

Document title:

Progress Energy Florida, Inc. Reimbursement Accounts – Health Care & Child/Elder Care

Document number:

HRI-PGNF-00006

Applies to: Progress Energy Florida, Inc. (bargaining unit employees)

Keywords: human resources information; benefits booklets

Progress Energy Florida, Inc. Child/Elder Care Reimbursement Account
 Progress Energy Florida, Inc. Health Care Reimbursement Account
 Summary Plan Description
 Progress Energy, Inc.
 Employer Identification No. 56-2155481, Plan No. 526
 Effective January 1, 2009

This booklet is a Summary Plan Description (SPD) for the Progress Energy Florida, Inc. Child/Elder Care Reimbursement Account and the Progress Energy Florida, Inc. Health Care Reimbursement Account (the "Plan"). The Plans are sponsored by Progress Energy, Inc. and are available to regular, full-time bargaining unit employees of Progress Energy Florida, Inc.

If there are inconsistencies between this booklet and the Plan documents, the terms and conditions of the Plan documents will govern. In no case does this document imply or guarantee any right of future employment.

The Plan Sponsor reserves the right to amend or terminate the Plan or any plan benefit at any time based on the cost of the benefits or other considerations without prior approval of or notification to any party.

Reference Forms

- FRM-PGNF-00008, FlexPower Benefits Change Form
- FRM-SUBS-01060, Child/Elder Care Reimbursement Account Claim Form
- FRM-SUBS-01061, Health Care Reimbursement Account Claim Form
- FRM-SUBS-01101, Flexible Spending Account Direct Deposit Authorization Form
- HRI-SUBS-30004, Guide to Benefits for Domestic Partners

<u>Eligibility</u>	3
<u>Full-time employees</u>	3
<u>Leaves of absence</u>	3
<u>Enrollment, Changes, and Effective Date</u>	4
<u>Enrollment</u>	4
<u>Qualifying events</u>	4
<u>Effective date</u>	5
<u>Contributions and Forfeitures</u>	6
<u>Effect on other benefits</u>	6
<u>When Participation Ends</u>	7
<u>Child/Elder Care Reimbursement Account</u>	7
<u>Health Care Reimbursement Account</u>	7
<u>COBRA coverage</u>	7
<u>Other COBRA information</u>	10
<u>Health Care Reimbursement Account</u>	12
<u>Eligible dependents</u>	12
<u>Annual contribution limits</u>	12
<u>Covered expenses</u>	12
<u>Expenses not covered</u>	12
<u>Orthodontia treatment reimbursement</u>	13
<u>Health Care example</u>	14
<u>Child/Elder Care Reimbursement Account</u>	15
<u>Eligible dependents</u>	15
<u>Annual contribution limits</u>	15
<u>Covered expenses</u>	16
<u>Dependent care tax credit</u>	17
<u>Expenses not covered</u>	17
<u>Filing Reimbursement Requests</u>	18
<u>Health Care reimbursement requests</u>	18
<u>Child/Elder Care reimbursement requests</u>	19
<u>How to submit claims</u>	19
<u>Direct Deposit</u>	20
<u>Questions</u>	20
<u>If your reimbursement request is denied</u>	20
<u>Additional Plan Information</u>	21
<u>Plan Identification</u>	21
<u>Costs and funding</u>	21
<u>Administration</u>	21
<u>Plan Administrator</u>	21
<u>Claims Administrator</u>	21
<u>Agent for service of legal process</u>	22
<u>Continuation of Plan and Plan amendments</u>	22
<u>Health Insurance Portability and Accountability Act (HIPAA)</u>	22
<u>Your Rights Under ERISA</u>	23

The Plan covers employees and their dependents who meet the eligibility requirements specified herein. Certain employees who are eligible are represented by the International Brotherhood of Electrical Workers.

Leased employees as defined in Section 414(n) of the Internal Revenue Code and independent contractors are not covered by the Plan.

Full-time employees

Regular, full-time bargaining unit employees of Progress Energy Florida, Inc. are eligible to participate in one or both of the following Reimbursement Accounts:

- Health Care Reimbursement Account - used for health care expenses, such as medical, dental, and vision plan deductibles, copayments, coinsurance, and other eligible expenses not paid or reimbursed by other benefit plans.
- Child/Elder Care Reimbursement Account - used for dependent care expenses that are incurred to enable you to work.

Leaves of absence

You may continue to participate in the Health Care Reimbursement Account by making contributions on pre-tax basis to the extent permitted by the Internal Revenue Code of 1986, as amended (otherwise on an after-tax basis) if you are granted a leave of absence as permitted in the Employee Handbook for:

- Newborn care
- Adoption/foster care
- Military service
- Any other absence that qualifies under the Family and Medical Leave Act

If you do not continue to participate in the Health Care Reimbursement Account while on leave of absence and you return to work in the same calendar year, you may resume participation when you return to work.

Your contributions to the Child/Elder Care Reimbursement Account must cease while you are on leave, with the exception of military leave. You may re-enroll immediately upon your return to work. If you return to work in the same calendar year, your previous election will be reinstated. If the leave was for birth or adoption, you may elect to increase the contribution amount. If you are on a military leave, your contributions will remain at the same amount through the end of the calendar year unless you contact the Employee Service Center to change your elections.

Enrollment

New employees

If you are a regular, full-time bargaining unit employee, you **must enroll through the online web enrollment system or submit an employer-provided enrollment form to the Employee Service Center within 30 days of your hire or reclassification date (e.g., change from non-bargaining classification to bargaining unit classification) if you wish to participate in the Health Care and/or the Child/Elder Care Reimbursement Accounts during the year in which you are hired or reclassified.** If you do not enroll within 30 days of your employment or reclassification date, you must wait until the next annual benefits enrollment period to enroll unless you have a qualifying change in family or employment status.

