

Document title:

# Dental Plan of Progress Energy Florida, Inc.

Document number:

## HRI-PGNF-00004

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

Keywords: human resources information; benefits booklets

Summary Plan Description  
 Progress Energy, Inc.  
 Employer Identification No. 56-2155481  
 Plan No. 526  
 Effective January 1, 2011 (unless otherwise noted)

*This document is a Summary Plan Description (SPD) for the Dental Plan of Progress Energy Florida, Inc., a component plan under the Progress Energy, Inc. Welfare Benefit Plan (the "Plan"), sponsored by Progress Energy, Inc. (Progress Energy or the company).*

An SPD is a summary of the official plan documents that govern the terms, conditions and administrative operations of a benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (ERISA). It does not describe every plan provision in full detail, and it does not alter any plan or any legal instrument related to the plan's creation, operations, funding or benefit payment obligations. Every effort has been made to ensure that this document reflects relevant plan provisions in effect as of January 1, 2011. However, if there are any inconsistencies between this document and the official plan documents (including any insurance contracts), the terms and conditions of the applicable official plan documents (including any insurance contracts) will govern. In no case does this document imply or guarantee any right of future employment.

Regular, full-time bargaining unit employees of Progress Energy Florida, Inc. (Progress Energy Florida) and their eligible dependents are eligible to participate in the Dental Plan of Progress Energy Florida, Inc.

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

**Reference Documents and Forms**

- FRM-PGNF-00008, FlexPower Benefits Change Form
- FRM-SUBS-00877, Group Dental Claim Form
- HRI-SUBS-30004, Guide to Benefits for Domestic Partners

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# Eligibility

The plan covers bargaining unit employees and their dependents who meet the eligibility requirements specified herein. Certain employees who are eligible for the plan are represented by the International Brotherhood of Electrical Workers. Retirees are not eligible to participate in the plan except as COBRA participants for the duration of any COBRA coverage elected.

In addition, leased employees as defined in Section 414(n) of the Internal Revenue Code and independent contractors are not eligible to participate in the plan.

## **Newly Eligible Employees**

Regular, full-time bargaining unit employees are eligible to enroll in one of the Progress Energy-sponsored dental plan options on the first day of employment or reclassification (e.g., from non-bargaining classification to bargaining unit classification) with Progress Energy Florida.

You pay the full cost for dental coverage. Payroll deductions are taken on a before-tax basis. Payroll deductions for newly eligible employees will begin with the paycheck following processing of enrollment.

## **Dependents**

If you are eligible for and you elect dental coverage for yourself, you may also elect to cover your eligible dependents. To be covered, each eligible dependent must be listed by name, Social Security number, relationship and date of birth. Eligible dependents include:

- Your spouse or domestic partner <sup>1</sup>
- Children under age 26 who:
  - Are your biological children; or
  - Have been placed with you for legal adoption, whether or not the adoption has become final; or
  - Are your stepchildren or domestic partner's children; or
  - Are your foster children; or
  - Are your ward under a legal guardianship appointment or for whom you have legal custody under a valid court decree.
- Your unmarried children age 26 or older<sup>2</sup>:
  - Who are incapable of self-support because of mental or physical disability, provided they became disabled before age 26, 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 continuously since age 26.

<sup>1</sup>Your domestic partner is eligible only if you both satisfy the criteria described in the Declaration of Domestic Partner Relationship form and have submitted a Declaration of Domestic Partner Relationship form to the Employee Service Center. The Guide to Benefits for Domestic Partners (HRI-SUBS-30004) and forms are available through ProgressNet or from the Employee Service Center at 800-546-5705 or [employee.service@pgnmail.com](mailto:employee.service@pgnmail.com). Such documents are hereby incorporated by reference and made a part of this SPD. **Your former spouse (by divorce, legal separation or annulment) and former stepchildren may not be covered under this plan unless the two of you remarry (or reconcile, in the case of legal separation); likewise, your former domestic partner and domestic partner's children may not be covered unless you and your former domestic partner re-establish a domestic partner relationship.**

<sup>2</sup>For children who are disabled, you must notify the Employee Service Center within 30 days of the child reaching age 26 and provide the necessary documentation.

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

**Qualified Medical Child Support Order**

A qualified medical child support order (QMCSO) is an order issued by a court or through a state administrative process established under state law. In addition, national medical support notices will be treated as QMCSOs. A QMCSO may direct the Plan Administrator to cover a child for benefits under the dental plan. Upon receipt of the order, the Plan Administrator will review the order to determine whether or not it is a QMCSO. During this review period, the Plan Administrator will instruct the Benefits Administrator to 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 instruct the Benefits Administrator to 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 Benefits Administrator will pay any claims on behalf of the child to the extent required by the revised order.

**Employment of Both You and Your Dependent by Progress Energy**

If both you and your dependent are employed by a participating subsidiary of Progress Energy, each of you may elect to be covered under different Progress Energy-sponsored dental plans. Or, one of you may elect the No Coverage option and be covered as a dependent by the other. You may not be covered both as an employee and as a dependent under the Progress Energy-sponsored dental plans. These same restrictions apply if your dependent is a non-bargaining unit employee of a participating subsidiary of Progress Energy.

Also, if both you and your dependent are employed by a participating subsidiary of Progress Energy only one of you may cover your children, stepchildren or domestic partner children.

**Leaves of Absence**

If you make the required contributions, you may continue dental coverage for yourself and your eligible dependents while you are on a leave of absence as permitted in the Employee Handbook for:

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

# Enrollment and Changes

## **Enrollment for Newly Eligible Employees**

To elect dental plan coverage as a regular, full-time bargaining unit employee, you must enroll yourself and your eligible dependents in the dental plan within 30 days of your employment date or reclassification date. Also, you must enroll through Employee Self Service or on the enrollment form to elect the desired coverage and list each dependent by name, Social Security number, relationship and date of birth before any benefits may be paid. Coverage will be effective on your date of hire or reclassification if your elections are made within 30 days of such date.

You may choose from the following options: BU Dental Plan, CompBenefits (Select 15) or No Coverage. There are pre-existing condition exclusions for you and your covered dependents under the BU Dental Plan. CompBenefits (Select 15), your other dental option, is a dental HMO and you will need to contact them to obtain the pre-existing condition exclusions for you and your dependents.

Important: If you enroll in CompBenefits (Select 15) Plan or add dependents to that plan, you must also complete a separate CompBenefits (Select 15) Plan enrollment form.

## **Levels of Coverage**

If you enroll in the dental plan, three levels of coverage are available:

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

If you do not enroll in the dental plan within 30 days of your employment or reclassification date, your dental election will automatically default to the No Coverage option. You and your dependents will not be covered.

## **Enrolling Dependents**

You must cover yourself under one of the Dental Plan options in order to enroll your eligible dependents. Each dependent must meet the eligible dependent definition (see [Dependents](#) in the Eligibility section). Also, you must elect the plan, the appropriate level of coverage (self, self plus one or family) and list each dependent by name, Social Security number\*, relationship and date of birth through Employee Self Service or on the enrollment form before benefits can be paid. Coverage will be effective on your date of hire or reclassification if you enroll within 30 days of such date.

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

*\*Note: If you do not have the dependent's Social Security number, you should complete the rest of the information and submit your enrollment. You must call the Employee Service Center and add the dependent's Social Security number as soon as you receive it.*

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

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**Changing Your Elections**

After the 30-day newly eligible employee enrollment period has expired, you may not change your dental election until the next annual dental enrollment period unless you experience a qualifying event.

