအစိဂ်ါကိုးဘဉ်လီတဲဖိအကျိုလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနုတၢ်အိဉ်ဆူဉ်အိဉ်ချုအတၢ်ရဲဉ်တၢ်ကဲ အကးအလိၤဒီးဆိဉ်လီၤနီၢ်ဂ့ၢ် 0 တကုၢ်.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	تۆخ یارمە بەتسووچپیاریاڵی و یەمارەی،مرەهامرەبچیەکەیە تەموئیەفام ئیونۆفۆڵەتمارژمە بەبکیدنوویپەی،یکواز یکیوچگرەو ئیتریکداو ڕبت.تیوگرەو هرگ 0 ناشاپ تۆخ یتسوردفتیئالپەیسایپیتاکید ایئواڤلوارسوون .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 yíníkeedgo, 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 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	.دهای تفاوی رایگان زبان خود را به طور کامل و کتبی درخواست کنید. برای درخواست مترجم شفاهی با شماره تلفن رایگان ذکر شده در کارت شناسایی برنامه خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
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	ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܩܒܠ ܥܕܪܐ ܘܝܕܥܢܐ ܒܠܫܢܟ ܕܠܝܬ ܠܗ ܡܓܢ. ܠܡܒܥܐ ܠܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܣܦܪ ܕܛܠܦܘܢ ܕܒܟܪܛܝܣ ܕܚܒܪܘܬܟ ܕܐܝܬ ܒܗ ܟܠ ܡܢ ܕܐܢܬ ܒܥܐ ܠܡܐܬܝ ܠܟ ܥܠ ܐܝܕ

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 مفت فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Prescription Drug Program Guide for the Duke Energy Retiree Medical Plan

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SECTION 1 – WELCOME

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

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

- The CVS Caremark retail network consists of more than 65,000 participating retail pharmacies.
- Your long-term (maintenance) prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy. Maintenance medications also can now be filled at Costco® and Kroger® affiliated pharmacies.
- 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 65,000 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 or Costco or Kroger affiliated 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 or Costco or Kroger affiliated pharmacy at the applicable 90-day supply co-pay or coinsurance amount. If you do not use the CVS Caremark

Mail Service Pharmacy, a CVS retail pharmacy or a Costco or Kroger affiliated 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 automated 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 or Costco or Kroger affiliated 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®

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, 2025, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2026 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, 2025 would have 45 days (until February 14, 2025) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

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

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

Reviews & Appeals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances.

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

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

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

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

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

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

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

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

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

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

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final adverse benefit determination and any applicable time limits for bringing such a civil action;
- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge; and
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances.

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

Second Level Appeal Process for Pre-Service Claims
If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal

will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Legal Action

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

Discretionary Authority

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

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

UnitedHealthcare® is a registered mark of United Health Group, Inc.
GoodRx® is a registered mark of GoodRx Holdings, Inc.
Costco® is a registered mark of Costco Wholesale Corporation.
Kroger® is a registered mark of The Kroger Co.

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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-043

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 tables below:

<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>
</table>

<table>
<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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-044

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:

2025 retiree medical options and full monthly cost rates:

	Individual Only	Individual + Spouse	Individual + Child(ren)	Individual + Family
Catastrophic	$1,725	$3,159	$2,125	$3,561
Health Savings Plan 1	$1,937	$3,541	$2,484	$4,087
Standard PPO	$2,245	$4,103	$2,823	$4,687

Employees who newly retire from Duke Energy and enroll in Duke Energy's coverage pay the full cost of coverage. The 2025 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 a Health Reimbursement Account (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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-045

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-01-045 Attachment.

PERSON RESPONSIBLE: Shannon A. Caldwell

Duke Energy Kentucky - Electric

		12 Month Preceding 9/1/23 – 8/31/24	Base Period 9/1/24 – 8/31/25	Variance
1B110	Qualified Pension	461,114	430,981	(30,133)
1B112	Employee Savings Active	1,018,611	986,152	(32,459)
1B114	OPEB Active	21,646	18,460	(3,186)
1B210	Medical Active	1,104,706	1,227,331	122,625
1B212	Dental Active	46,266	48,308	2,041
1B214	Misc Other Fees	22	21	(1)
1B216	Long Term Disability	41,041	41,803	763
1B218	FAS112 Offset	336,888	177,599	(159,289)
1B310	Service/Safety Awards	9,562	12,444	2,882
1B312	Other Work/Family Benefits	-	4,268	4,268
1B410	Tuition Refund	4,191	6,728	2,536
1B510	Basic Life	14,686	15,343	658
1B512	Accidental Death & Dismember.	1,342	1,392	50
Total		3,060,076	2,970,830	(89,246)

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 'Medical Active' due to medical claims;
(2) Lower 'FAS112 Offset' due to LTD medical expense.

