

Document title:

# **Progress Energy Dental Plan**

Document number:

## **HRI-SUBS-00011**

Applies to: Progress Energy Carolinas, Inc.; Progress Energy Florida, Inc. (non-bargaining unit employees);  
Progress Energy Service Company, LLC

Keywords: human resources information; benefits booklets

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Progress Energy Dental Plan  
Progress Energy, Inc.  
Summary Plan Description  
Employer Identification No. 56-2155481, Plan No. 526  
Effective January 1, 2009

This booklet is a Summary Plan Description (SPD) for the Progress Energy Dental Plan (the "Plan") and provides information about the benefits available under the Dental Premium Plan.

The Plan is sponsored by Progress Energy, Inc. and is available only to eligible non-bargaining employees of Progress Energy Carolinas, Inc., Progress Energy Florida, Inc., and Progress Energy Service Company, LLC.

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. In no case does this document imply or guarantee any right of future employment.

### **Reference Documents and Forms**

FRM-SUBS-00011, Choice Benefits Change Form  
FRM-SUBS-00877, Group Dental Claim Form  
FRM-HRI-SUBS-30004 – Guide to Benefits for Domestic Partners

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The Plan covers employees and their dependents who meet the eligibility requirements specified herein and who are employed by a participating subsidiary. The Plan also provides benefits to eligible retirees and their dependents as described herein. A subsidiary is a participating subsidiary if it is within Progress Energy's controlled group and if it, with the approval of Progress Energy, Inc., has elected by action of its Board of Directors to participate in this Plan. The term "controlled group" shall mean the group of companies as defined in Section 1563(a) of the Internal Revenue Code (the "Code"). A participating subsidiary may elect to withdraw from participation in the Plan at any time.

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

**New employees**

Regular, full-time non-bargaining employees of Progress Energy Carolinas, Inc., Progress Energy Florida Inc., Progress Energy Service Company, LLC, and Progress Fuels Corporation (corporate employees) (participating subsidiaries of Progress Energy, Inc.) are eligible to enroll in the Plan on the first day of employment or reclassification to regular, full-time non-bargaining employment status.

You and your employer share the cost of dental coverage. Payroll deductions are taken on a before-tax basis. Payroll deductions for new employees will begin with the paycheck following processing of online enrollment or the enrollment form.

**Dependents**

If you are eligible for and elect dental coverage on yourself, you may also elect to cover your spouse or domestic partner and eligible children. Each eligible dependent to be covered must be listed by name, Social Security number, and date of birth on the employer-provided enrollment form. Eligible dependents are:

- Your spouse or domestic partner <sup>1</sup>
- Unmarried children under age 19 who:
  - Are your biological children and are mainly supported<sup>2</sup> by you, regardless of whether or not they live with you; or
  - Live with you, have been placed with you for legal adoption, whether or not the adoption has become final, and are mainly supported<sup>2</sup> 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>4</sup> and your spouse or domestic partner does not have employer-sponsored coverage available; 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 or your spouse's or domestic partner's biological or adopted children who meet the following requirements:
    - receive over one-half of their support<sup>2</sup> during the year from you, your spouse or domestic partner, or the child's parent from whom you or your spouse or domestic partner is divorced or legally separated; and
    - live for more than one-half of the year with you, your spouse or domestic partner, or the child's parent from whom you or your spouse or your domestic partner are divorced or legally separated; and
    - you or your spouse or domestic partner is 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>; and
    - if applicable, your stepchild's parent (who is your spouse or your domestic partner) does not have employer-sponsored coverage available.

- Your unmarried children under age 25, who are mainly supported<sup>2</sup> by you or your spouse or domestic partner, who are full-time students<sup>4</sup> in an accredited/licensed school, college, or university (you may be required to furnish proof of your dependent’s student status to the benefits administrator twice a year). 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 25 for full-time students), and
  - Who either live with you or live in a long-term care facility and are mainly dependent upon you or your spouse or domestic partner for support and care, and
  - for whom you can provide proof of their incapacity, residency, and dependency.

<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* 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)). **Your 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 Employee Service Center for consideration.

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

Under no circumstances can a child or spouse or domestic partner be eligible for Dependent coverage if he or she is on active duty in the armed forces.

**Note: Employees who cover ineligible dependents are in violation of the Company’s Code of Ethics and may be subject to disciplinary action up to and including termination of employment. They may also be required to pay damages and costs to the Company, including reimbursement of any benefit payments made with respect to an ineligible dependent.**

*Employment of both spouses or domestic partners by Progress Energy*

If both you and your spouse or domestic partner are employed by a participating subsidiary of Progress Energy, Inc., each of you may elect to be covered as an employee under the Plan. Or, one of you may elect the No Coverage option and be covered as a dependent by the other. You may not be covered both as an employee and as a dependent. Also, only one of you may cover your children. These restrictions also apply if your spouse or domestic partner is a bargaining unit employee of Progress Energy Florida, Inc.

**Leaves of absence**

If you make the required contributions, you may continue dental 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
- Any other absence that qualifies under the Family and Medical Leave Act
- Military service
- Disability

**Employees of the former Florida Power Corporation (non-bargaining employees), Progress Fuels Corporation (corporate employees), and Progress Telecom Corporation who were reclassified to disabled retiree status prior to January 1, 2002 (i.e., disability began prior to 1/1/02)**

Non-bargaining employees who were eligible for benefits under the FlexPower program and who became disabled prior to January 1, 2002, and who were subsequently classified to disabled retiree status under the Long-Term Disability Plan of Progress Energy Florida, Inc., are not eligible for Progress Energy, Inc.-sponsored dental coverage.

**Retirement credit-eligible participants**

Employees who met all eligibility requirements for receiving additional years of benefit service under the Carolina Power & Light Company Retirement Transition Support Program (Retirement credit-eligible participants) are entitled to receive coverage during the transition period in accordance with the guidelines of the Carolina Power & Light Company Retirement Transition Support Program. Progress Energy, Inc.-sponsored coverage is available as long as dental coverage is not available under another employer's plan.

**Former employees**

Terminated employees of a Progress Energy, Inc. participating subsidiary who have entered into a binding written agreement that grants the terminated employee and any of his or her otherwise eligible dependents the right to continued participation in the Plan may continue coverage according to the terms of the agreement.