***Annual Benefits Enrollment***

You may change your dental plan each year during annual benefits enrollment. Elections made during annual benefits enrollment are effective January 1 through December 31 of the following year (or through some earlier date if coverage ends as described in the [When Coverage Ends](#) section or if you make an election change as a result of a qualifying event).

***Qualifying Events***

The Internal Revenue Service rules do not permit you to change your FlexPower elections during the plan (calendar) year unless you have a qualifying event. **If you experience a qualifying event**, a completed employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) must be received by the Employee Service Center within 30 days of the event to modify your coverage. Changes due to birth, adoption or placement for adoption (a subset of HIPAA special enrollment right events) may be effective retroactively back to the date of the birth, adoption or placement for adoption, as long as such date is no more than 30 days prior to the date of notification, subject to the provisions of the underlying group dental plan. All other changes may only be effective on a prospective basis and no earlier than the first day of the pay period after the FlexPower Benefits Change Form is received by the Employee Service Center. Otherwise, you will have to wait until the next annual enrollment period to change your elections for the next plan year. All election changes must be consistent with the qualifying event and the following participant group guidelines.

- Regular, full-time, bargaining unit employees or employees on a leave of absence may not make any changes to their dental election until the next annual enrollment period unless they experience a qualifying event. Changes made as a result of a qualifying event must be requested within 30 days of, and be consistent with, the qualifying event.
- COBRA participants may not add dependents to their coverage until the next annual enrollment period unless they experience a qualifying event at any time during the year. However, they may elect to drop coverage or dependents without a qualifying event at any time during the year. Changes made as a result of a qualifying event must be requested within 30 days of, and be consistent with, the qualifying event.

**A dentist leaving the CompBenefits network is not a qualifying event that would permit you to change your dental election during the year.**

Qualifying events include:

- Your marriage or fulfillment of all Progress Energy domestic partner relationship requirements.
- Legal separation, annulment, divorce or termination of domestic partner relationship.
- Birth, adoption or placement for adoption, or change in custody of your child.
- Death of your spouse or domestic partner or child.
- Loss of dependent status (e.g., child reaching age 26).
- You, your spouse, domestic partner or child takes or returns from an unpaid leave of absence.
- Your spouse's, domestic partner's, child's or your dental coverage changes significantly (attributable to your, your spouse's, domestic partner's or child's employment or change in student status or to a significant cost change or coverage curtailment).
- Your spouse's, domestic partner's or child's employer conducts an annual enrollment and your spouse, domestic partner or child changes his or her dental benefit elections.

- You, your spouse, domestic partner or child changes from part-time to full-time employment or from full-time to part-time employment and that change impacts eligibility for dental coverage.
- Your spouse or domestic partner or child becomes employed or unemployed and that change impacts eligibility for dental coverage.

You, your spouse, domestic partner or child changes place of work or permanent residence (and the new location is outside the option's service area).

**In order to cover a new dependent due to a qualifying event**, a completed employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) must be received by the Employee Service Center within 30 days of the event even if you already have family coverage. The new dependent's name, Social Security number\*, relationship and date of birth must be listed on the form. Changes due to birth, adoption or placement for adoption (a subset of HIPAA special enrollment right events) may be effective retroactively back to the date of the birth, adoption or placement for adoption, as long as such date is no more than 30 days prior to the date of notification, subject to the provisions of the underlying group dental plan. All other changes may only be effective on a prospective basis and no earlier than the first day of the pay period after the FlexPower Benefits Change Form is received by the Employee Service Center. If the Employee Service Center does not receive the form within 30 days of the event, the dependent may not be added to your coverage until the next dental enrollment period for the next plan year.

*\*Note: If you do not have the dependent's Social Security number, you should complete the rest of the information and submit your enrollment. You must call the Employee Service Center and add the dependent's Social Security number as soon as you receive it or add through Employee Self Service.*

**When a dependent is no longer eligible for coverage**, you must return a completed employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) to the Employee Service Center within 30 days of the qualifying event to remove the dependent from coverage and reduce your dental premium if applicable. Termination of coverage will be effective on the date your dependent ceases to be eligible for coverage. Premiums will not be refunded retroactively.

If you do not remove the dependent from coverage, you will be covering an ineligible dependent.

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

Refer to the Guide to Benefits for Domestic Partners for details on adding or dropping coverage for your domestic partner.

# Dental Plan

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## Important Dental Plan Information

### **Dental Plan Coverage Options**

You may choose from the following options:

- No Coverage
- BU Dental Plan
- CompBenefits (Select 15) Plan

### **Primary and Secondary Coverage (only applies to BU Dental Plan)**

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

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

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

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

### ***Dependent children***

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

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

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

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

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

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

**AUTHORIZED COPY**  
***Dental Plan***  
***Important Dental Plan Information***

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When the BU Dental Plan is secondary, it gives you credit for savings resulting from coordination. This credit is used to provide payments for allowable expenses that would not have been paid if it were the only plan involved in the claim. This may result in 100% coverage of allowable expenses. The savings must be used in the same calendar year that they are accrued, otherwise they are lost.

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

***Medicare***

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

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

When you or your dependent(s) are eligible for Medicare and this plan is secondary, UMR, the Benefits Administrator, assumes that you have purchased Medicare Part B and use providers who accept Medicare and provides benefits accordingly, whether or not you have purchased it or actually use providers who accept Medicare. It is your responsibility to apply for and purchase Medicare Part B coverage and to use providers who accept Medicare when you or your dependent becomes eligible for Medicare.

## **BU Dental Plan**

Under the BU Dental Plan, dental benefits are paid based on the coverage category (preventive services, basic restorative services, major restorative services and orthodontic services) in which the expense falls. Dental provider charges are covered up to the U&C limits if they are necessary for the care of your teeth as determined by UMR, the Benefits Administrator, and if the services are started and completed while you are covered under the plan.

**Orthodontic services are only available to eligible dependent children.**

There are no restrictions on where you live within the United States to be eligible to enroll in the BU Dental Plan. There is not a preferred network of primary dental care providers and you can obtain dental care nationwide.

### **Enrollment Eligibility**

To participate in the BU Dental Plan, you must meet the Progress Energy-sponsored dental plan eligibility criteria (see the [Eligibility](#) section) and be an active regular, full-time employee or eligible dependent or a COBRA participant.

### **Dental Identification (ID) Card**

You will not receive a dental ID card from UMR. Before dental services are rendered, please inform your dentist that you or your dependent is a dental plan member with UMR. To obtain an ID card, go to FRM-SUBS-00877.

<b>BU Dental Plan Benefit Summary Chart</b>	
<b>Deductible (annual)</b>	\$25 per person \$75 family maximum
<b>Plan maximum (annual)</b>	\$1,000 per person
<b>Preventive</b>	Covered at 100% of U&C up to annual plan maximum  No deductible
<b>Basic restorative</b> <b>Fillings</b> <b>Extractions</b> <b>Oral surgery</b> <b>Root canals</b>	20% employee coinsurance after deductible
<b>Major restorative</b> <b>Crowns</b> <b>Bridges</b> <b>Dentures</b>	20% employee coinsurance after deductible
<b>Orthodontia</b>	50% employee coinsurance after deductible  (Only covered dependent children under age 26 are eligible for orthodontic benefits)  \$1,000 per person lifetime plan maximum
Note: Deductible and coinsurance amounts are what you pay.	

This summary is not a contract and contains only a general description of the plans. All benefits are subject to the terms and conditions of the respective plan documents.

