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Progress Energy Employee Assistance and Mental Health & Substance Abuse Services Plan

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

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Progress Energy Employee Assistance and Mental Health & Substance Abuse Services Plan
 Summary Plan Description
 Progress Energy, Inc.
 Employer Identification No. 56-2155481, Plan No. 526
 Effective January 1, 2009

This booklet is a Summary Plan Description (SPD) for the Progress Energy Employee Assistance and Mental Health & Substance Abuse Services Plan (the "Plan"). The Plan is sponsored by Progress Energy, Inc. and is available to eligible employees as follows:

- Employee assistance services are administered by ValueOptions and available to non-bargaining, regular full-time employees, part-time employees, temporary employees, long-term disability recipients, retirement credit-eligible participants, and retired employees of Progress Energy Carolinas, Inc., Progress Energy Florida, Inc., and Progress Energy Service Company, LLC, (participating subsidiaries of Progress Energy, Inc.) and their eligible dependents.
- Mental health and substance abuse services are administered by BCBSNC and Magellan Behavioral Health for the High Deductible Health Plan (HDHP) and by ValueOptions for participants in all other medical plans sponsored by Progress Energy, Inc. These services are available to non-bargaining, regular full-time employees, long-term disability recipients, retirement credit-eligible participants, and retired employees of Progress Energy Carolinas, Inc., Progress Energy Florida, Inc., LLC, and Progress Energy Service Company, LLC (participating subsidiaries of Progress Energy, Inc.) and their covered dependents who are enrolled in one of the Progress Energy, Inc.-sponsored medical options.

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

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

Call ValueOptions at 1-800-662-8800 for questions regarding the Employee Assistance Program and mental health and substance abuse services (except participants in the HDHP). If you have medical coverage under the HDHP you should call BCBSNC at 1-877-258-3334 for assistance in identifying a mental health professional or Magellan at 1-800-359-2422 for inpatient or outpatient services.

Reference Documents and Forms

FRM-SUBS-00011, Choice Benefits Change Form
 FRM-SUBS-01112, Value Options Claim Form
 FRM-SUBS-00879, BCBSNC Member Claim Form

Employee Assistance and Mental Health & Substance Abuse Services Plan	4
Employee Assistance Plan	5
Eligibility	5
When eligibility ends	5
Access to counseling	6
Fitness for Duty and Department of Transportation evaluations	6
Confidentiality	6
Mental Health & Substance Abuse	7
Eligibility	7
Continuation of eligibility	9
When eligibility ends	9
ValueOptions role	10
How to use the services	10
In case of emergency	10
Confidentiality	10
Claims	10
Benefits Summary – Value Options	11
Pre-approval requirements	12
Covered services	12
Services not covered	13
BCBSNC/Magellan’s Role	15
How to use the services	15
In case of emergency	15
Confidentiality	15
Claims	16
Benefits summary BCBSNC/Magellan	16
Covered services	17
Primary and Secondary Coverage	19
Value Options Claim and Appeal Procedure	21
Non-certification determinations	21
Level I appeal	21
Level II appeal	21
Retrospective Appeal	22
Time limit for appeals	22
Voluntary Level III appeal	22
Hold harmless requirement	22
Denial of claims for administrative reasons	22
Level I appeal	23
Level II appeal	23
BCBSNC/Magellan Appeal	24
Appeal of a denied claim	24
Second level appeal of a denied claim	25
Third level appeal of a denied claim	25

COBRA Coverage	27
Qualifying events	27
COBRA elections	27
Responsibility of employer to provide notice	28
Your responsibility to notify your employer	28
Cost of COBRA coverage	28
Partial Payments	28
Maximum period of coverage	28
Termination of COBRA coverage	29
Other COBRA coverage	30
Additional Plan Information	32
Qualified medical child support order	32
Health Insurance portability and Accountability Act of 1996(“HIPAA”)	32
Plan Identification	33
Costs and funding	33
Administration	33
Plan Administrator	33
Benefits Administrator	34
Participating subsidiaries	34
Agent for service of legal process	34
Continuation of Plan and Plan amendments	34
Your Rights Under ERISA	35
Receiving information about your plan and benefits	35
Prudent actions by plan fiduciaries	35
Enforcing your rights	35
Definitions	37

Employee Assistance and Mental Health & Substance Abuse Services Plan

The Progress Energy, Inc.-sponsored Employee Assistance Plan (EAP) helps employees and their families deal with personal issues, such as stress, grief, legal and financial matters, substance abuse, or marital and family difficulties that may be affecting their lives at work or at home. ValueOptions, an outside administrator, provides confidential assessments, short-term counseling, referral services, and treatment monitoring under the EAP.

Mental health and substance abuse services are administered by BCBSNC and Magellan Behavioral Health for HDHP medical plan participants and administered by ValueOptions for all other medical plan participants.

The Plan covers employees and their dependents who meet the eligibility requirements specified herein and who are employed by a participating subsidiary. 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 only participate in the Plan during the time it is a member of Progress Energy's controlled group. 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.

Eligibility

Regular, full-time non-bargaining employees and part-time employees, temporary employees, and all members of their household are eligible to receive EAP services on the first day of employment or reclassification date with Progress Energy Carolinas, Inc., Progress Energy Florida, Inc. (non-bargaining employees), and Progress Energy Service Company, LLC, (participating subsidiaries of Progress Energy, Inc.). Progress Energy, Inc. pays the full cost of coverage for EAP services.

Leaves of absence

You and the members of your household will continue to be eligible to receive EAP services while you are on leave as permitted in the Employee Handbook for:

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

Reclassifications or Terminations

If your employment status changes and you are reclassified as a long-term disability recipient, retirement credit-eligible participant, or a retired employee of a participating subsidiary, eligibility for EAP services will continue.

Employees who terminate their employment with a participating subsidiary, other than for retirement, are not eligible to receive EAP services except under COBRA.

Surviving dependents

If you die and you were eligible to receive EAP services at the time of your death, EAP coverage will continue for the members of your household as long as they continue to reside in the home and elect to continue EAP coverage. Eligibility for EAP services will terminate if the surviving spouse remarries or the domestic partner enters into a new domestic partner relationship.

COBRA continuation

Also, under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law, eligibility for EAP services may be continued at your cost for up to 18 months if you terminate employment. Dependents may continue to be eligible under COBRA for up to 36 months if you and your spouse legally separate or divorce, you and your domestic partner terminate your domestic partner relationship, or your dependent child no longer meets the dependent definition. Refer to the [COBRA Coverage](#) section for complete details.