**Retirement**

Employees must meet specific eligibility requirements to continue Progress Energy, Inc.-sponsored dental coverage after retirement. The age and service requirements differ depending upon the employer and the effective date of the employee's retirement. See the [Appendix](#) on page 33 for more detailed information about the age and service requirements that apply to you and your employer group. Employees who terminated between June 1 and December 1, 2005 pursuant to the terms of the Voluntary Enhanced Retirement Program may continue to be covered under the Plan, subject to the terms of that program.

**Coverage options**

You may choose from the following options:

- No Coverage
- Coverage under the Premium Plan

If you enroll in the Dental Plan, three levels of coverage are available:

- Self (employee only)
- Self + 1 (employee plus one eligible dependent)
- Family (employee plus two or more eligible dependents)

Each dependent must meet the eligible [dependent definition](#) and be listed by name, Social Security number, and date of birth through ProgressNet or on the employer-provided enrollment form to be covered under the Plan.

Please see the Guide to Benefits for Domestic Partners for an explanation of the tax impact of paying premiums for your domestic partner on a before-tax basis.

**New employee enrollment**

You must enroll yourself and your eligible dependents within 30 days of your employment or reclassification date.

You must cover yourself under the Plan in order to enroll your eligible dependents. Also, you must elect the appropriate category of coverage and list each dependent by name, Social Security number\* and date of birth through ProgressNet or on the employer-provided enrollment form before any benefits can be paid. Coverage will be effective on your date of hire if the Employee Service Center receives your form within 30 days of your hire date. If you do not enroll within 30 days of your employment date, your dental election will automatically default to the No Coverage option.

*\* If you do not have the dependent's Social Security number, you should complete the rest of the information and submit the form. You may call the Employee Service Center at a later date and add the dependent's Social Security number.*

If you decline dental coverage for yourself, you may not enroll your dependents.

If your dependent child is a full-time student, you will be required to provide proof of full-time student status. The Benefit Administrator is responsible for the student verification process. If you receive a student verification letter from the Benefits Administrator, you will need to provide information from the school verifying your dependent's student eligibility within the timeframe designated in the letter. If the information is not provided to the Benefit Administrator, the Employee Service Center will drop your dependent from dental coverage.

**Changing your election**

After the 30-day new employee enrollment period has expired, you may not change your dental election until the next biennial dental enrollment period unless you have a qualifying change in your family or employment status.

*Biennial dental benefits enrollment*

The Plan has biennial (every two years) enrollment periods and changes to your dental election may only be made at these times unless you have a qualifying event that will allow you to make a change. Elections made during dental enrollment periods are effective for two years. After the 2008-2009 plan years, the biennial dental enrollment periods will be for plan years 2010-2011, 2012-2013, etc.

*Qualifying events*

If you have a qualifying change in your family or employment status during the year, as described in the Internal Revenue Code (and as amended from time to time), you may be able to change your coverage election at that time. Qualifying events include:

- 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 or your spouse or domestic partner take or return from an unpaid leave of absence
- Your spouse's/domestic partner's or your employer-provided health care coverage changes significantly
- Your spouse's/domestic partner's employer conducts open 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
- You, your spouse or domestic partner, or dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You, your spouse or domestic partner, or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP<sup>1</sup>

<sup>1</sup>Employee must notify the Employee Service Center within 60 days of loss of Medicaid/CHIP or of the eligibility determination. All other qualifying events must be communicated to the Employee Service Center within 30 days of the event.

You must submit an employer-provided Choice Benefits Change Form (FRM-SUBS-00011) to the Employee Service Center within 30 days of the event if you have a qualifying change in your family or employment status and wish to change your dental election. The new election will be effective on the date of the qualifying change. **Otherwise, you will have to wait until the next biennial enrollment period. However all election changes must be consistent with the qualifying change and the following participant group guidelines:**

- Regular, full-time, non-bargaining employees and employees on a leave of absence may not make changes to their dental election until the next dental enrollment period unless they have a qualifying change in family or employment status. Changes made as a result of a qualifying event must be requested within 30 days of, and be consistent with, the qualifying event.
- Retired employees, including full-cost retirees, may make changes to their coverage within 30 days of a qualifying event, consistent with the qualifying event. However, they may elect to drop coverage or dependents without a qualifying change at any time during the year. They may also make changes during the next dental enrollment period.
- LTD recipients and COBRA participants may not add dependents to their coverage until the next dental enrollment period unless they have a qualifying change in family status. However, they may elect to drop coverage or dependents without a qualifying change at any time during the year. Changes made as a result of a qualifying event must be requested within 30 days of, and be consistent with, the qualifying event.

- Retirement credit-eligible participants may elect to drop coverage during the year or make changes that are consistent with the list of qualifying events. Also, if a retirement credit-eligible participant loses dental coverage under another employer's plan, coverage may be resumed under the Progress Energy Dental Plan by applying within 30 days of loss of coverage. Changes made as a result of a qualifying event must be requested within 30 days of, and be consistent with, the qualifying event.

**Notes:**

***1 To cover a new dependent, you must complete an employer-provided Choice Benefits Change Form even if you already have family coverage. The new dependent's name, Social Security number\*, and date of birth should be listed on the form. If the Employee Service Center does not receive the form within 30 days of the event, the dependent may not be added to your coverage until the next dental enrollment period.***

\* If you do not have the dependent's Social Security number, you should complete the rest of the information and submit the form. You may call the Employee Service Center at a later date and add the dependent's Social Security number.

- 2. When a dependent is no longer eligible for coverage, you must complete an employer-provided Choice Benefits Change Form to drop coverage for the dependent and reduce your dental premium (if applicable).**
- 3. Employees who cover ineligible dependents are in violation of the Company's Code of Ethics and may be subject to disciplinary action up to and including termination of employment. They may also be required to pay damages and costs to the Company, including any benefit payments made with respect to an ineligible dependent.**

**Usual and customary (U&C) limit**

Covered dental expenses are paid based on the usual and customary (U&C) limit. Usual and customary refers to the prevailing rate charged by providers in your area for similar services. UMR (formerly Fiserv Health), the Benefits Administrator, is responsible for determining the U&C limit. You are responsible for paying any amounts over the U&C limit.