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**How the BU Dental Plan Works**

There is not a preferred network of primary dental care providers so you can obtain dental care nationwide.

***Predetermination of Benefits***

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

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

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

***Alternative methods of treatment***

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

***Restorative/reconstructive***

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

***Prosthodontics***

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

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

**Questions**

If you have questions or need to verify eligibility for coverage, you or your provider may call **UMR** at 800-842-6475 with the patient's name and date of birth, employee's name and Social Security number and Group number (Progress Energy Florida 76 – 140056).

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

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

***Deductible***

The deductible each calendar year is \$25 per person up to a \$75 family maximum. This means that each covered individual pays the first \$25 of covered expenses each year, up to the \$75 family maximum, before the plan will pay benefits for these services. The deductible does not apply to preventive services. The amount you pay for expenses above the U&C limit does not apply toward the deductible.

***Coinsurance and Maximums***

The coinsurance amount is the percentage of U&C charges you pay for eligible expenses, as shown on the BU Dental Plan Benefit Summary Chart. All charges are subject to U&C limits. The maximum amount the plan will pay each year for eligible expenses is \$1,000 per person. You are responsible for amounts over the U&C limit and above the annual or lifetime maximum.

**How to File a Claim**

To file a dental claim under the BU Dental Plan through UMR, see the [Claims and Appeals](#) section.

***Covered Expenses***

Dental expenses covered under the BU Dental Plan are summarized below; however this list may not be all-inclusive. Covered dental expenses are the providers' charges for the services and supplies listed below which meet both of the following tests:

- They are necessary and customarily employed nationwide for the treatment of the dental condition.
- They are appropriate and meet professionally recognized national standards of quality.

If you have questions about the eligibility of a covered dental expense, contact **UMR** for verification. (See the BU Dental Plan Benefit Summary Chart for additional information on benefit levels.)

The procedure codes shown in parentheses are codes used by the American Dental Association.

**Preventive services**

- Application of desensitizing medications, but not more than twice per calendar year;
- Bitewing x-rays as required, but not more than twice per calendar year;
- Cephalometric x-rays, but only in connection with orthodontic diagnosis and only once in any period of 36 consecutive months;
- Complete mouth x-rays, as required, but not more than once in any period of 36 consecutive months (panoramic x-ray will be considered a complete mouth x-ray and subject to same limitation; when both panoramic x-ray and periapical x-rays are taken, payment maximum is panoramic x-ray maximum amount);
- Palliative (emergency) treatment of an acute condition requiring immediate care;
- Periapical (root area) x-rays as required;
- Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;
- Recementation of space maintainers, once per calendar year and at least six months after the initial placement date;
- Routine oral examinations and prophylaxis (including cleaning, scaling and polishing of teeth), but not more than twice per calendar year;
- Space maintainers necessary to prevent future orthodontic care (not made of precious metals) that replace prematurely lost teeth for dependent children under 14 years of age; no payment will be made for duplicate space maintainers;
- Topical application of fluoride in conjunction with prophylaxis, but not more than twice per calendar year.

***Covered Expenses***

**Basic restorative services**

- Adjustments to the maxillary and mandibular dentures, but not more than twice per calendar year and at least six months after the initial insertion of the denture;
- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
- Anesthesia administered and billed separately by an anesthesiologist during a medically necessary hospital confinement for dental treatment;
- Apicoectomy (dental root surgery);
- Endodontics, including pulpotomy (removal of the soft tissue in a decayed tooth), and root canal treatment (no payment will be made for root canal therapy until such services are completed; services are considered to be completed on the date the canals are sealed);
- Free soft tissue graft procedure, including donor site;
- General anesthesia (9220) and intravenous sedation (9240) in conjunction with procedure codes 7230, 7240 and 7241, subject to consultant review;
- General anesthesia services performed in a dentist's office: 1) if such services are performed by or under the direct personal supervision of a dentist qualified to administer general anesthesia, 2) billed by such dentist, and 3) are in connection with the performance of covered services. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation, the purpose of which is to render the patient unconscious; the allowance for the administration of a local infiltration or block anesthetic or nitrous oxide analgesia performed in conjunction with other covered dental procedures is included in the allowance for those covered dental procedures);
- Gingival curettage once per quadrant every 36 months; gingival curettage is not payable when performed on the same date of service as periodontal scaling;
- Gingivectomy and gingivoplasty;
- Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure, payable once per quadrant every 36 months;
- Repair of broken partial or complete dentures;
- Replacement of core build up (2950), only if satisfactory evidence is presented that at least five years have elapsed since the date of service when the procedure was performed;
- Root planing and periodontal scaling (4341), but not more than once per quadrant every 24 months;
- Routine extractions;
- Surgical procedures performed for the preparation of the mouth for dentures;
- Surgical removal of teeth;
- Tissue conditioning treatments for the upper and lower dentures, but not more than twice per calendar year.

**Major restorative services**

- Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays);
- Initial insertion of partial or complete dentures (including any adjustments during the six-month period following insertion);
- Relining and rebasing of immediate dentures only, more than six months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months;
- Repair of broken crowns, inlays, onlays or bridges;
- Replacement of an existing partial or complete denture or bridge by a new denture or by a new bridge, but only if satisfactory evidence is presented that:
  - The existing denture or bridge was inserted at least five years prior to the replacement; and
  - The existing denture or bridge is not serviceable and cannot be made serviceable; if the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services that are necessary to render such appliance serviceable.

***Covered Expenses***

- Replacement of cast post and core (2952) along with prefabricated post and core (2954) procedures, only if satisfactory evidence is presented that at least five years have elapsed since the date of service when the procedure was performed;
- Single unconnected crowns, inlays and onlays that are not part of a bridge or are not splinted together. Payment will be made for crown, inlay and onlay restorations only if the tooth cannot be restored with another material, such as amalgam with pin support; however, if the tooth can be restored with another material, payment for that procedure will be made toward the charge for the restoration selected by the participant and the dentist; the balance of the treatment charge remains the responsibility of the participant).

Note: Temporary crowns, plastic or acrylic (2710) and prefabricated resin crowns (2932) are payable only on children 13 years of age or younger. Permanent crowns or bridges are payable for age 14 or older. You may request a predetermination of benefits for prosthetics and crowns, inlay and onlay restorations totaling more than \$200 in allowable expenses. (See the [Predetermination of benefits](#) for details.)

**Orthodontic services**

Charges of an orthodontist for services and supplies rendered to a covered individual who is a dependent child **under** age 26, in connection with orthodontia treatment, will be included as covered dental expenses. However, these expenses will be subject to the following:

- Benefits payable will be considered 50% of covered orthodontia expenses, after any applicable deductible. The initial payment for covered orthodontia services shall be no more than 25% of the total liability. The remaining 75% will be payable in equal monthly amounts during the period covered by the approved treatment plan and while coverage is in effect.
- The aggregate benefit payable for all orthodontia treatment rendered during an individual’s lifetime will not exceed the orthodontia maximum benefit, regardless of any interruption in coverage. Any benefit payable for orthodontia treatment will not count against the family member's calendar year maximum.
- No benefits will be payable for repair or replacement of any orthodontia appliance.
- If orthodontia treatment is terminated for any reason before completion, only the charges for orthodontia services and supplies actually received before termination may be included as covered dental expenses.