Former employees

Terminated employees of a 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.

When eligibility ends

Eligibility for EAP services will end if one of the following events occurs:

- Your employment status changes and you no longer meet the employee eligibility criteria and you are not reclassified as a long-term disability recipient, retirement credit-eligible participant or retired employee.
- You transfer to a non-participating subsidiary or you transfer to a participating subsidiary that terminates its participation in the Plan or leaves the controlled group of companies.
- The Plan is terminated (eligibility for services will end on the date of such termination.)

Access to counseling

You may request counseling services for yourself or members of your household. You should call ValueOptions directly at 800-662-8800 to set up an appointment with a counselor for a face to face visit or you may talk with a counselor by phone. In case of an emergency, a ValueOptions staff clinician can be reached 24 hours a day, seven days a week by calling this number.

The counselor will help you with an assessment of the personal issue and then assist in developing a plan of action to resolve the issue. Short-term confidential counseling is provided through ValueOptions for all types of personal issues, such as marital and family issues, drug and alcohol abuse, financial difficulties, emotional problems, career and employment concerns, parenting issues, etc. Follow-up, including consultation and treatment monitoring, will be provided as needed.

Fitness for Duty and Department of Transportation evaluations

ValueOptions can also assist in identifying resources for Fitness for Duty (FFD) and Department of Transportation (DOT) evaluations.

Confidentiality

Conversations and visits with the ValueOptions staff are strictly confidential. Information with ValueOptions will not be disclosed unless a release is signed, except in limited circumstances as described below.

Information may be provided without a release in the following circumstances:

- If information is disclosed that ValueOptions considers imminently life threatening to you or others, ValueOptions will take prudent steps to prevent the threatened danger.
- If instances of juvenile or elder care abuse or neglect are disclosed, state law may require that this information be reported to the appropriate state office.
- When you are within the scope of the NRC Fitness for Duty rule and it has been determined that your condition constitutes a hazard to yourself or others, ValueOptions must disclose this information to your employer's EAP staff, who will report it to your management.
- Pursuant to a subpoena, court order, regulatory order, or as otherwise required by law.

Eligibility

Regular, full-time non-bargaining employees who are enrolled in one of the Progress Energy, Inc.-sponsored medical options are eligible for mental health and substance abuse services on the first day of employment or reclassification date with Progress Energy Carolinas, Inc., Progress Energy Florida, Inc. (non-bargaining employees), and Progress Energy Service Company, LLC.

Dependents

Dependents of eligible plan participants who meet the dependent eligibility requirements are eligible to receive mental health and substance abuse services if the dependent is also covered under one of the Progress Energy, Inc.-sponsored medical options. Eligible dependents are:

- Your spouse or domestic partner ^{1,2}
- Unmarried children under age 19 who:
 - Are your biological children and are mainly supported² 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 supported² by you or your spouse or domestic partner; or
 - Live with you, are your stepchildren or domestic partner’s children, are mainly supported² 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 Plan³ and your spouse or domestic partner does not have employer-sponsored coverage available; or
 - Live with you, are your foster children, are mainly supported² by you or your spouse or domestic partner, and you are responsible to provide the type of coverage available under this Plan³; 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 supported² by you or your spouse or domestic partner, and you are responsible to provide the type of coverage available under this Plan³; 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 support² during the year from you, your spouse or domestic partner, or the child’s parent from whom you or your spouse 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 is 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 Plan³; 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 25⁴, who are mainly supported² by you or your spouse or domestic partner, who are full-time students⁵ 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 age⁶):
 - 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.

¹Your 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). **Except through COBRA, 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.**

² 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.

³ 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.

⁴Effective January 1, 2009, the AvMed and BlueCare HMOs are subject to a Florida law under which the limiting age may be extended until the end of the calendar year in which the child reaches age 25, if the child meets the following requirements:

- The child is dependent upon the employee for support and maintains primary residence in the HMO Service Area; and
- The child is living in the household of the employee, or the child is a full-time or part-time student.

⁵ 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.

⁶ 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.

Leaves of absences

You and your eligible dependents will continue to be eligible to receive mental health and substance abuse services if you elect to continue medical coverage under one of the Progress Energy, Inc.-sponsored medical options while you are on one of the following leaves:

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

Reclassifications

If your employment status changes and you are reclassified as a long-term disability recipient, retirement credit-eligible participant, or retired employee and you meet the eligibility requirements to continue medical coverage under one of the Progress Energy, Inc.-sponsored medical options, you and your covered dependents will remain eligible for mental health and substance abuse services if you continue medical coverage under one of the specified medical options. (See the Medical booklet for eligibility requirements.)

Terminated employees

Employees who terminate are not eligible to receive mental health and substance abuse services unless they continue medical coverage under one of the Progress Energy, Inc.-sponsored medical options through COBRA.

Former employees

Terminated employees of a 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.

Continuation of eligibility

Generally, your eligibility to receive mental health and substance abuse services will continue as long as you continue to meet the eligibility requirements to continue medical coverage under one of the Progress Energy, Inc.-sponsored medical options and you are enrolled in one of the medical options.

Dependents

Dependent eligibility continues as long as your eligibility does, unless your dependent no longer meets the eligible dependent definition or is no longer covered under one of the Progress Energy, Inc.-sponsored medical options.

Surviving dependents

If you die and you were eligible for mental health and substance abuse services under the Progress Energy, Inc.-sponsored Plan, your eligible dependents will continue to be eligible to receive mental health and substance abuse services if they elect to continue medical coverage in one of the Progress Energy, Inc.-sponsored medical options. Eligibility for services will terminate if the surviving spouse or domestic partner remarries or enters into a new domestic partner relationship or the dependent child no longer meets the eligibility requirements.

COBRA coverage

Participants who no longer meet the eligibility requirements to receive mental health and substance abuse services may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Eligibility for mental health and substance abuse services may be continued for up to 18 months if you terminate employment and elect to continue medical coverage in one of the Progress Energy, Inc.-sponsored medical options under COBRA.

Dependents may elect to continue medical coverage in one of these options under COBRA for up to 36 months if you and your spouse legally separate or divorce, you and your domestic partner terminate your domestic partner relationship, or your dependent child no longer meets the dependent definition. Refer to the [COBRA Coverage](#) section for complete details.

When eligibility ends

Eligibility for mental health and substance abuse services will end if one of the following events occurs:

- Your employment status changes and you no longer meet the employee eligibility criteria for medical coverage under one of the Progress Energy, Inc.-sponsored medical plans.
- You transfer to a non-participating subsidiary or you transfer to a participating subsidiary that terminates its participation in the Plan or leaves the controlled group of companies.
- 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.*)
- The Plan is terminated (eligibility for services will end on the date of such termination.)