Annual enrollment

If you are a regular, full-time bargaining unit employee, you are eligible to enroll in the Health Care and the Child/Elder Care Reimbursement Accounts each year during annual benefits enrollment. You must enroll each year and make separate elections for each Account. Elections do not carry over from one year to the next. Participation is voluntary; therefore, you may elect not to participate.

If you do not enroll during annual benefits enrollment and later in the year have a qualifying change in your family or employment status, you may enroll within 30 days of the event as long as the enrollment is consistent with your status change.

Qualifying events

The Internal Revenue Service rules do not permit you to change your FlexPower elections during the plan (calendar) year unless you have a qualifying event that affects eligibility for coverage. **If you experience a qualifying event, you must submit a FlexPower Benefits Change Form (FRM-PGNF-00008) to the Employee Service Center within 30 days of the event in order to modify your coverage, otherwise, you will have to wait until the next annual enrollment period. The change will be effective the date of the qualifying event. All changes must be consistent with the qualifying event.**

Some qualifying changes in family or employment status are:

- Your marriage or fulfillment of all Progress Energy domestic partner relationship requirements;
- Legal separation, annulment, divorce or termination of domestic partner relationship;
- Birth, adoption or placement for adoption, or change in custody of your child;
- Death of your spouse or domestic partner or other dependent;
- Your child loses or regains dependent status (including a dependent child who is no longer a full-time student, or who returns to school or college as a full-time student);
- You, your spouse or domestic partner or dependent takes or returns from an unpaid leave of absence;
- Your spouse's or domestic partner's or your health coverage changes significantly (attributable to your spouse's or domestic partner's employment);
- Your spouse's or domestic partner's employer conducts an annual enrollment and your spouse or domestic partner changes his or her benefit elections;
- You, your spouse or domestic partner or dependent changes from part-time to full-time employment or from full-time to part-time employment;
- Your spouse or domestic partner or dependent becomes employed or unemployed; or
- You change your dependent care provider or the cost of your dependent care increases or decreases (provided the cost change is not imposed by a family member providing the care).

If you terminate participation in either Reimbursement Account due to a qualifying change and later in the year a second qualifying event occurs, you will not be eligible to re-enroll in the Account until the next annual benefits enrollment period.

Effective date

Elections made by new employees will be effective on the date of hire. New employees should check with the Employee Service Center to determine the date payroll deductions and participation will begin in order to estimate eligible expenses.

For elections that are made because of a qualifying change in employment or family status, the election will be effective as of the date of the qualifying event. If you did not participate in the Reimbursement Account prior to the event, subsequent contributions may not be used for expenses incurred prior to the date of the qualifying event. If you increase or decrease your contributions during the year, separate coverage periods will be established based on the amount elected in each period. Reimbursement for expenses incurred during a coverage period may not be more than the amount you elected for that period.

You elect how much you wish to contribute to each Account within the Plan limits when you enroll. The amount you elect for each Account will be divided by the number of pay periods over which the deductions will be taken and deposited in equal amounts into the designated Reimbursement Account. Lump sum contributions are not allowed.

You must decide how much you wish to contribute to the Health Care Reimbursement Account and/or the Child/Elder Care Reimbursement Account before deductions begin. Plan carefully in estimating your eligible health and child/elder care expenses and the amounts to contribute to the Reimbursement Accounts.

- If you contributed to a child/elder care reimbursement account through a previous employer in the same calendar year as your employment date with Progress Energy Florida, Inc., you may not contribute more than \$5,000 total (between the two employers) for the calendar year.
- If your spouse has access to a child/elder care reimbursement account through his or her employer, your joint limit is \$5,000 per calendar year.
- You may not transfer money from the Health Care Reimbursement Account to the Child/Elder Care Reimbursement Account or vice versa.
- You may use the Health Care Reimbursement Account only for eligible expenses incurred from January 1 of each Plan year through March 15 of the following year. You have until April 30 of the following year to submit a Plan year's eligible expenses. In an effort to ensure that you do not forfeit any unused dollars from the previous year, the Plan will reimburse you from the previous Plan year dollars first before using the dollars that you elected for the following year. After April 30, in accordance with IRS regulations, **any money left in your Health Care Reimbursement Account for the previous Plan year will be forfeited.** It will be used by the Plan Administrator to offset administrative expenses.
- You may use the Child/Elder Care Reimbursement Account only for eligible services received during the Plan year in which you are participating. The Plan year is January 1 through December 31. You have until March 31 of the following year to submit a Plan year's eligible expenses. After March 31, in accordance with IRS regulations, **any money left in your Child/Elder Care Reimbursement Account for the previous Plan year will be forfeited.** It will be used by the Plan Administrator to offset administrative expenses.
- According to federal law, you may not change your contribution amount during the year unless you have a qualifying change in your family or employment status that allows you to make a change. See the [Qualifying Events](#) section of this booklet for a list of the qualifying changes. To make a change, you must submit a FlexPower Benefits Change Form (FRM-PGNF-00008) within 30 days of the event.
- If, as a regular, full-time bargaining unit employee, you elect to terminate your participation in the Health Care Reimbursement Account because of a family or employment status change, only expenses incurred while you were contributing to the Account may be reimbursed. Therefore, if you have a family status change, it may be better to reduce your contribution level to the Health Care Account rather than terminate your participation.

Effect on other benefits

Before-tax contributions to the Reimbursement Accounts do not affect pay-related benefits for pension, life insurance, long-term disability and 401(k) plan contributions. However, your Social Security benefits may be reduced because you do not pay Social Security taxes on before-tax contributions to the Accounts. This means that if your taxable income is less than the maximum Social Security wage base, your future benefits which are based on the taxes you pay could be slightly reduced. In most cases, this benefit reduction should be very small.