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

UMR will consider 25% of the total cost and will pay 50% of that amount initially. The remaining balance will be divided by the number of months treatment is required and 50% of the monthly amount will be paid each month until the \$1,000 orthodontic maximum has been met, as long as the person's coverage remains in effect. If the treatment plan is completed early, payment of the remaining amount up to \$1,000 will be made upon appropriate notification from the orthodontist. Orthodontic payments will not be made for longer than the duration of the predetermined and approved treatment plan.



***Covered Expenses***

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

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

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

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

***Exclusions and Limitations***

Listed below are plan exclusions and limitations. The list may not be all-inclusive. Contact **UMR** at 800-842-6475 if you have questions as to whether or not a particular expense is covered.

**General exclusions**

- Any additional treatment necessitated by the participant’s failure to follow instructions, or lack of cooperation with the dentist.
- Any services paid or payable under the participant’s medical plan.
- Charges for services or supplies for failure to keep a scheduled visit with the dentist.
- Charges for services or supplies for sterilization (charges for sterilization are included in the allowance for other covered dental procedures).
- Charges for services or supplies when billed by other than a dentist unless listed under covered expenses.
- Covered services above the allowance for the least costly service, procedure, or course of treatment in accordance with the plan when the dentist and participant select a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned.
- Dental services received or rendered:
  - Through or in a veteran’s hospital or government facility due to a service connected disability;
  - That are covered under the Workers’ Compensation Law (accidental bodily injury connected with employment); or
  - That are covered by any other insurance policy providing dental benefits. Total payments will not exceed 100% of the total reasonable expenses actually incurred.
- Implantology, except related services such as implant-supported prosthetics (abutments or retainer crowns placed over the implant) or implant removal.
- Local anesthesia when billed separately by a dentist.
- Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone – lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
- Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain an occlusion. Such procedures include, but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.

***Exclusions and Limitations***

- Services for which the participant incurs no charge.
- Services or supplies that are not medically necessary according to accepted standards of dental practice, as determined after review by the plan’s consulting dentists, or that are not recommended or approved by the attending dentist.
- Services provided by a member of your, your spouse’s or domestic partner’s immediate family (spouse, domestic partner, children or parents) or by a person who resides in your home.
- Services rendered before the effective date of coverage or after termination of coverage.
- Services rendered primarily for cosmetic purposes, except for orthodontic services rendered for correction of defects incurred through traumatic injuries that occurred while this plan is in force.
- Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
- Treatment for any illness, injury, or dental conditions arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units; and suicide, whether sane or insane, attempted suicide or intentionally self-inflicted injury.

**Limitations**

- Alternative allowances will be paid on amalgam restorations when the following codes are submitted for posterior resin restorations: 2380, 2381, 2382, 2385, 2386, and 2387.
- Bitewing x-rays as required will be limited to no more than twice per calendar year.
- Complete mouth and panoramic x-rays will be limited to no more than once in any period of 36 consecutive months.
- Gingival curettage is payable once per quadrant every 36 months but not payable when performed on the same date of service as periodontal scaling.
- Gingivectomy or gingivoplasty will be reimbursed as procedure code (4210) when two or more teeth are billed on the same date of service, same quadrant.
- If the treatment plan for covered orthodontia services is satisfactorily completed in less than the period specified in the approved treatment plan, the plan will, upon notification from the orthodontist, make payment in the amount of the remainder of the liability.
- Periodontal scaling: procedure code (4341) is payable once per quadrant every 24 months.
- Preventive services will be limited to two routine exams and prophylaxis (including cleaning, scaling and polishing of teeth) during a calendar year.
- Restorations made of amalgam, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every 12 consecutive months.
- Sealants are payable on dependent children through age 16 and are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth.
- The amount of liability for orthodontia services shall be payable over a period not to exceed the length of the approved treatment plan.
- The initial payment for covered orthodontia services shall be no more than 25% of the liability.
- The remaining 75% of the liability for covered orthodontia services will be payable in equal monthly amounts during the period covered by the approved treatment plan and while coverage is in effect.
- Topical application of fluoride is limited to not more than twice per calendar year.

**Specific exclusions and limitations**

**(Prosthetics and crowns, inlay and onlay restoration)**

- Alternative allowances will be paid on amalgam restorations when the following codes are submitted for composite/resin inlays/onlays: 2650, 2651, 2652, and 2660.
- Alternative allowances will be paid on gold inlays/onlays when the following codes are submitted for porcelain/ceramic inlays/onlays: 2620, 2630.
- Any denture or bridge replacement made necessary by reason of loss, theft or participant alteration of a denture or bridge.

***Exclusions and Limitations***

- If a cast chrome or acrylic (plastic) partial denture will restore the dental arch satisfactorily and the participant and a dentist choose a more elaborate or precision attachment denture or bridge, payment will be made based on the allowance under this plan for the least costly alternative procedure in accordance with the plan. Any unpaid charges for a more elaborate procedure remain the responsibility of the participant.
- If the participant and dentist decide on personalized prosthetics or crowns, inlay and onlay restorations or specialized techniques opposed to standard procedures, payment will be made for the least costly alternative procedure in accordance with the plan. Any unpaid charges for personalized procedures will remain the responsibility of the participant.
- No payment will be made for any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the participant's coverage under this plan.
- No payment will be made for any duplicate or temporary denture, crown, or bridge.
- No payment will be made for procedure codes 2960, 2961, 2962, for Labial Veneer restorations.
- Payment from the plan for a nonprecious metal denture will be made toward the charge for the precious metal denture selected by the participant and dentist; the balance of the treatment charge remains the responsibility of the participant.
- When procedure code 2740 (porcelain/ceramic substrate crown) is submitted, an alternative allowance for procedure code 2751 (porcelain fused to predominantly base metal) is given for molars and bicuspid.

**Benefits after termination of coverage**

Expenses incurred by an individual after termination of the individual's coverage for dentures, fixed bridgework, or crowns will be considered to be expenses incurred when ordered, but only if the item is finally installed or delivered no later than 30 days after termination of coverage.

"Ordered" means:

- As to a denture, that impressions have been taken from which it will be prepared.
- As to any other item listed above, that the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item, and impressions have been taken from which it will be prepared.

## CompBenefits (Select 15) Plan

CompBenefits (Select 15) Plan is a dental care plan that provides comprehensive dental services through access to a coordinated system of dental care delivery. As a member of CompBenefits, you receive a full range of services. These include preventive care, routine care, and specialty care. There are no claim forms or deductibles. If the covered services are provided by your CompBenefits (Select 15) general dentist, you pay a copay for services.

If you are referred to a CompBenefits (Select 15) specialist (i.e., endodontist, orthodontist, oral surgeon, periodontist, prosthodontist, pediatric dentist), you will receive a 25 percent reduction from usual and customary fees for services performed. Note that general dentists will not see young children; they will need to see a pediatric dentist, who is considered a specialist. Refer to the CompBenefits *Schedule of Benefits and Subscriber Copayments* Booklet for details on covered benefits and copays.

CompBenefits stresses the importance of staying healthy through preventive care, routine visits and dental education. By encouraging early detection and treatment, CompBenefits can provide preventive care before long-term expensive dental restoration is required.

### **Enrollment Eligibility**

To participate in the CompBenefits (Select 15) Plan, you must meet the Progress Energy-sponsored dental plan eligibility criteria (see the [Eligibility](#) section) and be an active regular, full-time employee or eligible dependent or COBRA participant.

Prior to selecting CompBenefits, you should carefully consider the availability of participating providers within your service area. **Note, not all Florida counties have participating providers.**

If you join the CompBenefits (Select 15) dental health maintenance organization (DHMO), you must agree to remain a member for at least one year, unless you experience a qualifying event that allows you to drop coverage. You must complete a separate CompBenefits enrollment form.

