Dental Plan of Progress Energy Florida, Inc.

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

This booklet is a Summary Plan Description (SPD) for the Dental Plan of Progress Energy Florida, Inc. (the "Plan") and provides information about the benefits available under the BU Dental Plan (Comprehensive Dental Plan) and the CompBenefits (Select 15) Plan.

The Plan is sponsored by Progress Energy, Inc. and is available only to eligible bargaining unit employees of Progress Energy Florida, Inc. and their eligible dependents.

The Plan Sponsor reserves the right to amend or terminate the Plan or any plan benefit at any time based on the cost of the benefits or other considerations without prior approval of or notification to any party. In no case does this document imply or guarantee any right of future employment.

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

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

**New employees**

Regular, full-time bargaining unit employees of Progress Energy Florida Inc. are eligible to enroll in the Plan on the first day of employment or reclassification to regular, full-time employment.

You pay the full cost for dental coverage. Payroll deductions are taken on a before-tax basis. Payroll deductions for new employees will begin with the paycheck following processing of the online web enrollment or the completed employer-provided enrollment form.

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.

**Dependents**

If you are eligible for and you elect dental coverage on yourself, you may also elect to cover your eligible dependents. To be covered, each eligible dependent must be listed by name, Social Security number, and date of birth through the online web enrollment or on the employer-provided enrollment form. Eligible dependents include:

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

- They either live with you or live in a long-term care facility and are mainly dependent upon you or your spouse for support and care, and
- For whom you can give proof of their incapacity, residency, and dependency.

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

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

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

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

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

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

Employment of both spouses or domestic partners with Progress Energy

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

- Each of you may elect to be covered under a different dental plan, or one of you may elect the No Coverage option and be covered as a dependent by the other spouse or domestic partner.
- Only one of you may cover your dependent children.

Note: If both you and your spouse or domestic partner have children who are eligible dependents who were born or adopted before your current marriage or domestic partner relationship, you may each choose to cover specific children as designated on the employer-provided enrollment form or through the online web enrollment.

Leaves of absence

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

- Newborn care
- Adoption/foster care
- Military service
- Any other absence that qualifies under the Family and Medical Leave Act
Coverage options
You may choose from the following options:
- No Coverage
- BU Dental Plan (Comprehensive Dental Plan)
- CompBenefits (Select 15) Plan

If you enroll in one of the dental plans, three levels of coverage are available:
- Self (employee only)
- Self + 1 (employee plus one eligible dependent)
- Family (employee plus two or more eligible dependents)

Each dependent must meet the eligible dependent definition and be listed by name, Social Security number, and date of birth through the online web enrollment or on the employer-provided enrollment form to be covered under one of the dental plans.

New employee enrollment
You must enroll yourself and your eligible dependents within 30 days of your employment or reclassification date, as described above.

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

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

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

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

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

Changing your election
After the 30-day new employee enrollment period has expired, you may not change your dental election until the next annual dental enrollment period unless you have a qualifying change in your family or employment status. Employees and new hires are required to maintain the same dental option for the Plan year.

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 have a qualifying change in family or employment status.
Annual benefits enrollment
You may change your dental election each year during annual benefits enrollment. Elections made during annual benefits enrollment are effective January 1 through December 31 of the following year. There are no pre-existing condition exclusions for you or your dependents.

Qualifying events
The Internal Revenue Service rules do not permit you to change your FlexPower elections during the plan (calendar) year unless you have a qualifying event that affects eligibility for coverage. If you do experience a qualifying event, you must notify the Employee Service Center within 30 days of the event in order to modify your coverage. Otherwise, you will have to wait until the next annual enrollment period. However, if the qualifying event is due to loss of dependent status (e.g., divorce, termination of domestic partner relationship or a child who is no longer a full-time student or who exceeds the maximum age), the termination of coverage will be effective on the date of the qualifying event.

Some qualifying changes in family or employment status are:
- Your marriage, or fulfillment of all Progress Energy domestic partner relationship requirements;
- Legal separation, annulment, divorce or termination of domestic partner relationship;
- Birth, adoption or placement for adoption, or change in custody of your child;
- Death of your spouse or domestic partner or other dependent;
- Your child loses or regains dependent status (including a dependent child who is no longer a full-time student, or who returns to school or college as a full-time student);
- You, your spouse or domestic partner or dependent takes or returns from an unpaid leave of absence;
- Your spouse’s or domestic partner’s or your health coverage changes significantly (attributable to your spouse’s or domestic partner’s employment);
- Your spouse's or domestic partner’s employer conducts an annual enrollment and your spouse or domestic partner changes his or her benefit elections;
- You, your spouse or domestic partner or dependent changes from part-time to full-time employment or from full-time to part-time employment;
- Your spouse or domestic partner or dependent becomes employed or unemployed; or
- You, your spouse or domestic partner or dependent changes place of work or permanent residence (and the new location is outside of the Plan’s service area).

You must submit an employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) to the Employee Service Center within 30 days of the event if you have a qualifying change in your family or employment status and want to change your dental election. The new election will be effective on the date of the qualifying change. All election changes must be made within 30 days of the event and be consistent with the qualifying event and the following participant group guidelines.