ValueOptions' role

ValueOptions administers the employee assistance services for all participants and the mental health and substance abuse services under the Plan for participants in all medical plans sponsored by Progress Energy, Inc., other than the High Deductible Health Plan. Value Options' role in administering these services includes conducting a brief assessment, providing referrals, certifying care based on medical necessity, and processing claims.

How to use the services

To receive mental health and substance abuse services, you should call ValueOptions at 800-662-8800 before beginning treatment. For emergency services, you may call at any time. ValueOptions is staffed by trained professionals 24 hours a day, seven days a week.

When you call, a customer service representative will ask you to provide background information including a brief description of the concern, the patient's name and the employee's name and Social Security number. Then you'll be connected with a clinical care manager who will assist you (or the family member) in obtaining the right kind of professional assistance with the appropriate type of provider.

Precertification of treatment is required for any admission to an inpatient facility, residential treatment center, partial hospitalization program, or an intensive outpatient program or outpatient in-network treatment. In-network facilities must be used. There are no out-of-network benefits for these types of care.

Out-of-network benefits are available for outpatient care and precertification is not required for you to see an out-of-network provider.

In case of emergency

A mental health or substance abuse emergency is a condition in which the patient is a danger to him or herself or others. If an emergency arises and you cannot call ValueOptions, go immediately to any convenient hospital emergency facility. If you are admitted to the hospital on an emergency basis, you must call ValueOptions (800-662-8800) within 48 hours of admission to the hospital. If you cannot call, have a family member, friend or the hospital make the call.

After being stabilized, a patient who is admitted to an out-of-network facility in an emergency situation may be asked to transfer to a network facility for continuing treatment.

Confidentiality

All services provided by ValueOptions and all provider treatments are on a strictly confidential basis. Except as required by law, ValueOptions will not disclose to anyone that you have inquired about mental health or substance abuse benefits or are seeking or receiving treatment, unless a release is signed. However, in the following circumstances information may be provided without a release:

- If information is disclosed that ValueOptions considers imminently life threatening to you or others, ValueOptions will take prudent steps to prevent the threatened danger.
- If instances of juvenile or elder care abuse or neglect are disclosed, state law may require that this information be reported to the appropriate state office.
- Pursuant to a subpoena, court order, regulatory order, or as otherwise required by law.

Claims

When you use a provider in the ValueOptions network, you will not have to file a claim. In-network providers file directly with ValueOptions. With in-network providers, you pay only the copayment portion of the bill for outpatient service. (Note: Copays do not apply for inpatient admissions). In-network providers may not bill you for the difference between their usual charges and the ValueOptions discounted rate.

If you choose to use a non-network provider for outpatient care, you will be required to file your own claims with ValueOptions and you will have to pay 50% of the usual and customary charge as well as any amount above the provider's usual and customary rate. Reimbursements are mailed to you and not the provider. Claim forms are available from ValueOptions (800-662-8800) or the Employee Service Center (VoiceNet 770-5705 or 800-546-5705) and should be submitted to:

ValueOptions
Attn. Claims Dept.
PO Box 1347
Latham, NY 12110-8847

All Mental Health, Substance Abuse and Employee Assistance Program claims must be filed with complete information within 12 months of the date of service in order to be considered for reimbursement.

If you have claim questions, you may call ValueOptions at 800-662-8800.

Benefits summary – Value Options

- The first three claims received and paid for EAP, outpatient mental health or substance abuse, or a combination of EAP and outpatient mental health/substance abuse visits are covered at 100% each calendar year, if services are precertified by ValueOptions and a network provider is seen. Out-of-network EAP visits are not covered.
- A \$20 per visit copayment will apply after the first three visits of the year if services are precertified by ValueOptions and a network provider is seen. Out-of-network outpatient Mental Health/Substance Abuse visits are subject to coinsurance of 50% of the provider's usual and customary rates, plus any amount above usual and customary rates, up to 20 visits per year.
- Inpatient and alternative levels of mental health and substance abuse treatment must be precertified by ValueOptions to be covered.
- ValueOptions must be notified within 48 hours of emergency admissions to both in-network and out-of-network facilities. If ValueOptions is not notified, benefits will not be provided.
- Outpatient mental health and substance abuse treatment is covered if the provider is either a psychiatrist, psychologist, or master's level clinician who is licensed to practice independently without supervision. ValueOptions will certify services with Developmental Behavioral Pediatricians (medical doctors and pediatricians) who have completed a three-year fellowship in developmental behavioral pediatrics to provide outpatient services to members who are 18 and under. A higher level of benefits will apply if the treatment is precertified by ValueOptions and a network provider is seen.
- Usual and customary limits will apply to covered services received from an out-of-network provider or outpatient treatment that is not precertified. Usual and customary is the rate most providers typically charge for that service in that geographic area under similar circumstances. Benefits will not be paid for any amount over the usual and customary limit.

- Methadone maintenance services require precertification and are considered under the outpatient benefit.

Services	In-Network ¹	Out-Of-Network ²
Employee Assistance Plan (EAP) and Outpatient Mental Health & Substance Abuse (MH/SA)	<ul style="list-style-type: none"> • Precertification required • First three claims received and paid are covered at 100% (EAP and MH/SA combined) • \$20 copayment on subsequent visits (subsequent visits not permitted under EAP unless for separate EAP occurrences) • Unlimited number of mental health/substance abuse visits that meet medical necessity 	EAP Visits <ul style="list-style-type: none"> • Not covered Mental Health & Substance Abuse <ul style="list-style-type: none"> • 50% of U&C employee coinsurance on all visits; charges in excess of U&C will be the responsibility of the employee • 20 visits per year • precertification not required
Inpatient Mental Health & Substance Abuse	<ul style="list-style-type: none"> • Precertification required • 20% employee coinsurance • No deductible • \$1,000 annual out-of-pocket maximum • 60-day lifetime maximum for substance abuse • No lifetime maximum on number of days for mental health 	Not covered
Lifetime Plan maximum	\$2,000,000 per person ³	

¹ If covered services are received from in-network providers but precertification is not obtained from ValueOptions, the services will be considered out-of-network.

² Covered services received from an out-of-network provider or treatment that is not precertified will be subject to usual and customary limits. Charges in excess of U&C limits will be the responsibility of the employee.

³ The lifetime Plan maximum is combined with medical and includes benefits paid for medical and mental health and substance abuse services.