### **Dental Identification (ID) Card**

You will receive a dental ID card from CompBenefits.

**AUTHORIZED COPY**  
*Dental Plan*  
**CompBenefits (Select 15) Plan**

<b>Humana/CompBenefits DHMO (Select 15) Plan Benefit Summary Chart</b>	
<b>Deductible (annual)</b>	None
<b>Plan maximum (annual)</b>	Unlimited
<b>Preventive</b>	You pay a \$5 copay for each office visit (includes fluoride treatments to age 16)
<b>Basic restorative</b> <b>Fillings</b> <b>Extractions</b> <b>Oral surgery</b> <b>Root canals</b>	Applicable copay as described in Humana/CompBenefits (Select 15) Schedule of Benefits and Subscriber Copayments if done at a general dentist's office. 25% discount applies if performed by an endodontist or oral surgeon.
<b>Major restorative</b> <b>Crowns</b> <b>Bridges</b> <b>Dentures</b>	Applicable copay as described in Humana/CompBenefits (Select 15) Schedule of Benefits and Subscriber Copayments
<b>Orthodontia</b>	Plan provides 25% discount No lifetime maximum (children and adults)

This summary is not a contract and contains only a general description of the plans. All benefits are subject to the terms and conditions of the respective plan documents.

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**How the CompBenefits (Select 15) Plan Works**

CompBenefits only covers dental care services rendered by its own Preferred Provider Network of dentists. The CompBenefits (Select 15) Plan provides managed care dental services. To keep costs as low as possible, CompBenefits will negotiate the best possible prices with its providers. As a result, CompBenefits will periodically add new providers and terminate their relationship with others.

CompBenefits delivers services through private dentists who see CompBenefits members and practice in their own offices. Each member selects a general dentist to manage his/her care. The general dentist refers members to specialists as specialized care is needed.

***Choosing a general dentist***

When enrolling in CompBenefits (Select 15) Plan, you must choose a general dentist for yourself and each eligible member of your family from the CompBenefits (Select 15) provider network. You may choose a different general dentist for each eligible member of your family. You should contact the general dentist to make sure he or she is accepting new patients and is in the CompBenefits (Select 15) network prior to enrolling.

If you need help selecting or changing a general dentist, call CompBenefits to obtain a provider directory or visit the CompBenefits website [www.compbenefits.com](http://www.compbenefits.com). If your general dentist leaves the CompBenefits (Select 15) network, you will be notified and will need to select a new general dentist. **A dentist leaving the network is not a qualifying event that would permit you to change your dental election during the year.**

Refer to the Humana/CompBenefits enrollment booklet for a listing of participating general dentists and specialists.

**Questions**

Any questions you may have regarding benefits provided by the CompBenefits (Select 15) Plan should be directed to **CompBenefits** customer service at 800-342-5209.

**How to File a Claim**

For information regarding dental claims under the CompBenefits (Select 15) Plan, see the [Claims and Appeals](#) section.

**Covered Expenses and Exclusions**

If you are enrolled in the CompBenefits (Select 15) Plan, you will receive a Certificate of Coverage describing services and exclusions. Such document is hereby incorporated by reference and made a part of this SPD. You should review this material carefully.

# Claims and Appeals

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## Acts of Third Parties

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

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

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

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



## Benefit Claims and Appeals Procedures

The following are two different types of claims that may be made under the dental plan:

- Claims for plan benefits.
- Claims as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the plan or a particular plan option (referred to as an “eligibility or enrollment claim”).

### **Claims for Plan Benefits**

The Benefits Administrators for your dental plan options have been delegated the authority from the Plan Administrator to decide initial claims for plan benefits, as the initial claim administrators, and denied claims for plan benefits on review, as the denied claim reviewers. In connection with deciding initial claims and reviewing denied claims, each Benefits Administrator has the authority to interpret the applicable plan, decide claims-related questions and make factual determinations, each in its sole discretion. Such interpretations, decision and factual determinations shall be controlling. Progress Energy, Progress Energy Florida and the Plan Administrator have no discretionary authority with respect to claims for plan benefits.

Each Benefits Administrator may have specific claim determination procedures that comply with the applicable legal requirements described in this section but that may include additional details or steps that you should be aware of. Such claims submission procedures for your plan benefits are described in the following sections of this SPD for the plan options in which you participate. You also can obtain additional information by calling the Employee Service Center or applicable Benefits Administrator. To file a valid claim for plan benefits, you (or your authorized representative) must follow the claim submission procedures for the applicable plan as described in the following sections of this SPD that are applicable to the plan options in which you participate and any updating materials.

### ***Initial Claim***

Specific instructions about submitting claims are included in the following sections of this SPD. Generally, claims must be submitted in writing. Often, there are time limits that apply to submitting a claim. Make sure you know the time limits of each plan. If you delay submitting your claim, you could lose benefits.

Once your claim has been documented and you have filled out all the necessary forms, your claim generally is processed within the timeframes described below based on the type of claim it is.

### ***Denial of Initial Claim***

If any part of your claim is denied, you will be notified in writing. This notice will contain:

- The specific reason or reasons for the denial.
- Reference to the specific plan provisions on which the denial is based.
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
- A description of the plan’s internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination on appeal.
- If an internal rule, guideline, protocol or other similar criterion was relied on in the denial, either the specific rule, guideline, protocol or other similar criterion (or a statement that such a rule, guideline, protocol or similar criterion was relied upon in the denial) and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request.

**AUTHORIZED COPY**  
***Claims and Appeals***  
***Benefit Claims and Appeals Procedures***

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- If the denial is based on a medical necessity or experimental or investigative treatment, either a clinical or scientific explanation of the denial, applying the terms of the plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request.

***Appeals***

If any part of your claim is denied, you or your authorized representative may appeal the decision made on your claim. Generally, you have 180 days from the time you're notified of the denial of your claim to appeal.

Your appeal must be in writing. You should describe the decision you are appealing and state the reasons why you think the decision made on your claim was incorrect. You or your authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information related to your claim, and will be able to submit written comments, documents and other information relevant to your appeal.

Appeals should be directed to the Benefits Administrator with which you filed your initial claim. If you do not file an appeal within the time permitted, your claim will be deemed abandoned and you may not reassert it under these procedures or in a court or any other venue. If you fail to raise issues or present evidence on appeal, you may not be able to raise those issues or present that evidence in any later proceeding or judicial review of your claim.

Your claim will be given a full and fair review. Someone other than an individual involved in the initial claim, or a subordinate of such individual, will make the determination on appeal. The decision on review will not give deference to the initial adverse claim determination. 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.

A decision on your appeal will ordinarily be made within the timeframes described below based on the type of claim.

***Denial of Appeals***

You will be notified regarding the decision on your appeal in writing. If your appeal is denied, the denial notice will contain:

- The specific reasons for the denial of your appeal.
- Reference to the specific plan provisions on which the denial of your appeal is based.
- A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim.
- A statement regarding your right to sue under Section 502(a) of ERISA following any final internal adverse benefit determination and about any available voluntary alternative dispute resolution options.
- If an internal rule, guideline, protocol or other similar criterion was relied on in the denial, either the specific rule, guideline, protocol or other similar criterion (or a statement that such a rule, guideline, protocol or similar criterion was relied upon in the denial) and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request.
- If the denial is based on a medical necessity or experimental or investigative treatment, either a clinical or scientific explanation of the denial, applying the terms of the plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request.
- The statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

***Claims and Appeal Time Limits for Disability Determinations***

Special timeframes apply to claims and appeals involving disability determinations.