Child/Elder Care Reimbursement Account

In the event of termination of employment from Progress Energy Florida, Inc. or death, participation in the Child/Elder Care Reimbursement Account will end. **COBRA coverage does not apply to the Child/Elder Care Reimbursement Account.** Any money remaining in your Child/Elder Care Reimbursement Account after the termination date may be used only to pay eligible expenses that were incurred on or before the date your participation ended.

Health Care Reimbursement Account

In the event of termination of employment from Progress Energy Florida, Inc. or death, participation in the Health Care Reimbursement Account will end. Any money remaining in your Health Care Reimbursement Account after the termination date may be used only to pay eligible expenses that were incurred on or before the date your participation ended (except for COBRA continuation).

COBRA coverage

If coverage under the Health Care Reimbursement Account Plan terminates because of a qualifying event, you and your covered dependents may elect to continue participation in the Plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). An individual who is eligible to continue coverage under the provisions of COBRA is known as a qualified beneficiary.

A qualifying event is one of the events listed below, when the event causes a loss of eligibility under the Plan. Both the event itself and the resulting loss of benefits must occur in order to create a qualifying change as defined by COBRA. Qualifying events include:

For you:

- Termination of your employment with a participating subsidiary for any reason other than gross misconduct.
- Reduction in your hours of employment.

For your spouse or domestic partner:

- Your death.
- Termination of your employment (for reasons other than gross misconduct) or a reduction in your hours of employment.
- Your entitlement to Medicare.
- Divorce or legal separation, or termination of your domestic partner relationship.

For your dependent children:

- Your death.
- Termination of your employment (for reasons other than gross misconduct) or a reduction in your hours of employment.
- Your entitlement to Medicare.
- Divorce or legal separation, or termination of your domestic partner relationship.
- Loss of dependency status (including a dependent child who is no longer a full-time student, or who returns to school or college as a full-time student).

For retirees and their dependents:

- Loss of your coverage within one year before or after the commencement of proceedings under Title 11 (bankruptcy) United States Code with respect to your employer (this is a qualifying change only for retired employees and dependents, including surviving dependents of retired employees).

COBRA elections

Each qualified beneficiary may make a separate election to purchase COBRA coverage when a qualifying change occurs. For example, if you terminate employment and do not want to purchase COBRA coverage, your spouse, domestic partner and dependent children still have the opportunity to do so. Qualified beneficiaries who purchase coverage are eligible to participate in the Plan's annual benefits enrollment period.

Responsibility of employer to provide notice

If health (medical, dental, vision and/or health care reimbursement) coverage is lost because of termination of employment, reduction in work hours, death of the employee, employee becoming eligible for Medicare benefits, or commencement of a proceeding in bankruptcy with respect to your employer, you and your eligible dependents will automatically be notified of your COBRA rights.

Your responsibility to notify your employer

If health coverage is lost because of a divorce, termination of domestic partner relationship, legal separation or a dependent no longer meets the dependent definition, you, your spouse or your domestic partner must notify your employer within 60 days to drop the dependent from your Progress Energy, Inc.-sponsored coverage by submitting a FlexPower Benefits Change Form (FRM-PGNF-00008) to the Employee Service Center. The Employee Service Center may be contacted at 1-800-546-5705 to request forms and assistance. After being notified that a qualifying event has occurred, the employer will send notification of COBRA rights to the individuals for whom you completed a change form.

You and/or your eligible dependents have 60 days from the date you would lose coverage because of one of the events described above, or 60 days from the date you are notified of your right to elect continuation coverage under COBRA, if later, to make an election under COBRA. If a COBRA election is not made during this 60-day election period, continuation of coverage will not be available.

Cost of COBRA coverage

The cost of continuing coverage under COBRA is 102% (100% of the full cost of the coverage plus a 2% administration fee). For example, if you chose to contribute \$1,000 to your Health Care Reimbursement Account, your cost to continue coverage under COBRA would be \$85 per month (102% of \$1,000 = \$1,020 annually; \$1,020 divided into 12 monthly installments equals \$85 per month). When you elect to continue your Health Care Reimbursement Account through COBRA, you contribute on an after-tax basis; you no longer have the tax advantage you had when you were actively employed and making contributions on a pretax basis.

Your first payment covering the notification and election period is due no later than 45 days after the election is made. Subsequent payments are due on a monthly basis. All subsequent payments will have a 30-day grace period. Premium amounts are subject to change, even during a COBRA coverage period. COBRA participants will be notified of any change.

If your salary does not exceed 100% of the official poverty line and it is cost-effective, the state in which you live may be required to pay your COBRA premiums. Contact your state's Department of Human Services for more information.

Partial payments

If a partial COBRA payment is received that is not significantly less than the amount required to be paid for the period of coverage, the qualified beneficiary will receive a notice regarding the underpayment. The qualified beneficiary will be allowed 30 days from the date of receipt of the notice to make the necessary payment. Under the regulations, an "insignificant shortfall" is defined as an underpayment that does not exceed the lesser of \$50 or 10% of the full amount required to be paid for COBRA coverage. When a partial payment with a significant shortfall is received, COBRA coverage will be terminated as explained below in "Termination of COBRA Coverage".

Maximum period of coverage

Your covered dependents may be eligible for COBRA coverage for up to 36 months if coverage is lost because of one of the following qualifying events:

- Death of a participating employee.
- You become entitled to Medicare.
- Divorce or legal separation, or termination of your domestic partner relationship.
- Loss of dependency status by a dependent.

You and your eligible dependents may be eligible for COBRA coverage for up to 18 months (except in certain cases of disability) if you lose coverage because of one of the following qualifying events:

- Termination of your employment with a participating subsidiary for any reason other than gross misconduct.
- Retirement
- Reduction of your work hours.

The 18-month period may be extended to 36 months for your eligible dependents if divorce, legal separation, your death, your becoming entitled to Medicare benefits or loss of dependent status occurs during the initial 18-month period following any of the three qualifying events above.