**Deductible**

The deductible each calendar year is \$50 per person. This means that each covered individual pays the first \$50 of covered expenses each year for Basic and/or Major restorative services before the Plan will pay benefits for these services. The deductible does not apply for preventive and orthodontic services. The amount you pay for expenses above the U&C limit does not apply toward the deductible.

**Coinsurance and maximums**

The coinsurance amount is the percentage of U&C charges you pay for eligible expenses. All charges are subject to U&C limits. The maximum amount the Plan will pay each year for eligible expenses is called the annual Plan maximum. You are responsible for amounts over the U&C limit and above the annual or lifetime maximum.

**Predetermination of benefits**

You may request a predetermination of benefits before dental treatment begins if the treatment will cost \$200 or more. The review determines the extent of your coverage and what benefits are available. To request a predetermination of benefits, have your dentist submit a statement to UMR describing the condition, the planned course of treatment, and an estimate of charges.

UMR will prepare a determination of benefits that shows what coverage will be available and any alternative treatments identified through the predetermination process. You will be responsible for any charges in excess of the predetermined coverage amount if you and your dentist select a course of treatment that costs more than the approved amount.

Predetermination does not provide a guarantee of benefit payments. For example, if the annual Plan maximum has been exhausted or your participation in the Plan ends, no benefits will be paid even if a particular treatment plan has been reviewed and approved for coverage.

**Alternative methods of treatment**

The predetermination process examines possible alternative courses of treatment. When alternative courses of treatment are available, benefits under the Plan will be limited to the charges for the less expensive treatment. Such alternatives are likely to be encountered when planning certain restorative treatments or the use of prosthodontics.

*Restorative/reconstructive*

The Plan may authorize coverage for the use of amalgam instead of gold, baked porcelain restorations, crowns, or jackets, if amalgam will function adequately. In such cases, you will pay the cost difference for the more expensive treatment.

*Prosthodontics*

Charges for prosthodontic appliances are limited to the cost of cast chrome or acrylic partial dentures if they will restore the dental arch satisfactorily. The excess cost will be your responsibility if you and your dentist decide to use a more elaborate or precision appliance. Also, the excess costs will be your responsibility if you and your dentist decide to use personalized or specialized techniques instead of standard practices.

The replacement of dentures and fixed bridgework will be a covered expense only if the existing appliances can not be made serviceable. Payment is based on the cost of repair. Replacement is covered only if the appliance involved has been in use for a minimum of five years.

Dental benefits are paid based on the coverage category in which the expense falls. Dental provider charges are covered up to the U&C limits if they are necessary for the care of your teeth as determined by UMR, and if the services are started and completed while you are covered under the Dental Plan.

**Preventive services**

Eligible preventive services include:

- emergency exams and emergency palliative (pain-relieving) care that does not necessarily effect a cure
- topical fluoride application to exposed tooth surfaces twice per calendar year for children under age 19
- routine oral examinations and prophylaxis (cleaning and scaling of teeth) twice per calendar year per person
- topical sealant application to exposed tooth surfaces once every two calendar years for children under the age of 19
- fixed or removable space maintainers for children under age 19 to replace or maintain space for prematurely lost teeth
- full-mouth X-rays once in every 36 consecutive months per person, bite-wing X-rays twice in a calendar year per person, and other X-rays as required for diagnoses of specific conditions (except for orthodontia cases, which are covered separately)

**Basic restorative services**

Eligible basic restorative services include:

- alveolectomy (preparation of the mouth for dentures) involving at least six consecutive tooth sockets and performed as an independent procedure (not performed at the time the teeth are extracted)
- administration of anesthesia or analgesia when medically necessary and provided in conjunction with oral or dental surgery
- intravenous sedatives when medically necessary and provided in conjunction with oral surgery
- charges for consultation if the consulting dentist does not perform the surgical procedure in question
- excision of radicular (root) or dentigerous (surrounding the tooth) cysts
- endodontic treatment (procedures generally used to prevent and treat diseases of the dental pulp and the tip of the root) including root canal therapy
- surgical or non-surgical extraction
- fillings (amalgam, plastic, synthetic porcelain and composite)
- injection of antibiotic drugs by the attending dentist
- all other oral surgery if not covered under a Progress Energy, Inc.-sponsored medical plan
- periodontal cleanings and treatment (procedures generally used to prevent and treat diseases of the gums including gingivectomy)
- surgical treatment of temporomandibular joint syndrome (TMJ) if not covered under a Progress Energy, Inc.-sponsored medical plan
- dental root resection (apicoectomy)
- oral surgery to remove boney impacted teeth subject to \$2,000 per person lifetime maximum; oral surgery dental codes for impacted teeth are: D7230, D7240, D7241, D9220, D9221

**Major restorative services**

Eligible major restorative services include:

- installation of implants and related services such as implant-supported prosthetics (abutments or retainer crowns placed over the implant) or implant removal; replacement of implants will be covered only if the existing implant cannot be made serviceable and was installed at least five years prior to the replacement.
- initial installation of fixed bridgework (prosthetics) to replace missing natural teeth including inlays and crowns as abutments; excludes periodontal splinting and replacement of wisdom teeth
- initial installation of full or partial removable dentures to replace missing natural teeth and adjoining structures and any adjustments during the first six months following installation; excludes replacement of wisdom teeth

- inlays, onlays, crowns, or gold fillings but only when the teeth involved cannot be restored with amalgam, plastic, synthetic porcelain or composite fillings
- non-surgical treatment of temporomandibular joint syndrome (TMJ) if not covered under a Progress Energy, Inc.-sponsored medical plan
- repair or re-cementing of crowns, bridgework, dentures, etc., at least six months after the initial installation and no more often than once every 36 consecutive months
  - replacement of existing dentures or bridgework or the addition of teeth to existing partial dentures or bridgework, but only if:
    - the replacement or addition is the result of the loss of another natural tooth after the existing denture or bridge was installed, or
    - the existing denture or bridge cannot be made serviceable and was installed at least five years prior to the replacement, or
    - the existing denture or bridge is an immediate temporary device that cannot be made permanent.