***Notification of Initial Determination***

Disability benefit claim determinations will be made within 45 days of receipt by the applicable Benefits Administrator of all information necessary for determination of your claim. If extra time is needed to process your claim, you will be notified that up to an additional 60 days is required. If the extension is necessary due to your failure to submit enough information, the notice will also specify what information is needed. The determination period will be suspended on the date the Benefits Administrator sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have 45 days to respond to the request for information.

***Appeal of Determination***

If you receive an adverse benefit determination, you have 180 days from the time you're notified of the denial of your claim to appeal the decision in accordance with the ***Appeals*** section above. Your appeal must be in writing. A decision on your appeal will ordinarily be made within 45 days (or within 90 days if special circumstances require an extension).

***Dental Plan Claims and Review Time Limits***

Different timeframes apply to claims and appeals under the Progress Energy dental plans, depending on the type of claim made under the plan.

***Notification of Initial Determination***

After you make your claim for benefits in accordance with plan procedures, the following time limits apply:

**Urgent Care Claims**

An urgent care claim is one in which the plan determines that the application of non-urgent care time frames could seriously jeopardize the life or health of the claimant, the ability of the claimant to regain maximum function, or in the judgment of a physician would subject the claimant to severe pain that cannot be adequately managed otherwise.

If your claim involves urgent care, you will be notified of the benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Benefits Administrator.

If the Benefits Administrator is not provided sufficient information to make a decision, you will be notified within 24 hours after receipt of the claim. You will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the needed information. You will be notified of the decision on your claim as soon as possible, but generally not later than 48 hours after receipt of the information by the Benefits Administrator.

**Pre-Service Claims**

A pre-service claim is one in which the plan conditions the receipt of benefits, in whole or part, on approval of the benefit in advance of obtaining medical care.

If you have a pre-service claim, you will be notified of the benefit determination no later than 15 days after receipt of the claim by the Benefits Administrator.

The Benefits Administrator may extend this period for up to 15 days, if necessary. If extra time is needed to process your claim, you will be notified. If the extension is necessary due to your failure to submit enough information, the notice will also specify what information is needed. The determination period will be suspended on the date the Benefits Administrator sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have 45 days to respond to the request for information.

Post-Service Claims

A post-service claim is any claim for a benefit under a health benefit plan that is not an urgent care claim or a pre-service claim.

If you have a post-service claim, you will be notified of the benefit determination within 30 days after receipt of the claim by the Benefits Administrator.

The Benefits Administrator may extend this period for up to 15 days, if necessary. If extra time is needed to process your claim, you will be notified. If the extension is necessary due to your failure to submit enough information, the notice will also specify what information is needed. The determination period will be suspended on the date the Benefits Administrator sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have 45 days to respond to the request for information.

Concurrent Care Decisions

If the Benefits Administrator has previously approved an ongoing course of treatment to be provided over a period of time or number of treatments, you will be notified of any reduction or termination of the course of treatment in sufficient time before the end of the approved course of treatment to allow you to appeal the benefit determination.

If you request an extension of the course of treatment beyond the approved period of time or number of treatments and the claim involves urgent care, a determination will be made as soon as possible, and you will be notified of the benefit determination within 24 hours (provided you make the request at least 24 hours prior to the end of the course of treatment).

*Appeal of Determination*

If you receive an adverse benefit determination, you have 180 days to appeal the decision in accordance with the ***Appeals*** section above. Generally, your appeal must be in writing. However, for some plans, you may be able to register your appeal by telephone.

In addition, you may be able to appeal the denial of any part of your initial appeal through a second level appeal process. These two levels of appeal may be mandatory for pre-service and post-service claims. However, urgent care claims are only subject to one mandatory level of appeal.

Urgent Care Claims

If your claim involves urgent care, you can request an expedited appeal of an adverse benefit determination orally or in writing. You will be provided all necessary information by telephone, facsimile, or other available expeditious method.

You will be notified of the benefit determination on appeal not later than 72 hours after receipt of the appeal by the Benefits Administrator.

Pre-Service Claims

If you have a pre-service claim, you will be notified of the benefit determination on appeal within 30 days if the plan provides for only one appeal of an adverse benefit determination or within 15 days for each appeal if the plan provides for two mandatory appeals of an adverse determination.

Post-Service Claims

If you have a post-service claim, you will be notified of the benefit determination on appeal within 60 days if the plan provides for only one appeal of an adverse benefit determination or within 30 days for each appeal if the plan provides for two mandatory appeals of an adverse determination.

**Concurrent Care Claims**

If you have a concurrent care claim, you will be notified of the benefit determination on appeal within 30 days if the plan provides for only one appeal of an adverse benefit determination or within 15 days for each appeal if the plan provides for two mandatory appeals of an adverse determination.

**Eligibility and Enrollment Claims**

The Plan Administrator has the authority to decide initial eligibility or enrollment claims, as the initial claim administrators, and denied eligibility or enrollment claims on review, as the denied claim reviewers. In connection with deciding initial claims and reviewing denied claims, the Plan Administrator has the authority to interpret the applicable plan, decide claims-related questions and make factual determinations, each in its sole discretion. Such interpretations, decision and factual determinations shall be controlling. Progress Energy and Progress Energy Florida have no discretionary authority with respect to eligibility or enrollment claims.

To file a valid eligibility or enrollment claim, you (or your authorized representative) must follow the claim submission procedures as described in this SPD and any updating materials. Such a claim must be received by the Plan Administrator within 90 days after the end of the plan year in which you are claiming eligibility/enrollment should have occurred.

***Notification of Initial Determination***

Eligibility and enrollment claim determinations will be made within 30 days of receipt by the Plan Administrator of all information necessary for determination of your claim. If extra time is needed to process your claim, you will be notified that up to an additional 15 days is required. If the extension is necessary due to your failure to submit enough information, the notice will also specify what information is needed. The determination period will be suspended on the date the Plan Administrator sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have 45 days to respond to the request for information.

***Appeal of Determination***

If you receive an adverse claim determination, you have 180 days from the time you are notified of the denial of your claim to appeal the decision in accordance with the ***Appeals*** section above. Your appeal must be in writing and must be submitted to the Plan Administrator. A decision on your appeal will ordinarily be made within 60 days (or within 120 days if special circumstances require an extension).

**Timeline and Notification Requirements**

<b>Time Limits</b>	<b>Urgent Care Claims</b>	<b>Pre-Service Care Claims</b>	<b>Post-Service Claims</b>	<b>Disability Claims</b>	<b>Eligibility and Enrollment Claims</b>
<i>To make initial claim determination</i>	72 hours	15 days	30 days	45 days	30 days
<i>Extension (if proper notice is given and delay is beyond the plan's control)</i>	None	15 days	15 days	30 days (plus up to an additional 30 days)	15 days
<i>To request missing information from claimant</i>	24 hours	15 days	30 days	45 days	30 days
<i>For claimant to provide missing information</i>	48 hours	45 days	45 days	45 days	45 days
<i>For claimant to request appeal</i>	180 days	180 days	180 days	180 days	180 days
<i>To make determination on appeal</i>	72 hours	30 days (or 15 days, if plan provides two mandatory levels of appeal)	60 days (or 30 days, if plan provides two mandatory levels of appeal)	45 days (plus up to an additional 45 days)	60 days (plus up to an additional 60 days)

**Legal Action**

You have the right to bring a civil action under Section 502(a) of ERISA against a plan if you are not satisfied with the outcome of the internal claims and appeal procedure. Unless you have exhausted your internal administrative review rights under the plan, you generally are prohibited from bringing a civil action against the plan, the Benefits Administrator, the Plan Administrator, Progress Energy or Progress Energy Florida. If the plan provides for binding arbitration of any controversy between a plan participant or beneficiary and the plan, including, as applicable, its agents, employees, providers, and staff physicians, then any such controversy is subject to binding arbitration.