Pre-approval required

The following services require pre-approval by ValueOptions even if treatment has already been pre-authorized. For example, your therapist or hospital may have received approval to begin treatment; however, you must also get pre-approval from ValueOptions to assure coverage for any of the specialized services listed below:

- Psychological testing
- Biofeedback
- Hypnotherapy
- Sodium amytal interviews
- Electroconvulsive therapy
- Consultations by another mental health professional (except emergencies)

Covered services

Treatment services for psychiatric and substance abuse conditions are provided and include those listed below. This list may not be all-inclusive; contact ValueOptions for questions regarding coverage.

- Acute inpatient treatment, including substance abuse detoxification and rehabilitation
- Residential treatment centers
- Partial hospitalization programs
- Intensive outpatient programs
- Outpatient treatment with licensed providers including psychiatrists, psychologists, clinical social workers, psychiatric nurses, and licensed professional counselors
- Methadone maintenance services

Services not covered

The following services are not covered. This list may not be all-inclusive; contact ValueOptions for questions regarding coverage.

- Acupuncture
- Accommodations, services, supplies, or other items determined as neither clinically nor medically necessary
- Administrative psychiatric services when these are the only services rendered
- Any service or supply listed under general exclusions of the Medical Plan
- Bioenergetics therapy
- Carbon dioxide therapy
- Chart review
- Confrontation therapy
- Consultation with a mental health professional for adjudication of marital, child support, or custody cases
- Crystal healing treatment
- Cult deprogramming
- Custodial care
- Eating disorder and gambling programs based solely on the 12-step model
- Educational evaluation and therapy, including testing
- Educational treatment including reading clinics and special schools for mentally retarded or behaviorally impaired individuals
- Environmental ecology treatment
- EST (Erhard) or similar motivational services
- Examinations or treatments exclusively required as a part of legal proceedings if not medically necessary
- Experimental or investigative treatments
- Expressive therapies (art, poetry, movement, psychodrama) as separately billed services
- Guided imagery
- Hemodialysis for schizophrenia
- Hyperbaric or normobaric oxygen therapy
- Items specifically for personal comfort, hygiene or convenience, such as television, telephone, or private room for inpatient care; housekeeping, homemaker or meal services for outpatient care
- L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with a diagnosis of nutritional deficiency
- Marathon therapy
- Megavitamin therapy, nutritional formulas, food supplements, or special diets
- Narcotherapy with LSD
- Orthomolecular therapy
- Outpatient prescriptions
- Primal therapy
- Private duty nursing
- Private rooms (except when required for infection control)
- Rolfing
- Sedative action electrostimulation therapy
- Sensitivity training
- Services not authorized by ValueOptions
- Sex therapy (without a DSM IV diagnosis)
- Speech therapy
- Supervision of clinical treatment practitioners or team
- Training analysis (Tuition or Orthodox)

- Transcendental meditation
- Travel, whether or not recommended or prescribed as part of treatment
- Treatment for chronic, intractable pain at a pain control center or through a pain control program
- Treatment of sexual addiction, co-dependency, or any other behavior that does not have a DSM IV diagnosis
- Vocational assessment/school assessment
- Z therapy

BCBSNC/Magellan's role

BCBSNC/Magellan's administers the mental health and substance abuse services for participants in the High Deductible Health Plan. Its role under this Plan includes conducting a brief assessment, providing referrals, certifying care based on medical necessity, and processing claims.

How to use the services

To schedule an office visit, search for a participating provider on the BCBSNC website www.bcbsnc.com/members/progressenergy and schedule your appointment directly with the provider. You do not need certification for office visits. You may also contact BCBS customer service for assistance in identifying a mental health professional.

You must contact Magellan Behavioral Health at 800-359-2422 directly for certification in advance for inpatient and outpatient services, except for office visit services and in emergency situations. In the case of an *emergency*, please notify BCBS and/or Magellan as soon as reasonably possible, but in any case within 48 hours. Magellan is staffed by trained professionals 24 hours a day, seven days a week.

When you call Magellan, a customer service representative will ask you to provide background information including a brief description of the concern, the patient's name, the employee's name and the member ID number. Then you'll be connected with a clinical care manager who will assist you (or the family member) in obtaining the right kind of professional assistance with the appropriate type of provider.

Precertification of treatment is required for any admission to an inpatient or outpatient facility, residential treatment center, partial hospitalization program, or an intensive outpatient program or outpatient in-network treatment. In-network facilities must be used. There are no out-of-network benefits for these types of care.

You may choose to go to an out-of-network provider without certification and receive coverage at the lower benefit level. You will also receive coverage at the out-of-network benefit level and will be responsible for the difference between the allowed amount and the provider's full charge if you do not receive certification in advance from Magellan Behavioral Health for in-network inpatient and outpatient services.

In case of emergency

A mental health or substance abuse emergency is a condition in which the patient is a danger to him or herself or others. If an emergency arises and you cannot call Magellan, go immediately to any convenient hospital emergency facility. If you are admitted to the hospital on an emergency basis, you must call Magellan (800-359-2422) within 48 hours of admission to the hospital. If you cannot call, have a family member, friend or the hospital make the call.

After being stabilized, a patient who is admitted to an out-of-network facility in an emergency situation may be asked to transfer to a network facility for continuing treatment.

Confidentiality

All services provided by Magellan and all provider treatments are on a strictly confidential basis. Except as required by law, Magellan will not disclose to anyone that you have inquired about mental health or substance abuse benefits or are seeking or receiving treatment, unless a release is signed. However, in the following circumstances information may be provided without a release:

- If information is disclosed that Magellan considers imminently life threatening to you or others, Magellan will take prudent steps to prevent the threatened danger.
- If instances of juvenile or elder care abuse or neglect are disclosed, state law may require that this information be reported to the appropriate state office.
- Pursuant to a subpoena, court order, regulatory order, or as otherwise required by law.

Claims

In-network providers file directly with BCBSNC. For out-of-network office providers you will have to file claims with BCBSNC at the address on the back of your BCBSNC ID card.

With in-network providers, you must satisfy the deductible and pay the coinsurance portion of the bill for outpatient service. In-network providers may not bill you for the difference between their charges and the negotiated discounted rate.

If you choose to use a non-network provider for outpatient care, you will be required to file your own claims with Magellan and you will have to pay 50% of the allowed amount charge as well as any charges above the allowed amount rate. Reimbursements are mailed to you and not the provider. Claim forms are available from BCBSNC (877-258-3334) or the Employee Service Center (VoiceNet 770-5705 or 800-546-5705) and should be submitted to:

BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

All Mental Health and Substance Abuse claims must be filed with complete information within 12 months of the date of service in order to be considered for reimbursement.