Duke Energy Kentucky - Gas

		12 Month Preceding 9/1/23 – 8/31/24	Base Period 9/1/24 – 8/31/25	Variance
1B110	Qualified Pension	174,098	168,261	(5,837)
1B112	Employee Savings Active	396,636	380,813	(15,823)
1B114	OPEB Active	8,131	7,199	(932)
1B210	Medical Active	419,775	486,345	66,570
1B212	Dental Active	17,478	18,717	1,239
1B214	Misc Other Fees	8	9	1
1B216	Long Term Disability	15,487	16,336	849
1B218	FAS112 Offset	130,558	67,501	(63,057)
1B310	Service/Safety Awards	3,517	4,756	1,239
1B312	Other Work/Family Benefits	-	1,625	1,625
1B410	Tuition Refund	1,575	2,564	989
1B510	Basic Life	5,544	5,986	442
1B512	Accidental Death & Dismember.	507	544	37
Total		1,173,315	1,160,655	(12,660)

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 'Medical Active' due to medical claims;

(2) Lower 'FAS112 Offset' due to LTD medical expense.

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-046

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 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 Companies. In Section III and the first question of Section IV of the testimony provided by Shannon A. 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 testimony provided by Shannon A. 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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

CONFIDENTIAL STAFF-DR-01-047
(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-01-047(a) Attachment to reference the Committee Charter.

b. Our compensation philosophy is described on pages 7-10 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-01-047(c) Confidential Attachment for an annual study conducted by FW Cook in 2024.

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 December 11, 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 periodically, but no less frequently than annually, the individual objectives applicable to the Chief Executive Officer under the Corporation's short-term incentive plan and recommend that the independent members of the Board approve such objectives, and review and approve periodically, but no less frequently than annually, all other 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 independent members of the Board) 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.

Monitoring Incentive and Equity-Based Compensation Plans

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-01-047(c) CONFIDENTIAL ATTACHMENT

FILED UNDER SEAL

STAFF-DR-01-048

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-01-046, 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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-049

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-01-049 Attachment.

PERSON RESPONSIBLE: Bruce L. Sailers

Duke Energy Kentucky, Inc.
Average Monthly Number of Customers Annually 2022 - 2024 and Base Period
(Including Actual 6-month Base Period Separate from Forecast 6-month Base Period)

	Rate Schedules					
	RS	GS - Commercial	GS - Industrial	GS - OPA	FT-L	IT
2022	95,411	6,422	183	301	128	20
2023	96,519	6,587	171	302	125	18
2024	98,104	6,685	159	282	151	19
Base Period						
Actual Sep 2024 - Feb 2025	97,828	6,743	155	281	155	19
Forecast Mar 2025 - Aug 2025	98,690	6,640	169	291	153	19
Base Period Sept 2024 - Aug 2025	98,259	6,692	162	286	154	19

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-050

REQUEST:

In the formats provided in Schedule L, provide schedules of gas operations net income per MCF 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].

PERSON RESPONSIBLE: Linda L. Miller

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-051

REQUEST:

Provide, in the formats provided in Schedules M, comparative operating statistics for gas operations.

RESPONSE:

Please see STAFF-DR-01-051 Attachment.

PERSON RESPONSIBLE: Linda L. Miller

DUKE ENERGY KENTUCKY, INC.
KyPSC Case No. 2025-00125
Comparative Operating Statistics - Gas Operations
For the Calendar Years 2022 through 2024
(Total Company)