No civil action may be brought after the deadline imposed by the applicable plan, or more than one year after the date on which your claim is denied on final internal appeal if there is no other plan-specific deadline.

## BU Dental Plan - Claims Filing

### ***Filing a dental claim***

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

You must send the initial claim within...	To...
24 months of the date the expense was incurred.	UMR - Dental Claim Services PO Box 30541 Salt Lake City, UT 84130-0541

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

The plan and UMR reserve the right to require verification of any fact or assertion concerning any claim for covered dental expenses to ensure that benefits are paid appropriately. Submission of x-rays and other appropriate diagnostic materials may be requested. Failure to provide the requested information could result in the denial of the claims involved.

### ***Filing claims under more than one plan***

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

### **Claim questions**

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

## BU Dental Plan – Appeals Process

### *Appeal of a denied claim*

If a claim for benefits under the plan is partially or wholly denied, you will receive written notice of the denial within the timeframes outlined under the **Benefit Claims and Appeals Procedures** section above, and such notification will include the information described under that same section.

UMR Appeal Review	Step	Steps to follow in the UMR Appeal Process		
<b>First Level</b>	<b>1</b>	<p>To appeal the denial of a dental claim, you must send a written request to the Benefits Administrator.</p> <p>Any request for review should include:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;"> <ul style="list-style-type: none"> <li>▪ Employee's ID number</li> <li>▪ Employee's name</li> <li>▪ Any other information that may be helpful for the review</li> </ul> </td> <td style="width: 50%; padding: 2px;"> <ul style="list-style-type: none"> <li>▪ Patient's name</li> <li>▪ Nature of the appeal</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>▪ Employee's ID number</li> <li>▪ Employee's name</li> <li>▪ Any other information that may be helpful for the review</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient's name</li> <li>▪ Nature of the appeal</li> </ul>
<ul style="list-style-type: none"> <li>▪ Employee's ID number</li> <li>▪ Employee's name</li> <li>▪ Any other information that may be helpful for the review</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient's name</li> <li>▪ Nature of the appeal</li> </ul>			
	<b>2</b>	<p>Submit your written appeal within 180 days of the date of the initial denial notice to:</p> <p>UMR            PO Box 30541            Salt Lake City, UT 84130-0541</p>		
	<b>3</b>	<p>You will be notified in clear written terms of the decision within a reasonable time but no later than the timeframes outlined under the <b>Benefit Claims and Appeals Procedures</b> section above, and such notification will include the information described under that same section.</p>		
<p><i>If you are dissatisfied with the first level appeal review, you have the right to a voluntary second level appeal review. The plan waives any right to assert that you failed to exhaust administrative remedies if you do not elect this second, voluntary level of appeal, and the plan agrees that any statute of limitations or defense based on timeliness will be waived during the time that any voluntary appeal is pending.</i></p>				
<b>Second Level</b>	<b>1</b>	<p>Submit your written request for a voluntary, final, second level appeal review to the Plan Administrator within 180 days of receipt of the denial of your first level appeal to the address below. The letter should include any additional information you believe may affect the outcome of the review.</p> <p>Progress Energy Service Company, LLC            PO Box 1551, PEB 16ESC            Raleigh, NC 27602-1551</p> <p>You and your legal representative will have the right to examine all relevant documents and to submit written issues and comments about your claim.</p>		
	<b>2</b>	<p>The claim will be reviewed, including all information submitted with the original claim and review requests. A final decision will be made as soon as possible but not later than 30 days after the second review request is received, unless a 30-day extension is requested.</p>		



**AUTHORIZED COPY**  
***Claims and Appeals***  
***BU Dental Plan – Appeals Process***

UMR Appeal Review	Step	Steps to follow in the UMR Appeal Process
		<p>You will receive a written notice of the results of this review. The notice will include the reasons for the decision, will refer to the plan provisions on which the decision is based and will include the additional information included in your first notice of denial upon review described above.</p>
<p>The second level appeal of a benefits dispute is voluntary under ERISA. It is not necessary to complete a second level appeal before bringing a civil action under Section 502(a) of ERISA. With respect to second-level reviews of benefits disputes:</p> <ul style="list-style-type: none"> <li>▪ 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 second level appeal;</li> <li>▪ Any statute of limitations or other defense based on timeliness will be tolled during the time that any such voluntary appeal is pending;</li> <li>▪ You may submit a benefits dispute to a second level appeal only after completing a first level appeal;</li> <li>▪ The plan will provide you, upon request, sufficient information relating to a second level of appeal to enable you to make an informed judgment about whether to request a second level of appeal; and</li> <li>▪ No fees or costs will be imposed on you as part of a second level of appeal.</li> </ul> <p>If the Insurer 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.</p> <p>Benefits under the plan will be paid only if the Insurer decides in its discretion that you are entitled to them.</p>		

# CompBenefits (Select 15) – Claims Filing and Appeals Process

Under the CompBenefits (Select 15), there are no claims to file. If covered services are provided by your CompBenefits (Select 15) general dentist, you pay a copay for services. If you are referred to a CompBenefits specialist, you will receive a 25% reduction from usual and customary fees for services performed.

CompBenefits, the Benefits Administrator, is responsible for appeals. To appeal, see the plan’s Certificate of Coverage, which is hereby incorporated by reference and made a part of this SPD.

## When Coverage Ends

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

### **When Eligibility Ends**

Eligibility for dental coverage under the plan will end if one of the following events occurs:

- Your employment status changes (including retirement) and you no longer meet the employee eligibility criteria.
- You transfer to a non-participating subsidiary.
- Your employment status changes from a Progress Energy Florida, Inc. bargaining unit employee to a non-bargaining employee of one of the Progress Energy, Inc., participating subsidiaries. (*Certain Progress Energy non-bargaining employees are eligible for benefits under the Choice Benefits program.*)
- You are an employee of 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.)
- Your death.

### **When Eligibility Ends for Dependents**

Coverage for your dependents will continue as long as your coverage does unless your dependents no longer meet the eligible dependent definition. When a dependent is no longer eligible for coverage, you should complete an employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) to drop the dependent from your coverage within 30 days of the loss of eligibility. Coverage will end on the date your dependent loses eligibility. Eligibility for dependent children ends at 11:59 p.m. on the day before their 26<sup>th</sup> birthday.

**Employees who cover ineligible dependents are in violation of the company's Code of Ethics and may be required to pay damages and costs to the company, including reimbursement of any benefit payments made with respect to an ineligible dependent. In addition, if a dependent becomes ineligible, you must notify the Employee Service Center within 60 days in order for the dependent to be eligible for COBRA coverage.**

### **When Coverage Ends**

#### ***Terminated employees***

Dental coverage will end if you terminate employment (including retirement). Coverage will terminate on the last day of the base pay period in which your employment terminates. Terminated employees and their dependents are not eligible to continue dental coverage unless they qualify for and elect COBRA coverage as described in the [COBRA Coverage](#) section.