If a qualified beneficiary is eligible for the 18 months of coverage and is disabled (as determined by the Social Security Administration) on the date of the qualifying change, or at any time during the first 60 days of continued coverage, the 18-month coverage period may be extended by an additional 11 months for a total of up to 29 months of COBRA coverage from the date of the first qualifying event. This extension is designed to permit the individual to continue coverage until becoming entitled to Medicare.

A disabled qualified beneficiary who becomes eligible for the special 11-month extension must notify the COBRA administrator within 60 days of the Social Security determination of disability and prior to the end of the 18-month continuation period. The employer can charge up to 150% of the applicable premium during the 11-month disability extension. If coverage is extended to 29 months, coverage will cease upon a final determination that the qualified beneficiary is no longer disabled. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled.

Termination of COBRA coverage

A qualified beneficiary's COBRA coverage will be terminated before the end of the applicable maximum period if:

- The qualified beneficiary becomes entitled to Medicare.*
- The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation for a pre-existing condition of the beneficiary.
- The qualified beneficiary's contribution (premium payment) is not paid on time or is in an amount that demonstrates a significant shortfall.
- All Progress Energy, Inc.-sponsored benefit plans are terminated.
- The qualified beneficiary, with coverage extended to 29 months, is determined by the Social Security Administration to be no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations, as follows:

- If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the employer may terminate your COBRA coverage.

The law also says that, at the end of the 18-month, 29-month or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan *if* such an individual conversion health plan is otherwise generally available under the group health plan. Conversion to an individual policy is not available under the Progress Energy health plans.

If a qualified beneficiary's COBRA coverage is terminated for any of the above-referenced reasons, or the qualified beneficiary elects to discontinue coverage before the end of the applicable maximum period of coverage, the qualified beneficiary will not be eligible to re-elect coverage at a later date. If COBRA coverage is denied or terminated, qualified beneficiaries and eligible dependents will be notified in writing as to why coverage was denied or is being terminated.

**If you become entitled to Medicare after you elect to continue coverage under COBRA, your continued coverage will end on the date of your Medicare eligibility. Your covered dependents, however, may be eligible for 36 months of continued coverage from the date of the original qualifying event.*

Other COBRA Information

Multiple qualifying events

Should your dependents experience more than one qualifying event while COBRA coverage is still active, they may be eligible for an additional period of continued coverage, not to exceed a total of 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 Plan (a second qualifying event) your child may be eligible for an additional period of coverage not to exceed a total of 36 months from the date of your termination.

To be eligible for extended coverage after a second qualifying event, you or your dependent must notify the COBRA administrator within 60 days of the second qualifying event.

Changing your COBRA election

While you are continuing coverage under COBRA, you and your covered dependents may change your health care elections during the annual enrollment period. You will have the same options available to active employees and any changes to the Plan for active employees will automatically apply to your and your dependents' COBRA coverage. The rates for the coming year will also apply (plus the 2% administrative fee).

If you did not elect COBRA during the 60-day election period, you may not elect it during a subsequent annual enrollment period.

During the year, you may also make certain qualified status changes to your coverage, including:

- Add a new spouse or domestic partner or newborn or newly adopted child (or a child placed with you for adoption) to your health care coverage.
- Add an eligible dependent who loses other health care coverage.
- Add a dependent to your health care coverage if required by a Qualified Medical Child Support Order or other family relations judgment.
- Change your health plan if you move out of the Plan's coverage area.

You must notify the employer within 60 days of the event to change your coverage under COBRA. If you provide notice within 30 days of the date of your status change, your change in coverage will be effective on the date of your status change. If you provide notice after 30 days but within 60 days, your change will be effective on the date you notify the employer. In the case of a domestic relations judgment, decree or order, the child will be covered from the date specified in the judgment, decree or order.

If you are on a Family and Medical Leave (FMLA)

If you have taken a leave of absence under the Family and Medical Leave Act (FMLA), and you do not return to work at the end of your FMLA leave, you may elect COBRA coverage. You will experience a qualifying event on the last day of your FMLA leave, which is the earliest of:

- When you inform the employer that you are not returning at the end of the leave,
- The end of the leave, assuming you do not return, and
- When the FMLA entitlement ends.

For the purpose of the FMLA leave, you will be eligible for COBRA, as described earlier, only if:

- You or your dependents are covered by the Plan on the day before the leave begins (or become covered during the FMLA leave),
- You do not return to employment at the end of the FMLA leave, and
- You or your dependents lose coverage under the Plan before the end of what would be the maximum COBRA continuation period.

Note: You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your and your dependents' eligibility for coverage under the Plan. Progress Energy reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible.

When you or your eligible dependents incur health care expenses that qualify for reimbursement under the Health Care Reimbursement Account, the expenses should be filed with your Reimbursement Account. Your reimbursement will be the lesser of the total amount of the qualifying expenses or the total amount of your Health Care Reimbursement Account plan year election, minus any previous reimbursements.

Eligible dependents

For the Health Care Reimbursement Account, eligible dependents generally include anyone you claim as a dependent on your federal income tax return (please note that the Internal Revenue Code does not generally recognize domestic partners as tax dependents). You and your dependents do not have to be covered under any of the Progress Energy, Inc.-sponsored medical, dental, or vision plans to file claims under the Health Care Reimbursement Account.

Annual contribution limits

During annual enrollment, the minimum annual amount you may contribute to the Health Care Reimbursement Account is \$130 and the maximum annual amount is \$5,000. The money will be deducted in equal amounts from your pay based on the number of pay periods over which deductions will be taken.

If both you and your spouse are employed by Progress Energy Florida, Inc., each of you may elect to participate in the Health Care Reimbursement Account and contribute up to \$5,000 to each of the accounts. These limits also apply if your spouse is a non-bargaining employee within the controlled group of Progress Energy, Inc.