Line No.	Item (a)	Three Most Recent Calendar Years 2022 (b)	Inc. (c)	2023 (d)	Inc. (e)	2024 (f)	Inc. (g)
1	Cost per MCF of purchased gas	$5.28	67.22%	$3.84	(27.35)%	$3.64	(5.16)%
2	Cost of propane gas per MCF equivalent for peak shaving	11.99	(0.65)%	$0.00	(100.00)%	$0.00	-
3	Cost per MCF of gas sold	$ 6.64	43.72%	$ 5.12	(22.89)%	$ 5.29	3.32%
4	Transmission Maintenance Cost	$451,821	296.60%	$170,323	(62.30)%	$402,082	136.07%
	per transmission mile	19,644.39	313.84%	$7,096.79	(63.87)%	$18,276.46	157.53%
5	Distribution Maintenance Cost	$1,844,906	(4.04)%	$2,135,269	15.74%	$1,974,325	(7.54)%
	per distribution mile	$1,187.96	(5.46)%	$1,357.45	14.27%	$1,248.78	(8.01)%
6	Sales promotion expense	$349,758	3.75%	$74,027	(78.83)%	$72,026	(2.70)%
	per customer	$3.42	3.39%	$0.72	(79.03)%	$0.69	(4.33)%
7	Administration & general expense	$7,919,381	(0.07)%	$6,844,346	(13.57)%	$7,416,972	8.37%
	per customer	$77.33	(0.41)%	$66.16	(14.44)%	$70.58	6.67%
8	Wages and salaries - charged expense: per average employee	N/A	N/A	N/A	N/A	N/A	N/A
9	Depreciation expense:	$17,434,955	(5.14)%	$18,766,404	7.64%	$17,787,681	(5.22)%
10	per $100 of average gross depreciable plant in service	$2.20	(10.93)%	$2.20	0.05%	$1.89	(14.17)%
11	Rents:	$723,702	93.61%	$856,088	18.29%	$941,275	9.95%
12	per $100 of average gross plant in service	$0.09	81.25%	$0.10	9.20%	$0.10	-
13	Property taxes:	$4,404,843	1.83%	$3,197,497	(27.41)%	$4,870,600	52.33%
14	per $100 of average net plant in service	0.70	(6.67)%	0.47	(32.86)%	0.64	36.17%
15	Payroll taxes:	N/A	N/A	N/A	N/A	N/A	N/A
16	Payroll taxes: per average employee whose salary is charged to expense	N/A	N/A	N/A	N/A	N/A	N/A
17	Interest expense:	$ 9,315,867		$ 10,546,477		$ 11,015,566	
18	per $100 of average debt outstanding	N/A	N/A	N/A	N/A	N/A	N/A
19	per $100 of average plant investment	N/A	N/A	N/A	N/A	N/A	N/A
20	per MCF sold	$0.69	9.94%	$0.84	21.57%	$0.87	3.37%
21	Meter reading expense:	$18,214	5.98%	$11,204	(38.49)%	$28,502	154.39%
22	per meter	$0.18	5.95%	$0.11	(39.33)%	$0.27	150.93%

(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. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-052

REQUEST:

For the historical portion of the base period and the five preceding calendar years, provide a schedule detailing all nonrecurring charges by customer class which includes:

a. Type of charge;

b. Amount billed;

c. Amount recovered; and

d. Number of times the charge was assessed.

RESPONSE:

a. Please see STAFF-DR-01-052 Attachment.

b. Please see STAFF-DR-01-052 Attachment.

c. Please see STAFF-DR-01-052 Attachment. The amount recovered detail was not completely available for the request period covered by a legacy customer billing system. Therefore, the Attachment shows recovered amounts for calendar year 2020 and the months starting April 2022 onwards as well as for the historical portion of the base period.

d. Please see STAFF-DR-01-052 Attachment.

Please note that in STAFF-DR-01-052 Attachment some of the Late Payment Fees were not assigned to a specific customer class (such as residential) in the Company's billing

datasets from the legacy customer billing system. Some of those dollars appear in separate rows called Late Payment.

PERSON RESPONSIBLE: Douglas J. Heitkamp

YEAR 2020

	Charged				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$114,117	$2,319	$215	$45	$116,695
INDUSTRIAL	$26,867	$75	$11		$26,953
OPA	$6,603				$6,603
RESIDENTIAL	$102,680	$2,856	$4,565	$30	$110,131
LATE PAYMENT	$8,618				$8,618
Grand Total	**$258,885**	**$5,250**	**$4,791**	**$75**	**$269,001**

	Recovered				
Classification	**Late Payment**	**Reconnection**	**Return Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$43,780	$1,650	$154	$30	$45,614
INDUSTRIAL	$6,754	$75	$11		$6,840
OPA	$538				$538
RESIDENTIAL	$159,584	$2,164	$3,097	$30	$164,875
Grand Total	**$210,655**	**$3,889**	**$3,262**	**$60**	**$217,866**