If you have claim questions, you may call BCBSNC Customer Service 877-258-3334 or Magellan at 800-359-2422.

Benefits summary – BCBSNC/Magellan

- In-Network office services are subject to deductible and 20% employee coinsurance. Out-of-Network office services are subject to deductible and 50% of allowed amount with 20 visits/days outpatient limit per year for mental health and substance abuse services.
- Inpatient and alternative levels of mental health and substance abuse treatment must be precertified by Magellan to be covered.
- Magellan must be notified within 48 hours of emergency admissions to both in-network and out-of-network facilities. If Magellan is not notified, benefits will not be provided.
- Outpatient mental health and substance abuse treatment is covered if the provider is either a psychiatrist, psychologist, or master’s level clinician who is licensed to practice independently without supervision. Magellan will certify services with Developmental Behavioral Pediatricians (medical doctors and pediatricians) who have completed a three-year fellowship in developmental behavioral pediatrics to provide outpatient services to members who are 18 and under. A higher level of benefits will apply if the treatment is precertified by Magellan and a network provider is seen.
- Allowed amounts will apply to covered services received from an out-of-network provider or outpatient treatment that is not precertified. Allowed amount is the rate most providers typically charge for that service in that geographic area under similar circumstances. Benefits will not be paid for any amount over the allowed amount limit.
- Methadone maintenance services require precertification.

Services	In-Network ¹	Out-Of-Network ²
Outpatient Mental Health & Substance Abuse Administered by Magellan Behavioral Health	<ul style="list-style-type: none"> • Precertification from Magellan required for outpatient facilities¹ • 20% employee coinsurance after deductible 	<ul style="list-style-type: none"> • 50% of allowed amount employee coinsurance after deductible • 20 visits/days outpatient limit per year for mental health & substance abuse combined
Office Visits Administered by BCBSNC	<ul style="list-style-type: none"> • Unlimited office visits 	<ul style="list-style-type: none"> • 20 visits per benefit period
Inpatient Mental Health & Substance Abuse Administered by Magellan Behavioral Health	<ul style="list-style-type: none"> • Pre-certification required¹ • 20% employee co-insurance after deductible • No lifetime maximum on number of days for mental health • 60 day inpatient facility lifetime maximum for substance abuse 	<ul style="list-style-type: none"> • Not covered
Deductible	Integrated with medical/prescription drugs and applied to the HDHP deductible of \$2,500 self only/ \$5,000 self + 1 or family (in- or out-of-network)	
Out-of-pocket maximum	Integrated with medical/prescription drugs and applied to the HDHP lifetime plan maximum of \$3,000 self only/\$6,000 self + 1 or family (in- or out-of-network)	
Lifetime plan maximum	Integrated with medical/prescription drugs and applied to the lifetime plan maximum of \$2,000,000 per person ³	
Employee Assistance Program (EAP) Administered by ValueOptions	First three visits per calendar year per issue are free; then a \$20 co-pay. These services include counseling for family, child, and work-life issues. Legal and financial assistance is available as well. For more information, contact ValueOptions at 1-800-662-8800.	

¹ If covered services are received from in-network providers but precertification is not obtained from Magellan, the services will be considered out-of-network.

² Covered services received from an out-of-network provider or treatment that is not precertified will be subject to allowed amount limits. Charges in excess of the allowed amounts will be the responsibility of the employee.

³ The lifetime Plan maximum is combined with medical and includes benefits paid for medical and mental health and substance abuse services.

Covered Services

Mental Health and Substance Abuse Services

Office Visit Services

Certification by Magellan Behavioral Health is not required for office visit services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- Medically necessary biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy

The following rules apply to mental health office visit benefit maximums:

- Each service provided by a mental health provider will count as one visit
- Any mental health therapy services provided by a non-mental health provider during the course of an office visit will count as one visit.

Outpatient Services

Covered outpatient treatment services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under office visit services
- Partial day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

In order to take full advantage of your mental health benefits, and at the discretion of Magellan Behavioral Health, you may exchange one inpatient day for two outpatient treatments when medically necessary. Contact Magellan Behavioral Health at 800-359-2422 for more information.

Inpatient Services

Covered inpatient treatment services also include:

- Semiprivate room and board
- Detoxification to treat substance abuse.

Please note benefits for inpatient and outpatient medical care visits are limited to one visit per day.

How To Access Mental Health And Substance Abuse Services

When you need inpatient or outpatient facility mental health or substance abuse treatment, you should call a Magellan Behavioral Health customer service representative at 800-359-2422. The Magellan Behavioral Health customer service representative will refer you to an appropriate in-network provider and will give you the information you need to receive services. Although no certification is required for emergency situations, please notify Magellan Behavioral Health of your inpatient admission as soon as reasonably possible.

In order to receive in-network benefits for non-emergency inpatient and outpatient care:

- You or your provider must receive certification in advance from Magellan Behavioral Health, except for office visit services, and
- You must go to a Blue Options or Magellan network provider.

You should work with your doctor or other professional provider to make sure that certification has been obtained for partial day/night, intensive therapy, or inpatient services. See "Utilization Management." Contact Magellan Behavioral Health at 800-358-2422 for in-network certification.

Out of Network Benefit Level

You may choose to go to an out-of-network provider without certification. You will receive coverage at the out-of-network benefit level and will be responsible for the difference between the allowed amount and the provider's full charge.

Mental Health and Substance Abuse Services Exclusions and Limitations

- Psychoanalysis
- Counseling with relatives about a patient with mental illness, alcoholism, drug addiction or chemical dependency
- Inpatient confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities

Primary and secondary responsibility for claims

Primary and secondary responsibility for claims under the Progress Energy Employee Assistance and Mental Health & Substance Abuse Services Plan follows the same rules as the Progress Energy, Inc.-sponsored medical plan.

When you or a dependent is covered under a Progress Energy, Inc.-sponsored medical plan and another employer-sponsored plan, one plan is considered the primary plan and the other is the secondary plan. The primary plan pays claims first and the secondary plan pays claims after the primary plan has paid.

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

- The plan without a claims coordination provision will be primary and the plan with a claims coordination provision will be secondary.
- When both plans have coordination provisions, the plan covering the patient as an active employee will be primary.
- A plan that covers an active employee or a dependent of an active employee will be primary to a plan that covers the patient 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 patient the longest will be the primary plan.