New employees and employees who are enrolling due to a qualifying change may elect to contribute less than \$130 to the Health Care Reimbursement Account if the number of pay periods from which deductions will be taken is less than 26. The minimum amount that may be contributed per pay period is \$5.

Covered expenses

The IRS determines what type of expenses are eligible for reimbursement. Health care expenses that are deductible on your federal income tax return generally are eligible for reimbursement through the Health Care Reimbursement Account as long as they are not paid or reimbursed by a health care plan. However, you may not be reimbursed from your Health Care Reimbursement Account and claim the expense on your income tax return. Expenses are reimbursable based on when you incur the charges (i.e., January 1 of Plan year through March 15 of the following year), not based on when you actually pay the expenses.

The following are examples of eligible health care expenses for items purchased or services received during the Plan year in which you are participating:

- Contact lenses, contact lens solution, and prescription eyewear not covered by a vision plan
- Deductibles, copayments, and coinsurance (amounts not paid by medical, dental, or vision plans)
- Fertility treatments (including drugs and charges for artificial insemination and in vitro fertilization)
- Hearing aids and batteries
- Nicotine addiction prescription drugs and smoking cessation programs (if not paid by another plan or program)
- Non-prescription over-the-counter drugs intended to treat an injury or illness (e.g., cold or allergy medicines, antacids and pain relievers).

Expenses not covered

Expenses that are not eligible for reimbursement include:

- Athletic club fees (unless accompanied by a letter from the physician outlining medical necessity)
- Certain health-related home improvements (such as swimming pools)
- Expenses incurred for services provided in previous or future Plan years
- Expenses reimbursed through your or your spouse's health care plan
- Non-prescription drugs or dietary supplements used only for general good health (e.g., vitamins)
- Premiums paid for insurance coverage

By law, not all health care expenses are eligible for reimbursement under the Health Care Reimbursement Account. To determine the eligibility of an expense, access <http://hcet.ebia.com/fiservhealth/>

Orthodontia treatment reimbursement

If you are planning to contribute money to your Health Care Reimbursement Account for orthodontic expenses, you may wish to call UMR at 1-800-842-6475 before you enroll. UMR will assist you in determining what is allowed for reimbursement from your Account. The amount that may be reimbursed from your Health Care Reimbursement Account will be affected by the amount of expenses covered by a dental plan and the contract with your dentist.

Regardless of whether the orthodontic treatment is covered by a dental plan, your reimbursements for a Plan year will be based on the services actually received during that Plan year. If you pre-pay the total amount of orthodontic expenses for treatment that will occur over two or more Plan years, you cannot receive reimbursement for the total amount paid during that Plan year. You will only be allowed reimbursement for services actually *received* during the Plan year in which they occur. If the provider offers you a discount for paying the full amount in advance, you will need to request a breakdown of the discounted amount as if it had been paid in monthly installments. This breakdown can then be used to claim reimbursement from the Health Care Reimbursement Account.

UMR administers orthodontia expenses based on a reasonable payment schedule or service contract, which includes the expense detail provided with the claim. A reasonable payment schedule or service contract must be prepared by the orthodontist and must illustrate what orthodontia services are to be provided, when the services are planned to be provided (identified by month and year), and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided and subsequent proportional payments in anticipation of follow-up services.

Example: You enter into a contract agreement with the orthodontist for a total fee of \$4,500. The dental plan will cover \$1,000 of the expense, leaving you responsible for \$3,500. You and the provider agree that a \$500 down payment will be made at the time the braces are applied, leaving a balance of \$3,000 to be spread over 16 monthly payments of \$187.50.

The Health Care Reimbursement Account can then be used to claim the \$500 down payment (after the date the service was incurred), followed by the \$187.50 monthly payment once those payment due dates have passed.

You should file a copy of the service contract with UMR when you file your initial orthodontic claim under the Health Care Reimbursement Account. If you have elected the automatic claims reimbursement feature for eligible expenses not paid by the dental plan, no additional claims filing is necessary.

Health Care example

The following example shows how the Health Care Reimbursement Account may save you money on your taxes and is based on a married person with one exemption for federal income taxes. The actual taxes due on your income tax returns will depend on your individual circumstances, such as deductions, credits, and investment income.

Ann earns \$40,000 a year. She anticipates that she will pay \$1,500 out-of-pocket for medical, dental and vision care expenses that are not paid by an insurance plan. Based on this example, Ann will save \$340 in taxes when she uses the Health Care Reimbursement Account to reimburse herself for these expenses.

	Without Health Care Reimbursement Account	With Health Care Reimbursement Account
Gross annual pay	\$40,000	\$40,000
Health Care Account contribution	-----	1,500
Taxable pay	\$40,000	\$38,500
Federal, Social Security, Medicare taxes withheld*	5,715	5,375
Health care expenses (after-tax)	1,500	-----
Net annual pay after taxes and health care expenses	\$32,785	\$33,125
Tax savings	-----	\$340

*Assumes married filing status and one withholding allowance for Federal income tax purposes, 6.2% Social Security taxes, and 1.45% Medicare taxes.

If you are a single parent, or if you and your spouse are both employed, or if your spouse is a full-time student or incapable of self-care, you may use the Child/Elder Care Reimbursement Account for expenses incurred for someone to care for your dependents when the care is required to enable you to work. The Child/Elder Care Account does not cover health care expenses.

You will have to report the name, address and Social Security or taxpayer identification number of the person performing the dependent care services on your federal income tax form and on the Child/Elder Care Reimbursement Account claim form. If the provider is a tax-exempt organization, only the organization's name and address are needed.

Eligible dependents

The money in your Child/Elder Care Reimbursement Account may be used only to reimburse yourself for the expenses incurred for the care of dependents you claim on your federal income tax return who are either:

- Children under age 13; or
- Your spouse or legal dependent of any age who is physically or mentally disabled and incapable of self-care. (Your disabled dependent must spend at least eight hours a day in your home.)