Normally a denture is replaced by a denture, but if a professionally adequate result can be achieved only with bridgework, then the bridgework will be considered a covered expense.

**Orthodontic services**

Eligible orthodontic expenses include:

- active treatment including the necessary dental appliances such as braces
- diagnostics including radiography and modeling
- retention treatment which follows the course of active treatment
- surgical treatment including extraction

Orthodontic services are covered for participating employees, spouses or domestic partners and dependent children (under the age of 19\*). UMR administers orthodontia expenses based on a reasonable payment schedule or service contract that 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.

*\* If the dependent child is a full-time student, orthodontic services are provided until the dependent child reaches age 25 or no longer qualifies as an eligible dependent.*

Example: You enter a contract agreement with the orthodontist for a total fee of \$4,500 with a down payment paid at the time the braces are installed and 16 monthly payments for the remaining charges. In order to determine benefits under the Plan, UMR will use 25% or \$1,125 as the initial down payment. The difference of \$3,375 (\$4,500 - \$1,125) will be divided by 16 (months in treatment) to determine the monthly amount to be considered for payment by the Plan (\$210.94 in this example).

If the provider offers a discount to the member for paying the full amount in advance (or as one lump sum payment), you will then need to request that the provider break the services out to reflect what the contract agreement would have been, had you paid in monthly installments. This breakdown can then be used to claim reimbursement from the Plan.

UMR will consider 25% of the total cost (within U&C) and will pay 50% of that amount initially. The remaining balance will be divided by the number of months treatment is required and 50% of the monthly amount will be paid each month until the \$2,000 orthodontic maximum has been met, as long as the person's coverage remains in effect. If the treatment plan is completed early, payment of the remaining amount up to \$2,000 will be made upon appropriate notification from the orthodontist. Orthodontic payments will not be made for longer than the duration of the predetermined and approved treatment plan.

Only one statement is necessary when applying for orthodontic benefits. It should be completed by you and the orthodontist at the beginning of the active treatment plan. The orthodontist should indicate the estimated total cost of the program and the total length of time for orthodontic treatment.

Orthodontic payments are made only as described above and are not based on any payment schedule you may arrange with the orthodontist.

**Orthodontic exclusions and limits**

The following limits and exclusions apply specifically to orthodontic benefits:

- If orthodontic services end for any reason before the approved treatment is completed, coverage terminates the date the services end. Benefit payments up to the individual lifetime Plan maximum may resume if treatment resumes and the person is still covered under the Plan.
- Your orthodontist must submit a treatment plan to UMR. The diagnosis must show that your condition consists of a handicapping malocclusion that is abnormal and correctable. The Plan reserves the right to review your dental records, including X-rays and study models, to determine whether the orthodontia is eligible for coverage.
- The orthodontist must show that the misalignment of your teeth is severe enough to cause problems with normal mouth functions (chewing, speaking, breathing, etc.) and that the proposed treatment is not merely cosmetic but will correct or substantially improve the condition. UMR has the right to confirm and approve the treatment plan.
- Charges for replacement, or repair of any appliance furnished under the treatment plan, or for any duplicate device or appliance are not covered.

<b>Progress Energy Dental Plan</b>	
Deductible (annual)	\$50 per person
Plan maximum (annual)	\$1,500 per person
Preventive (two visits per person per year)	Covered at 100% of U&C up to annual Plan maximum No deductible
Basic restorative Fillings Oral surgery* Root canals Extractions	20% employee coinsurance after deductible  *\$2,000 per person lifetime Plan maximum for oral surgery to remove boney impacted teeth.
Major restorative Crowns Bridges Dentures	50% employee coinsurance after deductible
Orthodontia	50% No deductible \$2,000 per person lifetime Plan maximum
Note: Deductible and coinsurance amounts are what you pay.	

**Additional expenses not covered**

In addition to specifically excluded expenses, the Plan does not cover the items and services listed below. The list may not be all-inclusive. Contact UMR at 1-800-842-6475 if you have questions as to whether or not a particular expense is covered.

- Amounts in excess of U&C as determined by UMR
- Basic or major restorative services when treatment was begun before an employee or dependent became a participant in the Plan
- Charges for failure to keep appointments
- Cosmetic services
- Dietary or hygiene instructions
- Duplicate prosthetics or appliances or replacement of missing, lost, or stolen dentures or bridgework
- Intravenous sedatives (except when medically necessary for oral surgery)
- Myofunctional therapy
- Periodontal splinting
- Porcelain applied to crowns and false teeth to match the color of remaining teeth on other than the ten upper and lower front teeth
- Prosthetics that were ordered when the person was not covered by the Plan or that were installed more than two calendar months after coverage under the Plan ended
- Replacement of congenitally missing teeth
- Services, supplies, or expenses other than those specifically listed as covered expenses
- Services by other than an appropriate provider
- Services provided by a member of your or your spouse's or domestic partner's immediate family (spouse, domestic partner, children or parents) or by a person who resides in your home
- Services received by someone who resides permanently outside of the United States or Canada
- Services covered by any other benefit plan or insurance program paid for or sponsored by the Company
- Services received as a result of dental disease or injury caused by war, rebellion, or riot
- Services received as a result of dental disease or injury incurred while committing or attempting to commit a crime
- Services received in any employer-sponsored clinic or medical department
- Services or supplies that are not necessary or that are experimental in nature according to accepted standards of dental practice or that are not recommended or approved by the attending dentist
- Treatment for the purpose of altering vertical dimension, restoring occlusion, splinting or replacing tooth structure lost as a result of abrasion, attrition or erosion unless covered elsewhere in this document.
- Treatment not approved by the Department of Health and Human Services, the Food and Drug Administration, or the American Dental Association
- Treatment that is covered by Workers' Compensation
- Treatment that is covered by any governmental body or agency unless payment is required by law

If you and your eligible dependents are covered under this Plan and another employer-sponsored plan, benefits under this Plan will be coordinated with the other plan. Under coordination of benefits, the primary plan provides benefits until its limits are reached. Then the secondary plan provides benefits based on the amount not paid by the primary plan.