Notes:
1. To cover a new dependent, you must complete an employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) even if you already have family coverage. The new dependent's name, Social Security number*, and date of birth should be listed on the form. If the Employee Service Center does not receive the form within 30 days of the event, the dependent may not be added to your coverage until the next dental enrollment period.
   * If you do not have the dependent's Social Security number, you should complete the rest of the information and submit the form. You may call the Employee Service Center at a later date and add the dependent's Social Security number.

2. When a dependent is no longer eligible for coverage, you must complete an employer-provided FlexPower Benefits Change Form (FRM-PGNF-00008) to drop coverage for the dependent and reduce your dental premium (if applicable).

3. Refer to the Guide to Benefits for Domestic Partners for details on adding or dropping coverage for your domestic partner.
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 Claims Administrator of the BU Dental Plan (Comprehensive Dental Plan), is responsible for determining the U&C limit. You are responsible for paying any amounts over the U&C amount.

Deductible
The deductible each calendar year is $25 per person and $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 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 (Comprehensive Dental Plan) Benefit Summary. 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 maximum.

Predetermination of benefits
You may request a predetermination of benefits before dental treatment begins for any treatment that will cost $200 or more. Predetermination is required for prosthetics and crowns, inlay and onlay restorations totaling more than $200 in allowable expenses. 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 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.
If alternate services or supplies are used to treat a dental condition, covered dental expenses will be limited to the services and supplies that are customarily employed nationwide to treat the disease or injury and that are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the member's current oral condition. See the Limitations section for some examples of how this provision operates.

**Covered dental expenses**

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

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.

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

**Preventive services**

Eligible preventive services include:

- Routine oral examinations and prophylaxis (including cleaning, scaling and polishing of teeth), but not more than twice per calendar year;
- Topical application of fluoride in conjunction with prophylaxis, but not more than twice per calendar year;
- Palliative (emergency) treatment of an acute condition requiring immediate care;
- Application of desensitizing medicaments, but not more than twice per calendar year;
- Periapical (root area) x-rays as required;
- Bitewing x-rays as required, but not more than twice per calendar year;
- 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);
- Panoramic x-ray for the removal of third molars when performed by a different provider on a different date of service;
- Cephalometric x-rays, but only in connection with orthodontic diagnosis and only once in any period of 36 consecutive months.

**Basic restorative services**

Eligible basic restorative services include:

- Repair of broken partial or complete dentures;
- 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;
- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
- Routine extractions;
- 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);
• 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);

• General anesthesia (9220) and intravenous sedation (9240) are paid in conjunction with procedure codes 7230, 7240 and 7241, subject to consultant review;

• Anesthesia administered and billed separately by an anesthesiologist during a medically necessary hospital confinement for dental treatment;

• Tissue conditioning treatments for the upper and lower dentures, but not more than twice per calendar year;

• 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;

• Recementation of space maintainers, once per calendar year and at least six months after the initial placement date;

• 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;

• Surgical removal of teeth;

• Surgical procedures performed for the preparation of the mouth for dentures;

• Apicoectomy (dental root surgery);

• 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;

• Free soft tissue graft procedure, including donor site; and

• Root planing and periodontal scaling (4341), but not more than once per quadrant every 24 months.

**Major restorative services**

Eligible major restorative services include:

• 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;

• 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);

• 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;

• 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;
• 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); and
• Repair of broken crowns, inlays, onlays or bridges.

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. Predetermination will be required for prosthetics and crowns, inlay and onlay restorations totaling more than $200 in allowable expenses. (See the Predetermination of benefits section for details.)

Orthodontic services
Charges of an orthodontist for services and supplies rendered to a covered individual who is a dependent child under age 19 or age 23 if a full-time student, 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.

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.

UMR will consider 25% of the total cost (within U&C) and will pay 50% of that amount initially. The remaining balance will be divided by the number of months treatment is required and 50% of the monthly amount will be paid each month until the $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.

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

- Preventive services will be limited to two routine exams and prophylaxis (including cleaning, scaling and polishing of teeth) during a calendar year.
- Topical application of fluoride is limited to not more than twice per calendar year.
- 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.
- 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.
- Gingival curettage is payable once per quadrant every 36 months. Gingival curettage is non-payable when performed on the same date of service as periodontal scaling.
- Periodontal scaling: procedure code (4341) is payable once per quadrant every 24 months.
- 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.
- 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.
- 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.
- Sealants are payable on dependent children through age 16. This is limited to the first and second molars for primary teeth and the bicuspid and molars for the permanent teeth.
- Alternative allowances will be paid on amalgam restorations when the following codes are submitted: (2380, 2381, 2382, 2385, 2386, 2387), for posterior resin restorations.