Because domestic partners are generally not considered dependents for the purpose of federal income tax, dependent care expenses for your domestic partner and /or your domestic partner’s children will typically not be eligible for reimbursement.

Annual contribution limits

If you elect to participate in the Child/Elder Care Reimbursement Account, the minimum annual amount you may contribute is \$130 and the maximum annual amount is \$5,000 based on the [maximum contribution chart](#). Also, if you contributed to a child/elder care reimbursement account through a previous employer in the same calendar year as your employment date with Progress Energy Florida, Inc., you may not contribute more than \$5,000 total (between the two employers) for that calendar year.

If both you and your spouse are employed, each of you may elect to participate in a Child/Elder Care Reimbursement Account, but your joint contribution limit would be \$5,000.

The money you elect to contribute will be deducted in equal amounts from your pay based on the number of pay periods over which deductions will be taken.

When estimating your dependent care expenses, remember to consider any time that your dependents will be away on vacation or at a summer camp, any change in your work hours or anything else that would impact your dependent care expenses.

Federal law currently places these maximums on the annual amount eligible for reimbursement for dependent care:

Child/Elder Care Reimbursement Account	
<i>If you are:</i>	<i>Your maximum annual contribution amount will be:</i>
Single	\$5,000
Married and your spouse's earned income is less than \$5,000	100% of your spouse's earned income
Married and your spouse's earned income is more than \$5,000	\$5,000 (if your spouse also has a dependent care account, your joint maximum is \$5,000)
Married but you and your spouse file separate tax returns	\$2,500
Married but your spouse has no earned income	You may participate only if your spouse is either a full-time student for at least five months a year or is incapable of self-care. In either case, your limit for each qualifying month is \$250 if you have one eligible dependent and \$500 if you have two or more eligible dependents. However, your maximum annual contribution amount is \$5,000.
<i>Note: Earned income means the amount you and your spouse will be paid by your employers during the calendar year.</i>	

Covered expenses

Generally, dependent care expenses that are necessary for gainful employment and that qualify to be used to calculate the dependent tax credit on your federal income tax return are considered eligible for reimbursement through the Child/Elder Care Reimbursement Account.

Payments to the following are examples of eligible dependent care expenses:

- Day care centers, nursery schools, preschool or other programs below the kindergarten level, before-school and after-school programs at or above the kindergarten level, and summer day camps, including computer, soccer and other day camps. (The school or center must comply with state and local laws, provide care for seven or more children, and receive a fee for its services.)
- Individuals, excluding your dependents and your children under the age of 19, who provide care in or outside your home.
- Dependent care centers that provide day care, not residential care, for dependent adults. (The center must comply with state and local laws.)
- Agency and application fees, if required to obtain the services of an au pair or other care provider, and costs for a care provider's room and board and any employment taxes paid on behalf of a care provider.

If you work part-time, you must allocate your expenses between days worked and days not worked, unless day care expenses must be paid on a weekly or longer basis.

If you take a short, temporary leave of absence, such as for minor illness or vacation, you may submit your expenses provided the dependent care payments are made on a weekly or longer basis. Expenses incurred during a longer leave, such as a short-term disability leave, may not be considered employment-related.

For a complete list of eligible expenses, click here or visit the following:

http://www.fiservhealthservices.com/AP-Web/DCA%20List/Eligible_and_Ineligible_Expense_List.htm. You may also call UMR with questions about what qualifies as an eligible expense under the Plan.

Dependent care tax credit

For most people, using the Child/Elder Care Reimbursement Account will be the most tax-effective way to pay dependent care expenses. For others, however, a better option may be to claim the dependent care tax credit that is based on family income and currently available on federal income tax returns. You may not be reimbursed from your Child/Elder Care Reimbursement Account and claim the same expenses on your income tax returns.

A federal tax credit equal to 35% of qualifying dependent care expenses up to \$3,000 a year (\$6,000 if you have two or more dependents) is available if your family income is \$15,000 or less. The percentage decreases gradually as family income rises to \$43,000. At that level and above the available tax credit is equal to 20% of qualifying dependent care expenses. Tax credits for dependent care may also be available on state individual income tax returns.

You should talk with your tax advisor if you have questions about the federal and state dependent care tax credits and the effect the credits may have on your contributions to your Child/Elder Care Reimbursement Account.

Expenses not covered

The following expenses are considered ineligible by the IRS for reimbursement under the Child/Elder Care Reimbursement Account:

- Dependent care services provided by your spouse, your children under age 19, or someone you claim as an exemption on your federal income tax return
- Kindergarten expenses, tuition, and fees (primary purpose is for education rather than child care)
- Overnight camp, even if the overnight camp separates daytime expenses from the rest of the bill
- Transportation costs between your home and the dependent care center
- Clothing, entertainment, or food

To determine whether an expense is or is not eligible, click [here](#) or visit the following:

http://www.fiservhealthservices.com/AP-Web/DCA%20List/Eligible_and_Ineligible_Expense_List.htm.

AUTHORIZED COPY
Filing Reimbursement Requests

The money you put into your Health Care Reimbursement Account may be used only for eligible expenses incurred from January 1 of each Plan year through March 15 of the following year. You have until April 30 of the following year to submit eligible expenses. In an effort to ensure that you do not forfeit any unused dollars from the previous year, the Plan will reimburse you from the previous year dollars first before using the dollars that you elected for the following year. After that date, in accordance with tax regulations, any money remaining in your Health Care Reimbursement Account must be forfeited and will be used by the Plan Administrator to offset administrative expenses. Therefore, you need to estimate carefully and contribute only as much money as you anticipate spending on eligible health care expenses that you or your eligible dependents incur during the Plan year.