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. If a plan does not contain the birthday rule, the rule set forth in that plan will determine the order of benefits.

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

Medicare

Active employees

If you are actively employed, the Progress Energy, Inc.-sponsored plan will be primary and Medicare will be secondary:

- For you, if you are covered by both the Progress Energy, Inc.-sponsored plan and Medicare.
- For your dependent, if you have a Medicare-eligible dependent covered under a Progress Energy, Inc.-sponsored plan.

When you or a dependent reaches age 65, your participation in the HDHP will end, and you may enroll in the Standard, Choice or Choice Plus Medical Plan.

Retired employees or surviving dependents

Medicare will be primary and the Progress Energy, Inc.-sponsored plan will be secondary:

- For you, if you are retired or a surviving dependent and are age 65 or over.
- *For you, if you are disabled when you retire and are entitled to Medicare (regardless of your age).
- *For you, if you are eligible for LTD benefits and have received Social Security benefits for 24 months (regardless of your age).
- *For your dependent, if you have a Medicare-eligible dependent covered under a Progress Energy, Inc.-sponsored plan and you are retired or eligible for LTD benefits (regardless of your age).

You should send the Employee Service Center a copy of the Medicare card so your coverage and premium may be changed appropriately.

If you are retired or a surviving dependent when you or a dependent becomes eligible for Medicare, your participation in the HDHP or Choice Plus Plan will end. In addition to electing coverage under a different Progress Energy, Inc.-sponsored medical plan option, you should apply for and purchase Medicare Part B when you or your dependent first becomes eligible for Medicare. The Progress Energy, Inc.-sponsored plan will assume you have purchased Medicare Part B and coordinate benefits accordingly, regardless of whether or not you are actually covered under Part B.

Non-certification determinations

Value Options may not certify care if it determines that such care is not medically necessary for clinical reasons in a particular case. The provider or the patient may appeal a non-certification determination. There are three levels of appeal of non-certification determinations.

Level I appeal

If a ValueOptions peer advisor (Psychiatrist or Ph.D licensed Psychologist) determines that care cannot be certified, you or the participating provider may request a Level I appeal within 180 calendar days of receipt of the notification of non-certification. This level of appeal provides the participating provider an opportunity to review the patient's clinical condition with a peer advisor who was not involved in the non-certification determination. Under usual circumstances, a decision is completed within 15 calendar days of receipt of the appeal request and medical records for a standard Level I appeal.

If a delay in making a decision might seriously jeopardize the life or health of the member, it is essential that the participating provider request an "expedited" Level I appeal immediately. The treating provider must be available to discuss the case. For expedited or urgent appeals, members must be in an inpatient level of care, but have not been already discharged, or the delay would impact the life/health of the member. In these cases, ValueOptions will make the Level I determination no later than three business days (or 72 hours, whichever is shorter) from the date of such request. As part of the appeals process, a member, designated representative, provider, or facility rendering service can submit written comments, documents, records, and other information relating to the case. ValueOptions takes all such submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.

If the non-certification determination is upheld on appeal, Value Options will notify the provider of the patient in writing. The notification will include: (i) specific reasons for denial. (ii) specific reference to pertinent Plan provisions, (iii) a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; (iv) a statement of your right to bring an action under Section 502(a) of ERISA, and (v) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision (or a statement that it will be provided without charge upon request).

Level II appeal

If a Level I appeal upholds the non-certification determination, the participating provider may request a Level II alternative appeal within 90 days of the Level I appeal recommendation. This level of appeal involves referral to an independent outside review organization. (i.e., peer review analysis).

Using nationally recognized standard references for psychiatric and substance abuse treatment, the independent reviewer will determine whether the participating provider's treatment plan and services rendered are medically/psychologically necessary. The reviewer may contact the participating provider and/or ValueOptions by telephone to discuss specific aspects of the patient's signs and symptoms and the proposed treatment.

Level II appeal determinations are made within 15 calendar days of the receipt of the Level II appeal request. Level II appeals are typically standard appeals, not expedited. The independent reviewer will render a decision in writing and the review organization will transmit the results to ValueOptions Regional/Unit Medical Director. ValueOptions will notify the treatment provider and the patient of the results. ValueOptions will certify those services that are found to be medically/psychologically necessary by the independent reviewer.

If the non-certification determination is upheld following a Level II appeal, the notice will include the same information included in the notice following a Level I appeal.

Retrospective appeal

A retrospective appeal is an appeal requested after a member has been discharged from the level of care or services under review have already been rendered. A retrospective appeal must be requested within 30 calendar days of the non-certification notification. A retrospective appeal is completed by ValueOptions within 30 calendar days of the appeal request.

If the non-certification determination is upheld following a retrospective appeal, the notice will include the same information included in the notice following a Level I appeal.

Time limit for appeals

A Level I appeal must be requested within 180 days of the noncertification notification. ValueOptions will complete Level I appeals within 15 calendar days, urgent/expedited Level I appeals within three business day (or 72 hours, whichever is shorter) and retrospective appeals within 30 calendar days. A Level II appeal must be requested within 90 days of the Level I appeal decision. ValueOptions will render Level II appeal decisions within 15 calendar days of the request.

Voluntary Level III Appeal

If ValueOptions upholds a non-certification determination following a Level II appeal, you may submit a voluntary Level III appeal to the Plan Administrator. Your request must be submitted in writing within 180 days of receipt of the appeal decision. The Plan Administrator will complete its review not later than 30 days upon receipt of appeals records.

You may obtain further information regarding your appeal rights by contacting the Progress Energy Employee Service Center at 800-546-5705 or VoiceNet 770-5705.

Hold harmless requirement

The participating provider is contractually responsible to hold the patient harmless for any charges incurred until the entire appeals process is completed. If a patient wishes to continue treatment once the appeals process is completed, the participating provider must obtain the patient's written consent to be financially responsible for any care thereafter. The patient's consent must be signed and dated on or after the date that the appeals process is completed. ValueOptions may request a copy of this consent form.

Denial of claims for administrative reasons

ValueOptions may also deny a claim for administrative reasons if it determines that the Plan does not cover the care in question. There are two levels of appeal of claims that are denied for administrative reasons.

If a claim for benefits under the Plan is partially or wholly denied for administrative reasons, you should receive written notice of the denial within 30 days of the date your claim is received. Under special circumstances, up to 45 days may be taken. In this case, you will be informed of the extension within the original 30-day period describing the special circumstances requiring an extension of time and the date by which a decision is expected to be made. The notice of denial will include the reasons for the denial, a reference to specific Plan provisions on which the denial is based, any information needed to complete the claim, and a description of the claim review process including a statement of your right to bring a civil action under Section 502(a) of ERISA.