	Number of Times Assessed				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	5,861	38	38	3	5,940
INDUSTRIAL	226	1	1		228
OPA	164				164
RESIDENTIAL	36,188	73	727	2	36,990
LATE PAYMENT	2,540				2,540
Grand Total	**44,979**	**112**	**766**	**5**	**45,862**

	Charged				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$154,357	$265	$715	$30	$155,367
INDUSTRIAL	$26,374	$0	$11		$26,385
OPA	$4,747		$0		$4,747
RESIDENTIAL	$462,962	$7,815	$15,725	$75	$486,577
LATE PAYMENT	$3,700				$3,700
Grand Total	**$652,141**	**$8,080**	**$16,451**	**$105**	**$676,776**

	Recovered				
Classification	**Late Payment**	**Reconnection**	**Return Check**	**Field Collection**	**Grand Total**

NOTE: The detail for amounts recovered was not available for this time period from the legacy billing system.

	Number of Times Assessed				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	6,066	4	123	2	6,195
INDUSTRIAL	228	0	1		229
OPA	56		0		56
RESIDENTIAL	167,723	115	2,549	5	170,392
LATE PAYMENT	1,251				1,251
Grand Total	**175,324**	**119**	**2,673**	**7**	**178,123**

YEAR 2022

	Charged				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$39,017	$180	$20		$39,217
INDUSTRIAL	$1,105		$3		$1,108
OPA	$1,954				$1,954
RESIDENTIAL	$182,832	$360	$1,318		$184,510
RESIDENTIAL - Legacy system	$443,407	$880	$2,094		$446,382
Grand Total	**$668,315**	**$1,420**	**$3,434**	**$0**	**$673,171**

	Recovered				
Classification	**Late Payment**	**Reconnection**	**Return Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$38,020	$180	$18		$38,217
INDUSTRIAL	$1,105		$3		$1,108
OPA	$1,912				$1,912
RESIDENTIAL	$176,325	$349	$1,253		$177,927
RESIDENTIAL - Legacy system: Detail not available from legacy billing system for this time period.					
Grand Total	**$217,362**	**$529**	**$1,273**	**$0**	**$219,164**

	Number of Times Assessed				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	3,547	2	7		3,556
INDUSTRIAL	84		1		85
OPA	71				71
RESIDENTIAL	78,693	4	241		78,938
RESIDENTIAL - Legacy system	44,508	10	761		45,279
Grand Total	**126,903**	**16**	**1,010**	**0**	**127,929**

NOTE: The company switched customer billing systems during 2022. Data for the months covered by the prior legacy system is displayed on its own row above. Some data including amount recovered data detail was not available.

	Charged				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$106,186	$720	$263		$107,168
INDUSTRIAL	$6,186		$13		$6,198
OPA	$7,426				$7,426
RESIDENTIAL	$520,786	$2,880	$6,228		$529,894
Grand Total	**$640,583**	**$3,600**	**$6,503**	**$0**	**$650,686**

	Recovered				
Classification	**Late Payment**	**Reconnection**	**Return Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$102,824	$713	$233		$103,770
INDUSTRIAL	$6,052		$13		$6,065
OPA	$7,420				$7,420
RESIDENTIAL	$506,153	$2,580	$5,213		$513,947
Grand Total	**$622,449**	**$3,293**	**$5,458**	**$0**	**$631,201**

	Number of Times Assessed				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	6,583	8	104		6,695
INDUSTRIAL	143		5		148
OPA	236				236
RESIDENTIAL	150,464	32	2,406		152,902
Grand Total	**157,426**	**40**	**2,515**	**0**	**159,981**

	Charged				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$51,331	$630	$250		$52,211
INDUSTRIAL	$6,859		$5		$6,864
OPA	$1,973		$3		$1,976
RESIDENTIAL	$280,445	$4,519	$7,628		$292,592
Grand Total	**$340,609**	**$5,149**	**$7,885**	**$0**	**$353,642**

	Recovered				
Classification	**Late Payment**	**Reconnection**	**Return Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$50,092	$630	$203		$50,924
INDUSTRIAL	$7,140		$5		$7,145
OPA	$1,973		$3		$1,976
RESIDENTIAL	$268,787	$4,393	$6,329		$279,509
Grand Total	**$327,992**	**$5,023**	**$6,539**	**$0**	**$339,554**