Primary and secondary responsibility for a claim is usually determined as follows:

- The plan without a claims coordination provision is primary and the plan with a claims coordination provision is secondary.
- When both plans have coordination provisions, the plan covering an active employee is primary and the plan covering a spouse or domestic partner of an active employee is secondary.
- A plan that covers an active employee or a dependent of an active employee is primary to a plan that covers the person as an inactive (retired or terminated) employee or as a dependent of an inactive employee.

If a determination of responsibility cannot be made using the above guidelines, the plan that has covered the person the longest will be primary.

### **Dependent children**

If a dependent child is covered by two or more employer-sponsored plans, the "birthday rule" will apply unless there has been a divorce. Under the birthday rule, the plan of the parent whose birthday occurs first in the year is primary regardless of the year of birth. For example, the plan of the parent with a February birthday is primary to the parent with a May birthday. The father's plan will be primary if a plan does not contain the birthday rule.

If there has been a divorce and the courts assigned financial responsibility for a child's health care to one parent, that parent's plan is primary. Otherwise, in the case of a divorce:

- the plan of the parent with custody pays first and the plan of the stepparent pays second.
- the plan of the parent without custody pays third (second if there is no stepparent or the stepparent does not participate in an employer-sponsored dental plan).

### **How coordination of benefits works**

When this Plan is secondary, benefits are coordinated with benefit payments from the other plan. This means that the total amount paid under all plans can be equal to, but not greater than, the total of expenses considered usual and customary.

Under the coordination of benefits provision, the primary plan provides benefits until its limits are reached. The secondary plan then provides benefits based on the amount not paid by the primary plan until the limits of the secondary plan are reached. If a third plan is involved, it then provides benefits. The total amount paid by all applicable plans cannot be greater than the total amount of the allowable expense.

When this Plan is secondary, it gives you credit for savings resulting from coordination. This credit is used to provide payments for allowable expenses that would not have been paid if it were the only plan involved in the claim. This can result in 100% coverage of allowable expenses.

After all plans have paid benefits, you are responsible for any remaining charges including amounts in excess of the U&C limit. The total amount paid by the Plan under the coordination process cannot be greater than the amount that normally would be paid for the claim involved.

**Medicare**

Medicare normally excludes most dental expenses, but when coverage is available and Medicare is primary, the coordination of benefits provisions will apply.

If you are actively employed and are covered both by this Plan and by Medicare, this Plan will be your primary plan. Generally, Medicare is primary only if you are retired and are age 65 or over, or if you have been disabled and received Social Security benefits for 24 months.

When you are eligible for Medicare and this Plan is secondary, UMR assumes that you have purchased Medicare Part B and provides benefits accordingly, whether or not you have purchased it. It is your responsibility to apply for and purchase Medicare Part B coverage when you or your dependent becomes eligible for Medicare.

**Verifying coverage**

To verify eligibility for coverage, you or the provider may call UMR at 1-800-842-6475 with the following information:

- Patient's name and date of birth
- Employee's name and Social Security number
- Group number: Progress Energy 76 - 140056

A claim form is required when filing dental services with UMR. The Group Dental Claim Form (FRM-SUBS-00877) is available online through ProgressNet and from the Employee Service Center. You may also use the standard dental claim form available from your dentist. Retain a copy of the form and statement for your records.

The claim should be mailed to:

UMR - Dental Claim Services  
PO Box 30541  
Salt Lake City, UT 84130-0541

You will receive an explanation of benefits indicating how your claim was processed and the amount of benefits, if any, that was paid. Your dentist will also receive a copy of the explanation of benefits if you elect to have the payment sent directly to the dentist.

The Plan and UMR reserve the right to require verification of any fact or assertion concerning any claim for covered dental expenses to ensure that benefits are paid appropriately. Submission of X-rays and other appropriate diagnostic materials may be requested. Failure to provide the requested information could result in the denial of the claims involved. (See the [Claim and Appeal Procedures](#) section for additional information.)

**When to file**

You should hold claims until you have enough expenses to meet the deductible. After the deductible has been satisfied, you should wait until you have incurred \$50 of additional expenses or the end of the calendar year to file additional claims. All claims must be filed within 12 months of the date the expense was incurred.

**Filing with two plans**

Original statements should be submitted to the primary plan first if two or more plans are involved. When the primary plan responds, send a copy of that plan's explanation of benefits and copies of the bills to the secondary plan for payment consideration. If this Plan is secondary, it will not pay any benefit that would have been paid by the primary plan even if the claim was not filed with the primary plan.

**Claim questions**

Call UMR at 1-800-842-6475 if you have claim questions. Have available a copy of your charges, your explanation of benefits, and any other correspondence you may have received.

### **Employees**

Generally, your coverage will continue as long as you make the necessary contributions and continue to meet the eligibility requirements under the Plan.

If the Plan should be terminated, coverage ends on the date of such termination. Also, if the participating employer in which you are employed chooses not to participate in a particular benefit or leaves the controlled group of companies, coverage will be terminated.

Eligibility for benefits under the Choice Benefits program will also end if your employment status changes from an employee of a participating subsidiary to a Progress Energy Florida, Inc. bargaining unit employee. *(Progress Energy Florida, Inc. bargaining unit employees are eligible for benefits under the FlexPower program.)*

### **Dependents**

Coverage for your dependents will continue as long as your coverage does unless your dependents no longer meet the eligible [dependent definition](#). When a dependent is no longer eligible for coverage, you should complete an employer-provided Choice Benefits Change Form (FRM-SUBS-00011) to delete the dependent from your coverage within 30 days of the loss of eligibility. **Employees who cover ineligible dependents are in violation of the Company's Code of Ethics and may be subject to disciplinary action up to and including termination of employment. They may also be required to pay damages and costs to the Company, including reimbursement of any benefit payments made with respect to an ineligible dependent.**

### **Retirement Credit-eligible participants**

If you are continuing coverage as a retirement credit-eligible participant and become employed before the end of the transition period, you are not eligible to continue coverage under this Plan if dental coverage is available from your new employer, whether or not you elect the other coverage. However, coverage under this Plan may be resumed if loss of coverage under the other employer's plan should occur or when you become eligible to receive Progress Energy retirement benefits.