Level I Appeal

If the Benefits Administrator (ValueOptions) denies a claim for administrative reasons, you must send a written request to ValueOptions within 180 days of receipt of the initial denial notice. ValueOptions will re-examine the claim and consider any additional information supplied in support of the claim. ValueOptions will complete their review and notify you of their conclusions within 30 days of receiving your request for a review. If more than 30 days are needed, you will be notified prior to the end of the 30 days that additional time is required. The latest you will receive a written review decision is 45 days after the date you submit your review request. If your claim is denied, the notice of denial will include (i) specific reasons for denial, (ii) specific reference to pertinent Plan provisions, (iii) a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claims; (iv) a statement of your right to bring an action under Section 502(a) of ERISA, and (v) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision (or a statement that it will be provided without charge upon request).

Level II Appeal

If your claim is denied again for administrative reasons, you can have it reviewed a second time by the Plan Administrator. You must request a Level II review within 180 days of the time you receive the notice of denial from the Level I 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 or your legal representative has the right to examine all relevant documents and to submit written issues and comments about the claim.

The Plan Administrator will review the claim, including all information submitted with the original claim and review requests. The Plan Administrator will either approve it or confirm the denial and explain which specific plan provision caused the denial. The Plan Administrator has to complete its review and notify you in writing of its conclusions within 30 days of receiving your request for a review. If more than 30 days are needed, you will be notified prior to the end of the 30 days that additional time is required. The latest you will receive a written review decision is 45 days after the date you submit your review request. If a denial of a claim for administrative reasons is upheld following a Level II appeal, the notice will include the same information included in the notice following a Level I appeal.

Appeal of a denied claim

If your claim is denied, you may request that your claim be reviewed. There are two levels of appeal for Pre-Service Claims and three levels of appeal for Post-Service Claims. The Benefits Administrator is responsible for making decisions regarding first and second level appeals and appeals of denied Urgent Care Claims. The Plan Administrator is responsible for making decisions regarding voluntary, third level appeals of denied Post-Service Claims.

To appeal the denial of a claim, you must send a written request for review to the Benefits Administrator (requests for third level appeals must be sent to the Plan Administrator) within 180 days of the date you receive the claim denial notice or you will lose your right to appeal. (You may request an expedited appeal of a denied Urgent Care Claim.) If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your administrative appeal rights, which is generally a prerequisite to bringing suit. In connection with an appeal, you have the right to review pertinent documents and other information relevant to your claim and to submit written comments, documents and other information relevant to your appeal. Copies of all information relevant to your claim will be provided free of charge upon request.

Your claim will be given a full and fair review. The decision on review will not give deference to the initial adverse claim determination and will be conducted by an individual who is not the same individual who made the initial adverse claim determination or a subordinate of such individual. If the claim determination is based in whole or in part on a medical judgment, including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted. This professional will be an individual who is neither an individual who was consulted in connection with the initial claim determination nor a subordinate of any such individual.

You will be notified regarding your appeal according to the procedures listed below. The procedure by which your appeal will be decided varies depending upon the type of claim. If it is determined that a claim is eligible for payment, it will be processed promptly. If the appeal is denied, the notice will include: (i) specific reason(s) for denial; (ii) specific reference(s) to the pertinent Plan provision on which the denial is based; (iii) a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to your claim; (iv) a description of the Plan's voluntary appeal procedures and a statement of your right to bring an action under Section 502(a) of ERISA; and (v) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision (or a statement that it will be provided without charge upon request). In addition, the identity of any medical or vocational expert consulted in connection with your appeal will be provided.

Urgent Care Claims - If you appeal a denial of an Urgent Care Claim and you have not yet received the medical care or treatment that is the subject of the claim, the appeal decision will be made by the Benefits Administrator within 72 hours after receipt of the appeal. There is only one level of appeal for Urgent Care Claims.

Pre-Service Claims - If you appeal a denial of a Pre-Service Claim, the Benefits Administrator will notify you of its decision regarding your first level appeal within 15 days of receipt of your appeal, and within 15 days of receipt of your second level appeal. The Pre-Service Claims appeals process does not apply to a decision that is based on the fact that the requested service is not covered or disputes regarding the dollar amount or number of covered visits that are limited under the plan.

Post-Service Claims - If you appeal a denial of a Post-Service Claim, the Benefits Administrator will notify you of its decision regarding your first level appeal within 30 days of receipt of your appeal, and within 30 days of receipt of your second level appeal.

Second Level Appeal for Post-Service Claims

If your appeal is denied, you may request a voluntary review of your denied claim. To request a second voluntary appeal, you must send a written request for review to the Benefits Administrator (BCBSNC) within 180 days of the date you receive notice that your appeal is denied. Your request should include any additional information you believe may affect the outcome of the review. You will have the right to examine all relevant documents and to submit written issues and comments about your claim. If you do not elect this voluntary level of appeal, the Plan will not assert that you failed to exhaust administrative remedies, and the Plan agrees that any statute of limitations or defense based on timeliness will be tolled from the date the Benefits Administrator receives your request for a voluntary review until the date the decision regarding the review is issued. Your decision to submit your denied claim to a voluntary appeal will not affect your rights to any other benefits under the Plan. Upon request, you will be given information about the voluntary appeals process, your right to have a legal representative involved in the process, the process of selecting the decision-maker and the circumstances, if any, which may impact the impartiality of the decision-maker. You will not be charged for this appeal. If your voluntary appeal is denied, you will receive written notice from the Benefits Administrator within 30 days after the request for review is received. The notice will generally include the same information that was included in your earlier denial notices.

First or second level appeals should be sent to:
 Blue Cross Blue Shield of North Carolina
 Appeals Department
 PO Box 30055
 Durham, NC 27702-3055

Third Level Appeal for Post-Service Claims

If you do not agree with the outcome of the second level appeal, you may notify the Plan Administrator in writing, at the address below, to request a voluntary, final, third level review of your claim. The letter must state why you disagree with how the claim was handled. You must request the review within 30 days of receipt of the denial of your second level appeal. The Plan Administrator will review the claim and determine if it is eligible for a third level review within 15 business days after receipt of your appeal. If your claim is eligible for appeal, as determined in the sole discretion of the Plan Administrator, the Plan Administrator will either approve your claim on appeal or confirm the denial and explain which specific plan provision caused the denial. The Plan Administrator will complete its review and notify you in writing of its conclusions within 30 days of receiving your request for the third level review, unless a 30-day extension is requested.

