

Document title:

# **Vision Plan of Progress Energy Florida, Inc.**

Document number:

## **HRI-PGNF-00005**

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

Keywords: human resources information; benefits booklets

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Vision Plan of Progress Energy Florida, Inc.  
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 Vision Plan of Progress Energy Florida, Inc. (the "Plan"). The Plan is sponsored by Progress Energy, Inc. and is available to regular, full-time bargaining unit employees of Progress Energy Florida, Inc. and their eligible dependents.

If there are inconsistencies between this booklet and the insurance contract, the terms and conditions of the contract 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.

Call EyeMed Vision Care 1-866-723-0514 for questions regarding vision benefits.

### **Reference Form**

FRM-PGNF-00008, FlexPower Benefits Change Form  
HRI-SUBS-30004, Guide to Benefits for Domestic Partners

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The Plan covers bargaining unit employees and their dependents who meet the eligibility requirements specified herein. Certain employees who are eligible for the Plan 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.

### **New employee enrollment**

Regular, full-time bargaining unit employees are automatically enrolled in the Plan on the first day of employment or reclassification (e.g., from non-bargaining classification to bargaining unit classification) with Progress Energy Florida, Inc. Membership cards are automatically issued in the month following employment and are renewed February 1st of each year thereafter. You will be issued two membership cards. Your employer pays the full cost of coverage.

### **Dependents**

If you enroll your eligible dependents for medical and/or dental coverage through Progress Energy Florida, Inc., these dependents will be automatically enrolled for vision coverage. If you need to add additional eligible dependents to the Vision Plan, contact the Employee Service Center.

Eligible dependents under the vision plan are:

- Your spouse or domestic partner <sup>1</sup>
- Unmarried children under age 19 who:
  - Are your biological children and are mainly supported by you, regardless of whether or not they live with you; or
  - Live with you, have been placed with you for legal adoption, and are mainly supported by you or your spouse or domestic partner; or
  - Live with you, are your stepchildren or domestic partner's children, are mainly supported <sup>2</sup> by you or your spouse or domestic partner, and you and/or your spouse or domestic partner is responsible to provide the type of coverage available under this Plan <sup>3</sup>; or
  - Live with you, are your foster children, are mainly supported <sup>2</sup> by you or your spouse or domestic partner, and you are responsible to provide the type of coverage available under this Plan <sup>3</sup>; or
  - Live with you, are your ward under a legal guardianship appointment or for whom you have legal custody under a valid court decree, are mainly supported <sup>2</sup> by you or your spouse or domestic partner, and you are responsible to provide the type of coverage available under this Plan <sup>3</sup>; or
  - Are your biological or adopted children who meet the following requirements:
    - Receive over one-half of their support <sup>2</sup> during the year from you or the child's parent from whom you are divorced or legally separated; and
    - Live for more than one-half of the year with you, or the child's parent from whom you are divorced or legally separated; and
    - You are required by a legal separation agreement, divorce decree, qualified medical child support order, or court order to be legally responsible to provide the type of coverage available under this Plan<sup>3</sup>.
- Your unmarried dependent children under age 23, as described above, who are full-time students <sup>4</sup> as defined by the school they attend, in an accredited/licensed school, college, or university. Under no circumstances will an individual taking courses through a correspondence school be considered a full-time student.
- Your unmarried children (regardless of age <sup>5</sup>):
  - Who are incapable of self-support because of mental retardation or physical disability, provided they became disabled on or before age 19 (or before age 23 for full-time students), and
  - They either live with you or live in a long-term care facility and are mainly dependent upon you or your spouse for support and care, and
  - For whom you can give proof of their incapacity, residency, and dependency.

**Employees who cover ineligible dependents are in violation of the Company's Code of Ethics.** They may be required to pay damages and costs to the Company, including reimbursement of any benefit payments made with respect to an ineligible dependent.

<sup>1</sup> Your domestic partner is eligible only if you both satisfy the criteria described in the Declaration of Domestic Partner Relationship and have submitted a Declaration of Domestic Partner Relationship to the Employee Service Center. The Guide to Benefits for Domestic Partners (HRI-SUBS-30004) and forms are available through ProgressNet or the Employee Service Center at 1-800-546-5705 or [employee.service@pgnmail.com](mailto:employee.service@pgnmail.com). **A divorced spouse may not be covered under this Plan unless the two of you remarry; likewise, your former domestic partner may not be covered unless you re-establish a domestic partner relationship with this individual.**

<sup>2</sup> To determine if you provide more than half of a child's support, you must first determine the total support provided for that child. Total support includes amounts spent to provide food, lodging, clothing, education, medical and dental care, recreation, transportation and similar necessities.