The money you put into your Child/Elder Care Reimbursement Account may only be used for expenses incurred during the period you were participating in that Plan year. The Plan year is January 1 through December 31. You have until March 31 of the following year to submit eligible expenses. After that date, in accordance with tax regulations, any money remaining in your Child/Elder Care Reimbursement Account must be forfeited and will be used by the Plan Administrator to offset administrative expenses. Therefore, you need to estimate carefully and contribute only as much money as you anticipate spending on eligible dependent care expenses that your eligible dependents incur during the Plan year.

Under both the Health Care Reimbursement Account and the Child/Elder Care Reimbursement Account, claims are processed on a weekly basis. An Explanation of Benefits form will be mailed to your home address. When submitting reimbursement requests, each request should be for at least \$10 except when you file your final request for a plan year.

Health Care and Child/Elder Care Reimbursement Request forms should be submitted to:

UMR - FSA Claims
PO Box 8022
Wausau, WI 54402-8022

Reimbursements for eligible health care expenses will be either the total amount of the qualifying expense or the total amount you plan to contribute to your Health Care Reimbursement Account minus any previous reimbursements, whichever is less.

If there is enough money in your Child/Elder Care Reimbursement Account, you will be reimbursed in full for the amount of the eligible dependent care expenses. If there is not enough money in your Account, the request will be partially reimbursed and the balance automatically reimbursed to you in \$10 increments as additional money is contributed to your Account from future payroll deductions.

If you are reimbursed from the Health Care Reimbursement Account or the Child/Elder Care Reimbursement Account for expenses or services that are not eligible, or the reimbursement is more than is allowed by law, the amount that was erroneously reimbursed or overpaid will become taxable income to you. You will be responsible for paying taxes on these amounts.

Health Care reimbursement requests

To be reimbursed for an eligible health care expense under the Health Care Reimbursement Account, follow the steps below. In some cases, proof of medical necessity may be required to support a health care reimbursement request.

- Pay your portion of the qualifying health care expenses.
- For health care expenses not covered under a group-sponsored benefit plan, submit a completed Health Care Reimbursement Account Claim Form (FRM-SUBS-01061) with your receipt or explanation of benefits to UMR. The receipt or explanation of benefits must include:
 - Patient's name
 - Description of service, treatment, or purchase
 - Date and amount of expense
 - Name of person or organization receiving payment

In addition to mailing claims for reimbursement, you may submit claims online and fax or email documentation for faster claims turnaround time (see below).

If you or your dependents are covered under another group health care plan, the claim should be filed with that plan first. When you receive an explanation of benefits, send a copy of the explanation of benefits and itemized receipt with a completed Reimbursement Request Form to UMR.

Child/Elder Care reimbursement requests

To be reimbursed for an eligible dependent care expense under the Child/Elder Care Reimbursement Account:

- Pay the bill.
- Submit a completed Child/Elder Care Reimbursement Account Claim Form (FRM-SUBS-01060) to UMR with either a copy of the front and back of the canceled check or receipt, with the following information:
 - Employee's name
 - Dependent's name, age, and relationship to employee
 - Dates care was provided
 - Amount of the expense
 - Name of dependent care provider
 - Provider's signature, if an individual

In addition to mailing claims for reimbursement, you may submit claims online and fax or email documentation for faster claims turnaround times.

How to submit claims to UMR

Filing on the Web

Go to the UMR web site (<https://fhs.umar.com/>). The web claim entry tool provides basic online editing and transaction summary functions. Your claim will wait in queue for the arrival of your receipts. So for fast 48-hour turnaround, fax or e-mail a copy of your receipts for immediate reimbursement. If you have any additional questions about Web claim entry, contact UMR at 1-800-826-9781. Web claims must be submitted and receipts received by April 30 for Health Care reimbursement requests and March 31 for Child/Elder Care reimbursement requests.

Filing by US Mail

Reimbursement Account claim forms and required receipts that are mailed to UMR must be **postmarked by April 30 for Health Care reimbursement requests and March 31 for Child/Elder Care reimbursement requests** and sent to the following address:

UMR - FSA Claims
PO Box 8022
Wausau, WI 54402-8022

Filing by Fax

UMR will accept faxed copies of claim forms and required receipts as long as they are **received on or before April 30 for Health Care reimbursement requests and March 31 for Child/Elder Care reimbursement requests**. Fax the form to either of the following numbers: 1- 877-390-4782 (toll-free) or 1-715-841-7049.

Link to Claim Forms

Health Care Reimbursement Account claim form
Child/Elder Care Reimbursement Account claim form

Direct Deposit

Health Care and Child/Elder Care Reimbursement Account payments may be deposited directly into the bank account of your choice by UMR. If you wish to take advantage of this opportunity, you must submit a Flexible Spending Account Direct Deposit Authorization Form (FRM-SUBS-01101) which is accessible on ProgressNet. The form must be mailed to UMR at the address shown on the form. Please allow 2-3 weeks for the change to be effective.

Questions

If you have any questions about your Health Care Reimbursement Account, your Child/Elder Care Reimbursement Account, or qualifying expenses, you should call UMR at 1-800-842-6475.

If your reimbursement request is denied

If a reimbursement request for benefits is partially or wholly denied, you will usually receive written notice of the denial within 30 days of the date your request is received. Under certain circumstances, up to 45 days may be taken. In this case, you will be informed of the extension within the original 30-day period. Your notice of denial will include the reasons for the denial, refer to the specific Plan provisions on which the denial was based, describe any information needed to complete the reimbursement request and describe the review process, including your right to bring a civil action under ERISA. You may wish to have a denied reimbursement request reviewed.

For a first review, send a written request to the Claims Administrator within 180 days of receipt of the denial notice. The Claims Administrator will re-examine the reimbursement request and consider any additional information supplied in support of the request. You will be informed, in writing, within 30 days of the outcome of this review. If your reimbursement request is denied on review, your notice of denial will include the specific reason(s) for the denial, refer to the specific Plan provisions on which the denial was based, state that you are entitled to receive upon request, and without charge, copies of all documents, records and other information relevant to your claim, describe the Plan's voluntary review procedures, state your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, and state that you and the Plan may have other, voluntary alternative dispute resolution options.