Like a second level appeal of a benefits dispute, a third level appeal is voluntary under ERISA. It is not necessary to complete a third level appeal before bringing a civil action under Section 502(a) of ERISA. With respect to third-level reviews of benefits disputes,

- the Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to a third level appeal;
- any statute of limitations or other defense based on timeliness will be tolled during the time that any such voluntary appeal is pending;
- you may submit a benefits dispute to a third level appeal only after completing a second level appeal;
- the Plan will provide you, upon request, sufficient information relating to a third level of appeal to enable you to make an informed judgment about whether to request a third level of appeal; and
- no fees or costs will be imposed on you as part of a third level of appeal.

A request for a voluntary third level appeal must be sent to the following address:

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

If the Benefits Administrator or Plan Administrator fails to follow the procedures outlined above consistent with the requirements of ERISA with respect to your claim, you will be deemed to have exhausted all administrative remedies under the Plan and will have the right to bring a civil action under section 502(a) of ERISA.

Benefits under the Plan will be paid only if the Plan Administrator or the Benefits Administrator, as applicable, decides in its discretion that you are entitled to them.

COBRA coverage

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

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 should notify your employer within 60 days 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. The deadline for submitting the change form to the Employee Service Center is 30 days from the date of the qualifying change (except as permitted under the COBRA regulations). The deadline is extended to 60 days when coverage is lost due to a divorce, termination of domestic partner relationship or when dependents no longer meet the dependent eligibility definition. 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 \$300 per month (employee and employer contributions combined), the cost for COBRA coverage would be \$306 per month. During the 11-month extension period for disabled qualified beneficiaries, the cost increases to 150% of the total cost of the coverage beginning with the 19th month of COBRA coverage.

Your first payment covering the notification and election period is due no later than 45 days after the election is made. Subsequent payments are due on a monthly basis. All subsequent payments will have a 31-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 60 days of any final determination that he or she is no longer disabled.

Termination of COBRA coverage

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

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

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

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

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

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

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

Other COBRA Information

Multiple qualifying events

Should your dependents experience more than one qualifying event while COBRA coverage is still active, they may be eligible for an additional period of continued coverage, not to exceed a total of 36 months from the date of the first qualifying event. For example, if you terminate employment, you and your dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the plan (a second qualifying event) your child may be eligible for an additional period of coverage not to exceed a total of 36 months from the date of your termination.

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

Changing your COBRA election

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

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

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

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

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

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

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

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

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

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

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

Provider compensation

The relationship between the Plan’s Benefit Administrator and participating providers is contractual. Compensation for participating providers is based on a variety of payment mechanisms. For example, some providers receive a fee each time they provide covered services to a plan participant and others are paid a global rate for a particular category of service.

For additional information on participating provider compensation, contact the Benefits Administrator.

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 must be treated as QMCSOs. A QMCSO directs the Plan Administrator to cover a child for benefits under the health care plan and also meets the criteria set forth in Section 609(a) of the Employee Retirement Income Security Act (ERISA). Upon receipt of the order, the Plan Administrator will review the order to determine whether or not it is a QMCSO. During this review period the Plan Administrator will hold all claims that may be payable for the children named in the order. The Plan Administrator will notify in writing all persons named in the order of the determination. If the Plan Administrator determines the order is a QMCSO, its terms must be followed to the extent required by law. If you are subject to a QMCSO, 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 Plan 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.

Plan Identification

The official name of the Plan is the Progress Energy Employee Assistance and Mental Health & Substance Abuse Services Plan. The Plan number is 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 27601-1551

Costs and funding

Benefits and operating expenses for the mental health and substance abuse services under the Progress Energy Employee Assistance and Mental Health & Substance Abuse Services Plan are funded through contributions from participating subsidiaries of Progress Energy, Inc. Benefits and operating expenses for employee assistance services under the Plan are paid from the general assets of the participating subsidiaries of Progress Energy, Inc.

Administration

The Plan is a welfare benefit 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 27601-1551

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.

Benefits Administrator

The Benefits Administrator is:

ValueOptions (for all plans except HDHP)
PO Box 12438
5001 S. Miami Blvd.
Suite 200
Research Triangle Park, NC 27709

BCBSNC (for HDHP only)
BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

Appeals
P. O. Box 30055
Durham, NC 27702

Participating subsidiaries

Eligible employees and retirees of the following participating subsidiaries of Progress Energy, Inc. are 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 can 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 27601-1551

Continuation of the Plan and Plan amendments

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

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

Receiving information about your Plan and benefits

As a participant in the Progress Energy Employee Assistance and Mental Health & Substance Abuse Services 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 can 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 or the Employee Service Center. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the employee Benefits Security Administration.

Allowed amount - A health care expense that is covered in whole or in part by the Plan that covers you as an employee or a dependent.

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

COBRA coverage - Benefits purchased by or for a qualified beneficiary because of a qualifying event. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) states that if a qualifying event (such as death or divorce) causes a loss of health care coverage, the persons who lost coverage (the qualified beneficiaries) 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.

Copayment (copay) - Flat amount you pay for covered expenses (such as office visits) at the time you receive services or supplies.

HIPAA - The Health Insurance Portability and Accountability Act (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.

Medically necessary - Services or supplies provided by health care providers that are required for the diagnosis and/or treatment of a particular condition. The services or supplies must be consistent with the symptoms or diagnosis, commonly and usually noted throughout the medical field as proper treatment, and the most fitting supply or service that may safely be given to employees and covered dependents. For inpatient care, symptoms or conditions must be such that outpatient care would not be safe. The fact that a physician has performed or prescribed a procedure does not make it medically necessary.

Patient - A participant, dependent, or qualified beneficiary enrolled in the Plan who is receiving behavioral health care treatment.

Provider - A person or facility that provides health 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 employee - An employee hired for an indefinite period of time to work 40 or more hours per week.

Regular, part-time employee - An employee who is regularly scheduled to work 20-39 hours per week. These employees are paid for actual hours worked.

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.

Temporary, full-time employee – An employee hired for a period normally not to exceed six months and to work 40 or more hours per week.

Usual and customary (U&C) - 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, the Benefits Administrator will decide whether the charge is appropriate based on the complexity involved, the degree of professional skill required, the cost of supplies, and other pertinent factors.

The Benefits Administrator may decline to pay flat rate charges when procedures, fees, or time involved are not itemized. The Benefits Administrator 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 or to the annual out-of-pocket amounts.