<sup>3</sup> You may be required to sign an affidavit attesting to the fact that you are responsible to provide the type of coverage available under this Plan.

<sup>4</sup> Children who are full-time students, as defined by the school they attend, continue to be eligible for coverage during semester breaks and absences due to illness or injury for up to 120 days. To continue coverage beyond the 120 days, due to illness or injury, documentation of the need for the absence and satisfactory evidence of intent to return to full-time attendance must be submitted to the Plan Administrator for consideration.

<sup>5</sup> For children who are disabled, you must notify the Employee Service Center and provide the necessary documentation.

### **Employment of both spouses or domestic partners with Progress Energy**

You may not be covered both as an employee and as a dependent under the Progress Energy-sponsored Vision Plan. If both you and your spouse or domestic partner are employed by a participating subsidiary of Progress Energy, Inc., the following guidelines apply:

- Each of you may be covered separately under the Vision Plan or one of you may be covered as a dependent by the other spouse or domestic partner.
- Only one of you may cover your dependent children.

Note: If both you and your spouse or domestic partner have children who are eligible dependents who were born or adopted before your current marriage or domestic partner relationship, when you enroll for medical and dental coverage, you may each choose to cover specific children as designated on the employer-provided enrollment form or through the online web enrollment. These children will be automatically enrolled in the Vision Plan.

### **Leaves of absence**

If you make the required contributions, you may continue vision coverage under the Plan on yourself and your eligible dependents while you are on 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

The Plan is administered by EyeMed Vision Care and is separate from the medical and all other benefit plans offered by Progress Energy, Inc. The vision providers listed in the medical plan provider directories are to be used only for medically-related ophthalmological problems which are not covered by the Plan.

Under the Plan, employees and their family members can receive an annual eye exam and may select eyewear such as lenses and frame or contacts that are covered under the Plan.

You must use providers who are participating in the EyeMed Vision Care network. The Plan provides no benefits if you use a non-EyeMed Vision Care provider.

For details on plan benefits, refer to the *Benefit Summary* on the next page.

**How to use your EyeMed Vision Care benefits**

- Select a provider from the customized list provided with your membership card. You also may call EyeMed Vision Care's Member/Patient Services at 1-866-723-0514 or log on to [www.enrollwitheyemed.com/select](http://www.enrollwitheyemed.com/select).
- Present your EyeMed membership card to purchase eyewear.
- Pay your provider directly. There are no forms or paperwork to complete.
- If you need Lasik or PRK treatments, you must use a U.S. Laser Network provider. To locate a provider near you, go to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) and click on the Laser Vision Correction section or call 1-877-552-7376, as described on page 7.

**Benefit Summary**

Vision Care Services	Member Cost *
<b>Exam with Dilation as Necessary</b>	\$40 Copay
<b>Complete Pair Eyeglasses Purchase Discounts**:</b> Frame, lenses, and lens options purchased in same transaction	
<b>Frames:</b> (any available frame at provider location)	40% off retail price
<b>Standard Plastic Lenses:</b>	
Single vision	\$50
Bifocal	\$70
Trifocal	\$105
<b>Lens Options:</b>	
UV Coating	\$15
Tint (solid and gradient)	\$15
Standard scratch-resistance	\$15
Standard polycarbonate	\$40
Standard anti-reflective coating	\$45
Standard progressive (add-on to bifocal)	\$65
Other add-ons and services	20% off retail price
<b>Contact Lenses</b>	
Conventional (discount applied to materials only)	15% off retail price
<b>Laser Vision Correction:</b>	
Lasik or PRK	15% off retail price – or – 5% off promotional price
<b>Frequency:</b>	
Examination	Once every 12 months
Frame	Unlimited
Lenses or contact lenses	Unlimited

\* You must use providers who are participating in the EyeMed Vision Care network. The Plan provides no benefits if you use a non-EyeMed Vision Care provider.

\*\* Frame, Lens & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.