If your reimbursement request is denied again, you may have it reviewed a second time. You must request a review within 180 days of the time you receive the notice of denial from the first review. A final decision will be made as soon as possible but not later than 30 days after the second review request is received. You will get a written notice of the results of this review. If your reimbursement request is denied on second review, your notice will include the same information as your notice of denial on initial review.

Plan identification

The official names of the Plans are the Progress Energy Florida, Inc. Child/Elder Care Reimbursement Account and the Progress Energy Florida, Inc. Health Care Reimbursement Account. These Plans are a part of the Progress Energy, Inc. Welfare Benefit Plan, Plan number 526. The employer identification number (EIN) issued by the Internal Revenue Service for Progress Energy, Inc. is 56-2155481.

The Plan Sponsor's address is:

Progress Energy, Inc.
PO Box 1551, PEB 16ESC
Raleigh, NC 27602-1551

Costs and funding

Benefits under the Plans are funded through contributions by participating employees. All other costs and expenses under the Plans are funded through contributions from Progress Energy Florida, Inc.

Administration

The Plan is a salary reduction plan and is subject to the continuing approval of the Internal Revenue Service. The Plan year ends on December 31 of each year and the Plan operates and maintains records on a calendar-year basis.

Plan Administrator

A Plan Administrator has been appointed, as required by law, to be responsible for the operation of the Plan. The Plan Administrator has overall responsibility for the operation of the Plan and controls the administration of the Plan. The Plan Administrator has the exclusive right in its sole discretion to interpret the Plan and to decide any and all matters arising thereunder.

Although the Plan Administrator has the right to interpret the provisions of the Plan and to decide all matters arising thereunder, the Plan Administrator does not have the authority to deviate from the provisions of the Plan or to approve any exceptions to the Plan. The Plan Administrator has a fiduciary obligation under applicable law to apply the provisions of the Plan as it is written.

If it should become necessary to contact the Plan Administrator, call or write referring to the Plan identification numbers.

The Plan Administrator is:

Progress Energy Service Company, LLC
PO Box 1551, PEB 16ESC
Raleigh, NC 27602-1551
1-800-546-5705

The Employee Service Center provides administrative services for Plan participants and can be reached at the address above, by calling 1-800-546-5705 or by email at employee.service@pgnmail.com.

Claims Administrator

The Plan has arranged for claims to be administered under an administrative agreement, group number 76-140056 and plan number 7672-02-140056, by:

UMR
PO Box 8022
Wausau, WI 54402-8022
1-800-842-6475
www.fhs.umar.com

Agent for service of legal process

Legal process may be served upon the Plan's agent, Sponsor, or Administrator.

The Plan's agent for service of legal process is:

Vice President - Human Resources
Progress Energy Service Company, LLC
PO Box 1551
Raleigh, NC 27602-1551

Continuation of Plan and Plan amendments

The Plan Sponsor reserves the right to amend or terminate the Plan or any Plan benefit at any time based on the cost of the benefits or other considerations without prior approval of or notification to any party.

Qualified medical child support order

A qualified medical child support order (QMCSO) is an order issued by a court or through a state administrative process established under state law. In addition, national medical support notices will be treated as QMCSOs. A QMCSO directs the Plan Administrator to cover a child for benefits under the health care plan. Upon receipt of the order, the Plan Administrator will review the order to determine whether or not it is a QMCSO. During this review period the Plan Administrator will hold all claims that may be payable for the children named in the order. The Plan Administrator will notify in writing all persons named in the order of the determination. If the Plan Administrator determines the order is a QMCSO, its terms must be followed to the extent required by law. You must pay the appropriate cost of coverage as for any dependent coverage. If the Plan Administrator determines the order is not a QMCSO, a revised order may be prepared for submission and review. The Plan Administrator will discontinue holding claims at the time an order is determined not to be a QMCSO. If a revised order is submitted and determined to be a QMCSO, the Claims Administrator will pay any claims on behalf of the child to the extent required by the revised order.

Health Insurance Portability and Accountability Act (“HIPAA”)

HIPAA Privacy Rule

The Plan is required to handle protected health information (“PHI”) about you in keeping with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). HIPAA limits both the purposes for which the Plan may use or disclose PHI and the persons who may have access to PHI. Further, as a result of HIPAA, both the Plan and the Plan Sponsor are required to take certain protective measures with respect to PHI. A description of how PHI about you may be used and disclosed and your rights under HIPAA’s Privacy Rule may be found in the Plan’s Notice of Privacy Practices (“NPP”) available from the Plan’s Privacy Official.

HIPAA Security Rule

The Plan Sponsor shall reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan. The Plan Sponsor shall:

- (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- (ii) ensure that the adequate separation required by § 164.504(f)(2)(iii) of the HIPAA Security Regulation is supported by reasonable and appropriate security measures;
- (iii) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (iv) report to the Plan any security incident of which it becomes aware.

The Privacy and Security Officials may be contacted by phone at 1-800-546-5705 or email privacy.official@pgnmail.com.

The following statement is provided in compliance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Receiving information about your Plan and benefits

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

- Examine without charge at the Plan Administrator's office and at other specified locations such as worksites, all Plan documents governing the Plan, including insurance contracts and collective bargaining agreement, and a copy of the latest annual report (Form 5500 Series) filed by the 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 operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health plan coverage for yourself, spouse, domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent actions by Plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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. If your claim for a welfare benefit is denied, 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.

Enforcing your rights

Under ERISA, there are steps that you may take to enforce the above rights. For instance, if you request materials from the 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 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. In addition, if you disagree with the 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 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).

If you have any questions about the Plan, you should contact the Plan Administrator or the Employee Service Center. 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 NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.