### **Terminated employees or dependents who lose eligibility status**

Dental coverage will end if you terminate employment or your dependent loses eligibility. Coverage will terminate on the last day of the base pay period in which your employment terminates or on the date your dependent loses eligibility. Terminated employees and dependents who lose dependency status are not eligible to continue coverage unless they qualify for COBRA coverage as described in the [COBRA](#) section.

### **Surviving dependents**

If you die as a regular, full-time non-bargaining employee, long-term disability recipient, retirement credit-eligible participant, or retired employee, your eligible dependents may be covered as surviving dependents. As an alternative, your covered dependents may elect coverage as COBRA participants.

Eligible surviving dependents may continue their coverage without interruption, waive coverage or elect coverage if they apply within 30 days after the Employee Service Center is informed of your death and pay the required contributions in a timely manner. If your surviving spouse or domestic partner is eligible for other employer-sponsored dental coverage, he or she will not be eligible to elect coverage as a surviving dependent. If your spouse or domestic partner is no longer eligible for other employer-sponsored dental coverage, he or she will be eligible to elect coverage as a surviving dependent within 30 days of the loss of coverage. Coverage on the surviving spouse or domestic partner will terminate if he or she remarries or establishes a new domestic partner relationship. Coverage on a dependent child will terminate when the child no longer meets the eligible dependent definition.

Surviving dependents who no longer meet the eligibility requirements of the Plan may be eligible for COBRA coverage.

**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). Domestic partners and their eligible dependents are eligible for continuation coverage under COBRA under the same terms as those provided to employees and their eligible dependents. 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).

***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 to drop the dependent from your Progress Energy, Inc.-sponsored coverage by submitting a Choice Benefits Change Form (FRM-SUBS-00011) 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 the total cost of employee coverage is \$50 per month (employee and employer contributions combined), the cost for COBRA coverage would be \$51 per month. During the 11-month extension period for disabled qualified beneficiaries (discussed below), 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 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.
- 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 either of the two 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 (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 Plans 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.

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.

**Denial of 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. 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 or will state that such an explanation is available upon request.

**Submitting an appeal**

To have a denied claim reviewed, you must send a written request to the Benefits Administrator/Insurance Company within 180 days of receipt of the initial denial notice. The written request should be mailed to UMR, PO Box 8086, Wausau, WI 54402-8084. 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 the Benefits Administrator/Insurance Company. Individuals 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 claim 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 Plan 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 claim will be reviewed, 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 review request is received. You will receive a written notice of the results of this review. The notice will include the 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.

**Acts of third parties**

In the event you suffer an injury or illness caused by a third party, you assign to Progress Energy, Inc. any rights against the third party to recover benefits received under a Progress Energy, Inc.-sponsored dental plan for that injury or illness. You should notify the Plan Administrator that a third party is responsible for dental costs. In addition, you grant Progress Energy, Inc., on behalf of the Plan, an equitable lien, on a first-dollar basis, against any recovery that you have against any party, up to the amount of medical expenses advanced to you by the Plan.

You may be asked to sign an agreement to repay the Plan for any claims that were paid by the Plan that are or may be the responsibility of a third party. For example, if you are injured by another person and incur \$1,000 in covered dental expenses and you recover the \$1,000 in a lawsuit, you must repay the Plan the \$1,000 paid for those covered expenses. Similarly, if you incur \$1,000 in covered dental expenses in an accident and later the automobile insurance pays the \$1,000, you must repay the Plan for those expenses.

If you do not sign a reimbursement agreement or do not repay the Plan or otherwise fail to cooperate with these provisions, the Plan Administrator may stop payment on future claims, obtain a refund from payments previously made to providers, obtain a payment from the third party, or take other appropriate action. The Plan's rights of recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, under-insured motorists insurance, any medical payments, or no-fault or school insurance coverage.

This provision also applies to maintenance of benefits. For example, if you receive dental services and receive benefits from the Plan and later another group plan pays for the same charges, the Plan may recover the overpaid or duplicated benefits from you, the dental provider, or the other plan. Common law doctrines such as the "make whole" rule, the "common fund" rule, "comparative fault," and similar doctrines are inapplicable to benefits paid under this Plan.

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

**Plan identification**

The official name of the Plan is the Progress Energy Dental Plan. The 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**

Benefits under the Progress Energy Dental Plan are funded in part through contributions from participating employees. Benefits and operating expenses under the Progress Energy Dental Plan are also funded through contributions from participating subsidiaries of Progress Energy, 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 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, including but not limited to matters related to eligibility for benefits, application of Plan limitations, and the amount of any required contributions by or on behalf of any participants.

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 they are 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

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).

**Benefits Administrator**

The Plan has arranged for dental claims to be administered under an administrative agreement, group number 76-140056 and Plan number 7672-00-140056, by:

UMR  
PO Box 8086  
Wausau, WI 54402-8014

**Participating subsidiaries**

Eligible employees of the following participating subsidiaries of Progress Energy, Inc. may be covered by this Plan, subject to all eligibility requirements stated herein.

Progress Energy Carolinas, Inc.  
Progress Energy Florida, Inc. (non-bargaining employees)  
Progress Energy Service Company, LLC

**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.

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**Receiving information about your Plan and benefits**

As a participant in the Progress Energy Dental 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 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 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue 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.

**Benefit** - The payment to or on behalf of a participant or dependent because a covered expense was incurred under the terms of the Plan.

**Benefits Administrator** - The company (UMR) that administers the Progress Energy Dental Plan sponsored by Progress Energy, Inc.

**COBRA coverage** - Coverage purchased by or for a qualified beneficiary. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) states that if a qualifying event (such as death or divorce) causes a loss of employer-sponsored health care coverage, the person who lost coverage (the qualified beneficiary) must be given a chance to purchase continued coverage for a period of time. The coverage that is made available in this manner is referred to as COBRA coverage.

**Coinsurance** - The percentage of the covered expense you pay after the deductible has been met.

**Company** - Progress Energy, Inc., its operating divisions, and any subsidiary, affiliate, or contracting organization to which the benefits of the Plan have been extended.