**Additional Discounts:**

- Members will receive a 20% discount on items not covered by the Plan at network providers. The discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed providers' professional services or to contact lenses. Retail prices may vary by location.
- Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance.
- Lost or broken materials are not covered.

**Plan limitations and exclusions:**

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Services provided as a result of any Worker's Compensation law
- Non-prescription lenses and non-prescription sunglasses (except for 20% discount)
- Services or materials provided by any other group benefit providing for vision care. Benefits may not be combined with any discount offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered. Benefit is not available on those frames where the manufacturer prohibits a discount. Member is responsible for applicable taxes

**EyeMed Vision Care Laser Vision Correction Program**

A member is entitled to a 15% discount on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the member elects to obtain pre-operative and post-operative care from another provider outside the U.S. Laser Network, the other provider may charge additional fees for the pre-operative and post-operative care for which the member will be responsible and such fees are not subject to the 15% discount.

In lieu of the 15% discount outlined above, a member is entitled to a 5% discount on promotional pricing for LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a Lasik Plus Center, which is part of the U.S. Laser Network, and the member elects to obtain pre-operative and post-operative care another provider outside the U.S. Laser Network, the other provider may charge additional fees for the pre-operative and post-operative care for which the member will be responsible. Such fees are not subject to the 5% discount.

**Accessing the Laser Vision Correction Benefit**

1. To locate the nearest U.S. Laser Network provider, a member must call 1-877-5LASER6 (1-877-552-7376).
2. After the member has located a U.S. Laser Network provider, the member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed member. The member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the member is a good candidate for laser vision correction, the member should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the member must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
5. At the time the treatment is scheduled, the member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the member remits the deposit, U.S. Laser Network will issue to the member an authorization number confirming the EyeMed discount. This authorization number will be sent to the member's U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the member to pay or arrange to pay the balance of the fee.
8. After the treatment, the member should follow all post-operative instructions carefully. In addition, the member is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

**When coverage ends**

Eligibility for Vision Plan coverage will end on the last day of the month any of the following events occurs:

- Your employment status changes and you no longer meet the employee eligibility criteria for coverage under the Vision Plan of Progress Energy Florida, Inc.
- Your employment status changes from a bargaining unit employee of Progress Energy Florida, Inc. to a non-bargaining employee of one of the Progress Energy, Inc. participating subsidiaries. (*Certain Progress Energy non-bargaining employees are eligible for benefits under the Choice Benefits program.*)
- The Plan is terminated. (Eligibility for services will end on the date of such termination.)

*Terminated and retiring employees*

Employees whose employment terminates or who retire are not eligible to receive Vision Plan coverage unless they are eligible for and elect to continue coverage through COBRA. See [COBRA Coverage](#) section below.

*Dependents*

Dependent eligibility continues as long as your eligibility does, unless your dependent no longer meets the [eligible dependent definition](#).

**Employees who cover ineligible dependents are in violation of the Company's Code of Ethics.** In addition, if a dependent becomes ineligible, you must notify the Plan Administrator within 60 days in order for the dependent to be eligible for coverage under COBRA.

*Surviving dependents*

If you die and you were eligible for coverage under the Vision Plan, your eligible dependents will continue to be eligible to receive coverage under the Vision Plan if they are eligible to continue coverage under COBRA and elect to continue coverage as described below.

**COBRA coverage**

If coverage under the 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". Domestic partners and their eligible dependents are eligible under the same terms as those provided to employees and their eligible dependents.

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).

***Plans covered under COBRA***

In accordance with COBRA, you have the opportunity to continue your participation in the employer-sponsored medical, dental and vision plans under certain circumstances. These circumstances are called qualifying events.

***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, and/or vision) 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. After being notified that a qualified event has occurred, the employer will send notification of COBRA rights to the affected individuals.

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 the total cost of employee coverage is \$25 per month (employee and employer contributions combined), the cost for COBRA coverage would be \$25.50 per month. During the 11-month extension period for disabled qualified beneficiaries, the cost increases to 150% of the total cost of the coverage beginning with the 19th month of COBRA coverage.

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 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 is 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.

A participant or beneficiary has a right to file a claim for benefits under the Vision Plan of Progress Energy Florida, Inc., ask if he or she has a right to any benefits under the Plan, or appeal the denial of a claim for benefits under the Plan.