	Number of Times Assessed				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	7,199	7	98		7,304
INDUSTRIAL	156		2		158
OPA	197		1		198
RESIDENTIAL	181,082	54	2,910		184,046
Grand Total	**188,634**	**61**	**3,011**	**0**	**191,706**

Historical Base Period | September 2024 through February 2025

	Charged				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$36,642	$270	$175		$37,087
INDUSTRIAL	$5,361		$10		$5,371
OPA	$1,187		$3		$1,189
RESIDENTIAL	$171,302	$1,362	$3,968		$176,632
Grand Total	**$214,491**	**$1,632**	**$4,155**	**$0**	**$220,278**

	Recovered				
Classification	**Late Payment**	**Reconnection**	**Return Check**	**Field Collection**	**Grand Total**
COMMERCIAL	$35,202	$270	$143		$35,614
INDUSTRIAL	$5,351		$10		$5,361
OPA	$1,187		$3		$1,189
RESIDENTIAL	$160,588	$1,054	$3,135		$164,778
Grand Total	**$202,328**	**$1,324**	**$3,290**	**$0**	**$206,942**

	Number of Times Assessed				
Classification	**Late Payment**	**Reconnection**	**Returned Check**	**Field Collection**	**Grand Total**
COMMERCIAL	4,302	3	68		4,373
INDUSTRIAL	99		4		103
OPA	117		1		118
RESIDENTIAL	96,984	18	1,493		98,495
Grand Total	**101,502**	**21**	**1,566**	**0**	**103,089**

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-053

REQUEST:

For the forecasted portion of the base period and forecasted test year, provide a schedule detailing all nonrecurring charges by customer class which includes:

a. Type of charge;

b. Revenues forecasted;

c. Number of charges forecasted (except late payment penalties);

d. Basis for late payment penalties; and

e. Support of the nonrecurring charge.

RESPONSE:

The Company forecasts Miscellaneous Other Revenues in total to account 0488000 based on historical trends in actuals. Specific nonrecurring charges cannot be identified. The total forecasted amount included in account 0488000 for the base period is $26,000 and for the forecasted period is $52,000.

PERSON RESPONSIBLE: Claire C. Hudson

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

CONFIDENTIAL STAFF-DR-01-054
(As to Attachment BLS-3 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 Attachment BLS-3 only)

1. Please see STAFF-DR-01-054 Attachment KPSC Gas SFRs-2025 which is an electronic copy of the Company's application, Volume 10, 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 is a confidential, electronic version of the schedule provided in the Direct Testimony of Company witness Bruce L. Sailers. STAFF-DR-01-054 Attachment BLS-4 and STAFF-DR-01-054 Attachment BLS-5 are 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 Gas COSS 2025 for an electronic version of the Company's cost of service study.

PERSON RESPONSIBLE: Jefferson "Jay" P. Brown
Bruce L. Sailers
Douglas J. Heitkamp

STAFF-DR-01-054 ATTACHMENT KPSC GAS SFRs-2025

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 – SCH M-N – BASE PERIOD

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

Duke Energy Kentucky, Inc.
Calculation of Gas Service Reconnection Cost and Proposed Charge

Base Labor		$46.62	
Unproductive	20.3%	$9.47	Loads on Base - direct labor
Incentives	6.9%	$3.88	Loads on Base plus Unprod
Subtotal		$13.35	
Fringes	32.7%		
Payroll Tax	6.9%		
Subtotal	39.5%	23.71	Loads on Base plus Unprod plus Incentive
Fleet	5.2%	2.93	Loads on Base - direct labor
Loaded Labor w/ Fleet		$86.61	
Indirects	70.8%	$32.99	Load on Loaded Labor
Total Cost Per Hour Including Labor Items		$ 119.60	
Total Cost Per Hour Excluding Labor Items (Employee Performed Gas Reconnections)		$ 2.93	
Contracted Reconnection Rate (Contractor Performed Gas Reconnection)		[redacted]	
Percentage of Reconnections Performed:			
Employee		35.54%	
Contractor		64.46%	
Weighted Average Reconnection Rate		$ 112.14	
Proposed Reconnection Charge		$ 110.00	