**Covered expense** - The portion of a charge that is covered by the Plan.

**Deductible** - The amount you pay in a calendar year for covered expenses before any benefits are provided under the Plan.

**Effective date** - The date on which an event occurs under the Plan.

**HIPAA** - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which an employer may exclude coverage for medical conditions that are present before you enroll in the employer-sponsored health care plan. Under HIPAA, you are entitled to a certificate that shows evidence of your prior health coverage when your coverage under an employer-sponsored health care plan terminates.

**Long-term disability recipient** – A regular, full-time non-bargaining employee whose employment status was reclassified to long-term disability and who is eligible to receive benefits under his or her employer-sponsored long-term disability plan.

**Plan year** - The calendar year.

**Provider** - A person or facility that provides dental care and services in accordance with applicable state laws and licensing procedures.

**Qualified beneficiary** - A participant or dependent who is eligible for COBRA coverage because of a qualifying event.

**Qualified medical child support order (QMCSO)** - A judgment, decree, order, or approval of a property settlement agreement by a court that creates or recognizes the existence of a dependent's rights, or assigns to a dependent the right to receive benefits for which you or your dependent is eligible under the Plan.

**Regular, full-time non-bargaining employee** - An employee hired for an indefinite period of time to work at least 40 hours per week.

**Retirement credit-eligible participants** - Employees who met all eligibility requirements for receiving additional years of benefit service under the Carolina Power & Light Company Retirement Transition Support Program.

**Usual and customary (U&C) amount** - For any service or supply, the U&C amount will not exceed the lesser of:

- The amount customarily charged by the provider for it; or
- The charge for the service or supply made by other providers of comparable services or supplies in the same locality.

A special provision will apply when there are no providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, UMR will decide whether the charge is appropriate based on:

- The complexity involved
- The degree of professional skill required
- The cost of supplies
- Other pertinent factors

UMR may decline to pay flat rate charges when procedures, fees, or time involved are not itemized.

UMR determines whether or not a charge is usual and customary and will not pay any amount in excess of the U&C amount for certain expenses. The portion of a charge that is above the U&C amount does not apply to the annual deductible.

**Age and Service Requirements**

The following table describes how the age and service requirements relate to continuation and cost of dental coverage after retirement:

- the *Retirement Age and Service Requirements* reflect the minimum requirements for retirement;
- the *Welfare Benefits Age and Service Access Requirements* reflect the minimum requirements for access to unsubsidized (full cost) retiree health benefits; and,
- the *Welfare Benefits Age and Service Subsidy Requirements* reflect the minimum requirements for qualifying for subsidized retiree health benefits.

To qualify for subsidized retiree health benefits, you must meet the Welfare Benefits Age and Service Subsidy Requirements shown in the following table. If you do not meet the Welfare Benefits Age and Service Subsidy Requirements, you may be eligible for access to Progress Energy, Inc.-sponsored dental coverage based on the Welfare Benefits Age and Service Access Requirements. In the event that you meet neither the health benefits subsidized nor access requirements, you may still be eligible to retire under the Progress Energy Pension Plan according to the benefit and vesting service requirements but, you will not be eligible to elect health benefits at retirement.

Once you have met the minimum required age and years of service as described under the Welfare Benefits Age and Service Subsidy and/or Access Requirements, you will remain eligible for retiree health benefits (subsidized or access only) upon retirement.

Employees of a participating subsidiary may receive credit for prior service with a non-participating subsidiary only if that service was incurred during the time the non-participating subsidiary was within the controlled group of Progress Energy, Inc. (Note: service with Progress Telecom, LLC will be included only through December 31, 2004.) A non-participating subsidiary is an employer that is within Progress Energy’s controlled group of companies (as defined in Internal Revenue Code 1563) but that does not offer this Plan to its employees.