EyeMed Vision Care, as the Claims Administrator, has the responsibility and authority for making decisions about claims for benefits under the Vision Plan. The Plan Administrator will be the Claims Administrator with respect to all matters that are not the responsibility of the Claims Administrator, including, but not limited to, determinations related to the eligibility to participate in the Plan.

**Filing a claim**

Please refer to [Accessing the Laser Vision Correction Benefit](#) or [How to use your EyeMed Vision Care benefits](#) for information about receiving benefits under the plan.

**Notification of decision on claims**

If a claim for benefits under the Plan is partially or wholly denied, you will receive written notice of the denial within 30 days of the date your completed claim is received. Under special circumstances, up to 45 days may be taken. In such a case, you will be informed of the extension within the original 30-day period, the special circumstances requiring an extension of time and the date by which a decision is expected to be made. If the extension is necessary because of your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have up to 45 days to provide that information. The period for making the benefits determination will be tolled from the date on which the notice of the extension is sent to you until the date on which you respond to the request for additional information.

Your notice of denial will be written in a manner intended to be understood by you, include the specific reason(s) for the denial, refer to the specific Plan provisions on which the determination was based, describe any additional material or information necessary for you to complete the claim, explain why such material or information is necessary, and describe the Plan's claim review procedures and the time limits applicable to such procedures. The notice will include a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review and a statement of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the claim determination (or a statement that it will be provided free of charge upon request). If the denial was based on an internal rule, guideline, protocol or similar criterion, the notice will either state it or state that a copy will be provided free of charge upon request. If the denial was based on medical necessity, experimental treatment or similar exclusion or limit, the notice will either explain the scientific or clinical judgment for the determination applying the terms of the Plan to your circumstances or will state that such an explanation is available upon request.

**Appeal of denied claim**

To have a denied claim reviewed, you must send a written request to the Claims Administrator within 180 days of receipt of the initial denial notice. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. Your written request should be mailed to EyeMed Vision Care, L.L.C., Attn: Quality Assurance Dept, 4000 Luxottica Place, Mason, OH 45040. Your claim will be given a full and fair review. Individuals at EyeMed Vision Care who were not involved in the initial determination will re-examine the claim without affording deference to the initial determination, will consider any information you have submitted that relates to the claim, and, if your claim was denied based in whole or in part on a medical judgment, will consult with an identified health care professional who has training and experience in the field of medicine involved in the medical judgment. You will be informed in writing within 30 days of the outcome of this review.

If your claim is denied on review, you will receive written notice of the denial. The notice will include the specific reason(s) for the denial, refer to the specific Plan provisions on which the denial is 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 appeal is denied on review, you also have the opportunity for a voluntary second appeal. You must request a second appeal within 180 days of the time you receive the notice of denial from the first review. This request must be submitted in writing to the Claims Administrator and should include any additional information you believe may affect the outcome of the review. You and your legal representative will have the right to examine all relevant documents and to submit written issues and comments about your claim. The Plan waives any right to assert that you failed to exhaust administrative remedies if you do not elect this second, voluntary level of appeal, and the Plan agrees that any statute of limitations or defense based on timeliness will be waived during the time that any voluntary appeal is pending.

The Claims Administrator will review the claim, including all information submitted with the original claim and review requests. A final decision will be made as soon as possible but not later than 30 days after the second level appeal request is received. You will receive a written notice of the results of this review. The notice will include the Claims Administrator's reasons for the decision, will refer to the Plan provisions on which the decision is based and will include the additional information included in your first notice of denial upon review described above.

**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. 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](mailto:privacy.official@pgnmail.com).

**Plan identification**

The official name of the Plan is the Vision Plan of Progress Energy Florida, Inc. This Plan is 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**

Premiums under the Plan are funded through contributions from Progress Energy Florida, Inc.

**Administration**

The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. 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 delegated to the Claims Administrator overall responsibility for the operation and administration of the applicable portion of the Plan. The Claims Administrator has the exclusive right in its sole discretion to interpret the applicable portion of the Plan and to decide any and all matters arising thereunder, including but not limited to matters related to eligibility for benefits and application of Plan limitations.

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  
(919) 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](mailto:employee.service@pgnmail.com).

**Claims Administrator**

The Claims Administrator is:

EyeMed Vision Care  
4000 Luxottica Place  
Mason, OH 45040

The benefits are underwritten by Fidelity Security Life.

**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 the 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.

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.