#### ***Surviving dependents***

If you die as a regular, full-time bargaining unit employee, your eligible dependents may continue to be eligible to receive coverage under the dental plan if they are eligible to continue coverage under COBRA and elect to do so as described below.

## COBRA Coverage

If coverage under the dental plan terminates because of a qualifying event, you and your covered dependents may elect to continue participation in the plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Domestic partners and their eligible dependents are eligible for COBRA like continuation coverage under the same terms as those provided to employees and their eligible dependents. An individual who is eligible to continue coverage under the provisions of COBRA is known as a “qualified beneficiary.”

### **Eligibility for COBRA**

You become eligible for COBRA coverage if you would otherwise lose coverage due to a qualifying event. 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:***

- Retirement or 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.
- Retirement or 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.
- Retirement or 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 reaching age 26).

### **Plans Covered under COBRA**

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

### **Responsibility of Employer to Provide Notice**

If dental coverage is lost because of retirement, 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 you experience a qualifying event due to a divorce, termination of domestic partner relationship, legal separation or a dependent no longer meets the dependent definition, a FlexPower Benefits Change Form (FRM-PGNF-00008) has to be completed by you, your spouse or your domestic partner and received within 30 days by the Employee Service Center to drop the dependent from your Progress Energy-sponsored coverage (see [Changing Your Elections](#) under the Enrollment and Changes section). The Employee Service Center may be contacted at 800-546-5705 to request forms and assistance. If you do not notify your employer within 60 days from the date of the qualifying event, then your dependent will not be offered COBRA. After being notified within 60 days that a qualified 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.

***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.

**Cost of COBRA Coverage**

The cost of continuing coverage under COBRA is 102% of the plan's full cost rate (100% of the full cost of the coverage plus a 2% administrative fee). For example, if the total cost of employee dental coverage is \$50 per month for employee and employer contributions combined, the cost for COBRA coverage would be \$51 per month for dental. During the 11-month extension period for disabled qualified beneficiaries (described below), the cost increases to 150% of the total cost of the coverage beginning with the 19th month of COBRA coverage.

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

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

***Partial Payments***

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

**Maximum Period of Coverage**

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

- Your death.
- 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:

- Retirement or 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 event, or at any time during the first 60 days of continued coverage, the 18-month coverage period may be extended by an additional 11 months for a total of up to 29 months of COBRA coverage from the date of the first qualifying event. This extension is designed to permit the individual to continue coverage until becoming entitled to Medicare.

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

**Termination of COBRA Coverage**

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

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

*\*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 entitlement. Your covered dependents, however, may be eligible for 36 months of continued coverage from the date of the original qualifying event.*

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

- If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition does not apply to you by reason of HIPAA's restrictions on pre-existing 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 plan. Conversion to an individual policy is not available under the Dental Plan of Progress Energy Florida, Inc.

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.

### **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 your employer within 60 days of the second qualifying event by calling the Employee Service Center.

#### ***Changing Your COBRA Election***

While you are continuing coverage under COBRA, you and your covered dependents may change your dental 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 full cost 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 dental coverage.
- Add an eligible dependent who loses other dental coverage.
- Add a dependent to your dental coverage if required by a Qualified Medical Child Support Order or other family relations judgment.
- Change your dental 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, or
- 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.
- 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 if you are determined to be ineligible.



## Other Important Information

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<b>Plan Administration</b>	<b>Pgs 43-44</b>
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## Plan Information

### **Provider Compensation**

The relationship between the plan's Benefits Administrators 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; others are paid a global rate for a particular category of service; and others are paid a set dollar amount each month for each plan participant on their member panel whether or not the participants receive services.

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

### **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 Progress Energy 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 Progress Energy on behalf of the plan. Progress Energy 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 800-546-5705 or email [privacy.official@pgnmail.com](mailto:privacy.official@pgnmail.com).

## Plan Administration

### **Plan Identification**

The Dental Plan of Progress Energy Florida, Inc. is a separate component plan under the Progress Energy, Inc. Welfare Benefit Plan (the “Plan”).

The three-digit Plan number is 526.

The employer identification number (EIN) issued by the Internal Revenue Service for Progress Energy, Inc. (the Plan’s sponsor) is 56-2155481.

The Plan Sponsor’s address is:

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

### **Costs and Funding**

Benefits under the dental plan are funded through contributions from participating employees.

BU Dental Plan is self-insured and CompBenefits (Select 15 DHMO) is fully-insured.

Self-insured plans are plans under which the Plan Sponsor pays plan benefits (i.e., plan benefits are not paid by an insurer under an insurance policy); the Plan Sponsor contracts with third party claims administrators that decide claims for benefits and appeals of denied claims for benefits, but the Plan Sponsor (not the claims administrator) is ultimately financially responsible for all valid and covered benefit payments under self-insured plans

Fully-insured plans have an insurance policy in place to pay plan benefits (i.e., plan benefits are not paid by the Plan Sponsor); the insurer decides claims for benefits and appeals of denied claims for benefits, and the insurer (not the Plan Sponsor) is ultimately financially responsible for all valid and covered benefit payments under its applicable fully-insured plan(s)

### **Administration**

The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan year ends on December 31 of each year and the Plan operates and maintains records on a calendar year basis.

### **Plan Administrator**

A Plan Administrator has been appointed, as required by law, to be responsible for the operation of the Plan. The Plan Administrator has overall responsibility for the operation of the Plan and controls the administration of the Plan. The Plan Administrator has the discretionary authority 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. The Plan Administrator has delegated to the Benefits Administrators the exclusive authority in their sole discretion to determine claims for benefits under the Plan and to review denied claims for benefits on appeal, including the authority to interpret applicable provisions of the Plan and to make factual determinations.

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

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

The Plan Administrator is:

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

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

**Dental Plan Benefits Administrators**

The Plan Administrator has delegated authority to decide dental claims and appeals to the following respective Benefits Administrators:

BU Dental Plan  
UMR  
P. O. Box 30541  
Salt Lake City, UT 84130-0541  
Telephone Number: 800-842-6475  
[www.fhs.umar.com](http://www.fhs.umar.com)

CompBenefits (Select 15 DHMO) (Insurance Company)  
CompBenefits (Select 15 DHMO)  
P.O. Box 769649  
Roswell, GA 30076  
Telephone Number: 800-342-5209  
[www.compbenefits.com](http://www.compbenefits.com)

**Agent for Service of Legal Process**

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

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

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

**Continuation of 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.

## Your Rights Under ERISA

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, Inc. Welfare Benefit Plan (the "Plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

### **Enforcing Your Rights**

Under ERISA, there are steps that you may take to enforce the above rights. For instance, if you request certain 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court once you have exhausted the internal administrative claims and appeals process under the plan. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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).

**AUTHORIZED COPY**  
***Other Important Information***  
***Your Rights Under ERISA***

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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.

# Contact Information

The Employee Service Center provides administrative services for plan participants and representatives can be reached by calling 800-546-5705 or by email at [employee.service@pgnmail.com](mailto:employee.service@pgnmail.com).

## Benefits Administrators

Benefits Administrators		
<b>Dental</b>	UMR 800-842-6475  PO Box 30541 Salt Lake City, UT 84130-0541 <a href="https://fhs.umar.com">https://fhs.umar.com</a>	Humana/CompBenefits (Select 15 DHMO) 800-342-5209  PO Box 769649 Roswell, GA 30076 <a href="http://www.compbenefits.com">www.compbenefits.com</a>