**Age and Service Requirements**

<b>Employer Group</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<p><b>New employees hired or rehired on or after 1/1/2002</b></p> <p><b>Eligible employees<sup>1</sup> of Progress Energy Carolinas, Inc., Progress Energy Service Company, and Progress Energy Ventures, Inc. (regardless of hire date)</b></p> <p><b>Eligible employees hired by or transferred to NCNG on or after 1/1/2000<sup>2</sup></b></p> <p><b>Eligible employees hired by or transferred<sup>3</sup> to Progress Energy Florida, Inc. (non-bargaining employees), Progress Fuels (corporate employees), and Progress Telecom Corporation (or Progress Telecom, LLC) on or after 1/1/2002</b></p>	<p><b>Eligible employees hired by NCNG on or before 12/31/1999</b></p> <p><i>Note: Employees hired by NCNG on or before 12/31/1999, must meet the age and service requirements defined below to qualify for Progress Energy, Inc.-sponsored retiree dental coverage. Employees hired on or after 1/1/2000, must meet the age and service requirements defined in column 1.</i></p>	<p><b>Eligible employees of Progress Energy Florida, Inc. (non-bargaining employees), Progress Fuels (corporate employees), and Progress Telecom Corporation (or Progress Telecom, LLC) hired on or before 12/31/2001</b></p> <p><i>Note: Employees hired on or before 12/31/2001, who were receiving benefits under the FlexPower program prior to 1/1/2002, must meet the age and service requirements defined below to qualify for Progress Energy, Inc.-sponsored retiree dental coverage. Employees hired on or after 1/1/2002, must meet the age and service requirements defined in column 1.</i></p>
<p><b>Retirement Age and Service Requirements</b></p> <ul style="list-style-type: none"> <li>• Age 65 or older with at least 5 years of service; or</li> <li>• Age 55 or older with at least 15 years of service; or</li> <li>• 35 years of service regardless of age</li> <li>• The years of service, above, must be in a non-bargaining unit employment classification. Temporary and part-time service must comply with the benefit service definition as defined in the Progress Energy Pension Plan document in order to meet these requirements.</li> </ul> <p><b>Welfare Benefits Age and Service Access Requirements</b></p> <ul style="list-style-type: none"> <li>• Age 65 or older with at least 5 years of service; or</li> <li>• Age 55 or older with at least 15 years of service; or</li> <li>• 35 years of service regardless of age</li> <li>• The total years of service worked must include regular, full-time service for the minimum required years of service shown above.</li> </ul> <p><b>Welfare Benefits Age and Service Subsidy Requirements</b></p> <ul style="list-style-type: none"> <li>• Hired or rehired on or before 12/31/2001; and</li> <li>• Attained age 40 or completed 5 years of eligible service on or before 12/31/2001; and</li> <li>• Completion of 15 years of service after reaching age 40; or</li> <li>• Completion of 35 or more years of service</li> <li>• The total years of service worked must include regular, full-time service for the minimum required years of service shown above.</li> </ul>	<p><b>Retirement Age and Service Requirements</b></p> <ul style="list-style-type: none"> <li>• Age 65 or older with at least 5 years of service; or</li> <li>• Age 55 or older with at least 20 years of service</li> </ul> <p><b>Welfare Benefits Age and Service Access Requirements</b></p> <ul style="list-style-type: none"> <li>• Age 65 or older with at least 5 years of service; or</li> <li>• Age 55 or older with at least 20 years of service</li> <li>• The total years of service worked must include regular, full-time service for the minimum required years of service shown above.</li> </ul> <p><b>Welfare Benefits Age and Service Subsidy Requirements</b></p> <ul style="list-style-type: none"> <li>• Hired or rehired on or before 12/31/2001; and</li> <li>• Attained age 40 or completed 5 years of eligible service on or before 12/31/2001; and</li> <li>• Completion of 15 years of service after reaching age 40</li> <li>• The total years of service worked must include regular, full-time service for the minimum required years of service shown above.</li> </ul>	<p><b>Retirement Age and Service Requirements</b></p> <ul style="list-style-type: none"> <li>• Age 65 or older with at least 5 years of service; or</li> <li>• Age 55 or older with at least 15 years of service</li> </ul> <p><b>Welfare Benefits Age and Service Access Requirements</b></p> <ul style="list-style-type: none"> <li>• Age 65 or older with at least 5 years of service; or</li> <li>• Age 55 or older with at least 15 years of service</li> <li>• The total years of service worked must include regular, full-time service for the minimum required years of service shown above; <i>exception:</i> regular, part-time service on or before 12/31/2001 counts towards the Welfare Benefits Age and Service Requirements.</li> </ul> <p><b>Welfare Benefits Age and Service Subsidy Requirements</b></p> <ul style="list-style-type: none"> <li>• Hired or rehired on or before 12/31/2001; and</li> <li>• Attained age 40 or completed 5 years of eligible service on or before 12/31/2001; and</li> <li>• Completion of 15 years of service after reaching age 40</li> <li>• The total years of service worked must include regular, full-time service for the minimum required years of service shown above; <i>exception:</i> regular, part-time service on or before 12/31/2001 counts towards the Welfare Benefits Age and Service Requirements.</li> </ul>

*The notes below apply to the table on the previous page:*

<sup>1</sup>Applies to employees of Progress Energy Carolinas, Inc., Progress Energy Service Company, LLC and Progress Energy Ventures, Inc. (participating subsidiaries of Progress Energy, Inc.) who were eligible for benefits under the Progress Energy, Inc.-sponsored Choice Benefits program prior to 1/1/2002. Does not include any employees transferred or relocated to these subsidiaries who were eligible for benefits under the FlexPower program prior to the merger of the Choice Benefits and FlexPower benefit programs effective 1/1/2002, or employees who were hired by or transferred to NCNG prior to 1/1/2000.

<sup>2</sup>Applies to employees of NCNG who were eligible for benefits under the Progress Energy, Inc.-sponsored Choice Benefits program prior to 1/1/2000.

<sup>3</sup>Applies to former employees of Progress Energy Carolinas, Inc., Progress Energy Service Company, LLC, and Progress Energy Ventures, Inc. (participating subsidiaries of Progress Energy, Inc.) who were eligible for benefits under the Progress Energy, Inc.-sponsored Choice Benefits program prior to 1/1/2002. Does not include any employees transferred or relocated to these subsidiaries who were eligible for benefits under the FlexPower program prior to the merger of the Choice Benefits and FlexPower benefit programs effective 1/1/2002, or employees who were hired by or transferred to NCNG prior to 1/1/2000

*Additional Employer Group information regarding the previous table:*

**Column 1 – former CP&L employees:**

**For retirement from the former CP&L after 1/1/1993 (last day of active employment was on or after 1/1/1993) but on or before 1/1/2002 (last day of active employment was on or before 12/31/2001) –** retirees who met both the Retirement Age and Service Requirements AND the Welfare Benefits Age and Service Subsidy Requirements are eligible to continue Progress Energy, Inc.-sponsored retiree dental coverage at company-subsidized retiree rates. Retirees who met the Retirement Age and Service Requirements AND the Welfare Benefits Age and Service Access Requirements are eligible to continue retiree dental coverage at full cost rates.

**For retirement from the former CP&L on or before 1/1/1993 (last day of active employment was on or before 12/31/1992) –** retirees are eligible to continue Progress Energy, Inc.-sponsored retiree dental coverage on themselves and their eligible dependents at company-subsidized retiree rates.

**Column 3 – former Florida Progress employees:**

**For employees hired on or before 12/31/2001 – Retirement effective after 1/1/ 2002 (last day of active employment is on or after 1/1/2002) –** employees hired on or before 12/31/2001, and who retire after 1/1/2002, and who meet the Retirement Age and Service Requirements AND the Welfare Benefits Age and Service Access Requirements defined in column 3 on the previous page are eligible for Progress Energy, Inc.-sponsored retiree dental coverage on themselves and their eligible dependents. To qualify for dental benefits at company-subsidized retiree rates (reduced from full-cost rates), both the Retirement Age and Service Requirements AND the Welfare Benefits Age and Service Subsidy Requirements defined in column 3 on the previous page must be met.

**For retirement effective on or before 1/1/2002 (last day of active employment was on or before 12/31/2001) -** non-bargaining employees who retire from the former Florida Power Corporation, Florida Progress Corporation, or any participating subsidiary of the Progress Energy Florida, Inc.-sponsored FlexPower program on or before 1/1/2002, are not eligible for Progress Energy, Inc.-sponsored retiree dental coverage on themselves and their eligible dependents.