Duke Energy Kentucky, Inc.
Calculation of Meter Pulse Service Charges

Line No.	Equipment Descriptions	Cost
1	Installation of Meter Pulse Equipment:	
2	Pulser (1 of 2 options):	
3	Single Lead Metretek Pulser (#50116511):	$ 146.00
4	Dual Lead Metretek Pulser (#50130416):	$ 162.00
5	Average Pulser Cost (Average Lines 3 & 4)	$ 154.00
6	Intrinsically Safe Barriers (ISB) AC115/DC24V Power	$ 300.00
7	Weather-proof Box	$ 100.00
8	Total ISB Cost: (Line 6 + Line 7)	$ 400.00
9	Labor Hourly Rate	$ 118.08
10	Estimated hours	4.00
11	Total Labor (Line 9 x Line 10)	$ 472.32
12	Total Meter Pulse Equipment: (Line 5 + Line 8 + Line 11)	$ 1,026.32
13	Tariff Sheet Value Proposed: (Based on Line 12)	$ 1,025.00
14	Meter Index if needed (1 of 2 options):	
15	Life Lube Rotary Index (#50101099, #140013)	$ 584.00
16	Life Lube Rotary Index Conversion Kit (#140007, #140008)	$ 709.00
17	Average Meter Index Cost	$ 646.50
18	Labor Hourly Rate	$ 118.08
19	Estimated hours	1.00
20	Total Labor (Line 18 x Line 19)	$ 118.08
21	Total Meter Index (Line 17 + Line 20)	$ 764.58
22	Tariff Sheet Value Proposed: (Based on Line 21)	$ 760.00

Duke Energy Kentucky, Inc.
Pipeline Services
IT Balancing Charge Calculation based on Pipeline Rates Effective April 1, 2025

Charges based on Daily Balancing

				Annual Cost	
Demand Charges					
Columbia Gas FSS					
FSS MDWQ	5,500	$6.4610	12	$426,426.00	
Winter SST	5,500	$22.0480	7	$848,848.00	
Summer SST	2,750	$22.0480	5	$303,160.00	
Commodity Charges					
SST Inject *	406,704		$0.0204	$8,296.76	
FSS Inject	399,274		$0.0333	$13,295.81	
FSS Withdraw	394,375		$0.0333	$13,132.69	
SST Withdraw	387,170		$0.0190	$7,356.23	
Total				$1,620,515.48	
Total IT & FT Average Throughput				4,250,543	mcf
Cost for Daily Balancing (All Options)				**$0.3812**	**per mcf**

Charges Based on Carry-Over Amounts

Columbia Gas FSS					
FSS SCQ Summer (8%)	28,337	$0.1160	7	$23,009.61	
FSS SCQ Winter (10%)	35,421	$0.1160	5	$20,544.29	
				$43,553.90	
Total IT & FT Average Throughput				4,250,543	mcf
Charge for Monthly Carry-over				**$0.0102**	**per mcf**
Total Charge for Option 3				**$0.3915**	**per mcf**

* Commodity Charges include ACA of $0.0014

STAFF-DR-01-054 ATTACHMENT – DEK GAS COSS 2025

UPLOADED ELECTRONICALLY ONLY

DUE TO SIZE

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-055

REQUEST:

To the extent not already provided, provide all workpapers, calculations, and assumptions the utility used to develop its forecasted test period financial information in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

RESPONSE:

Refer to FR 16(7)(c) in the Company's Application in this proceeding for the assumptions used to develop the forecasted test period financial information [Vol. 1, Tab 23].

Refer to Volume 12 of Duke Energy Kentucky's Application in this proceeding for the work papers used to develop its forecasted test period financial information and please see STAFF-DR-01-054 Attachment KPSC GAS SFRs-2025 for the Excel version of the workpapers embedded within the applicable schedules.

PERSON RESPONSIBLE: Jefferson "Jay" P. Brown
Claire C. Hudson
Sharif S. Mitchell

Duke Energy Kentucky
Case No. 2025-00125
STAFF's First Request for Information
Date Received: May 7, 2025

STAFF-DR-01-056

REQUEST:

To the extent not already provided, provide all workpapers, calculations, and assumptions Duke Kentucky used to develop its forecasted test period financial information in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

RESPONSE:

This appears to be duplicative of the previous request. As such, please see response to STAFF-DR-01-055.

PERSON RESPONSIBLE: Legal