General exclusions

- 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.
- Charges for services or supplies when billed by other than a 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 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.
- Charges for services or supplies for failure to keep a scheduled visit with the dentist.
- 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.
- Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone – lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
- 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.
- Services for which the participant incurs no charge.
• Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the 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.
• Local anesthesia when billed separately by a dentist.
• Any services paid or payable under the participant’s medical plan.
• Covered services 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, will be based on the allowance for the least costly service, procedure, or course of treatment in accordance with the Plan.
• Implantology, except related services such as implant-supported prosthetics (abutments or retainer crowns placed over the implant) or implant removal.
• Any additional treatment necessitated by the participant’s failure to follow instructions, or lack of cooperation with the dentist.
• 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.
• Services rendered before the effective date of coverage or after termination of coverage.
• Charges for services or supplies for sterilization (charges for sterilization are included in the allowance for other covered dental procedures).

Specific exclusions and limitations
(Prosthetics and crowns, inlay and onlay restoration)
• 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.
• Any denture or bridge replacement made necessary by reason of loss, theft or participant alteration of a denture or bridge.
• 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.
• 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.
• Alternative allowances will be paid on amalgam restorations when the following codes are submitted; (2650, 2651, 2652, 2660), for composite/resin inlays/onlays.
• Alternative allowances will be paid on gold inlays/onlays when the following codes are submitted; (2620, 2630), for porcelain/ceramic inlays/onlays.
• 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.
• No payment will be made for procedure codes 2960, 2961, 2962, for Labial Veneer restorations.
BU Dental Plan (Comprehensive Dental Plan) Benefit Summary

<table>
<thead>
<tr>
<th>BU Dental Plan (Comprehensive Dental Plan)</th>
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<tbody>
<tr>
<td>Deductible (annual)</td>
</tr>
<tr>
<td>• Individual</td>
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<tr>
<td>• Family Maximum</td>
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<tr>
<td>Plan maximum (annual)</td>
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<tr>
<td>Preventive</td>
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<tr>
<td>Basic restorative</td>
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<tr>
<td>Fillings</td>
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<tr>
<td>Oral surgery</td>
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<td>Root canals</td>
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<td>Extractions</td>
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<tr>
<td>Major restorative</td>
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<tr>
<td>Crowns</td>
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<tr>
<td>Bridges</td>
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<tr>
<td>Dentures</td>
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<tr>
<td>Orthodontia</td>
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<td></td>
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<tr>
<td>Note: Deductible and coinsurance amounts are what you pay.</td>
</tr>
</tbody>
</table>

Coordination of benefits
If you and your eligible dependents are covered under the BU Dental Plan (Comprehensive Dental Plan) and another employer-sponsored plan, benefits under the BU Dental Plan (Comprehensive 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 plans, the "birthday rule" will apply unless there has been a divorce. Under the birthday rule, the plan of the parent whose birthday occurs first in the year is primary regardless of the year of birth. For example, the plan of the parent with a February birthday is primary to the parent with a May birthday. The father’s plan will be primary if a plan does not contain the birthday rule.

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

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

**How coordination of benefits works**

When the BU Dental Plan (Comprehensive Dental Plan) is secondary, benefits are coordinated with benefit payments from the other 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.

When the BU Dental Plan (Comprehensive 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.

After all plans have paid benefits, you are responsible for any remaining charges including amounts in excess of the U&C limit. The total amount paid by the BU Dental Plan (Comprehensive Dental 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 (Comprehensive 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 are eligible for Medicare and this Plan is secondary, UMR assumes that you have purchased Medicare Part B and provides benefits accordingly, whether or not you have purchased it. It is your responsibility to apply for and purchase Medicare Part B coverage when you or your dependent becomes eligible for Medicare.

**Benefits after termination of coverage**

Expenses incurred by an individual after termination of the individual's coverage under the BU Dental Plan (Comprehensive Dental Plan) 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.
Verifying coverage
To verify eligibility for coverage, you or the provider may call UMR at 1-800-842-6475 with the following information:

- Patient’s name and date of birth
- Employee’s name and Social Security number
- Group number: Progress Energy Florida, Inc. 76 - 140056

Filing a 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.

The claim should be mailed to:
UMR - Dental Claim Services
PO Box 8014
Wausau, WI 54402-8014

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 required. Failure to provide the requested information could result in the denial of the claims involved. (See the Claim and Appeal Procedures section for additional information.)

When to file
You should hold claims until you have enough expenses to meet the deductible. After the deductible has been satisfied, you should wait until you have incurred $50 of additional expenses or until the end of the calendar year to file additional claims. All claims must be filed within 24 months of the date the expense was incurred.

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

Claim questions
Call UMR at 1-800-842-6475 if you have claim questions. Have available a copy of your charges, your explanation of benefits, and any other correspondence you may have received.
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 pay a prepaid, fixed monthly premium and 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 (Select 15) Schedule of Benefits and Subscriber Copayments for details on covered benefits and copays under this Plan.

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.

As a dental health maintenance organization (DHMO), CompBenefits only covers dental care services rendered by its own Preferred Provider Network of dentists. 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.** Refer to the CompBenefits enrollment booklet for a listing of participating general dentists and specialists.

The CompBenefits (Select 15) Dental 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. If you join the CompBenefits (Select 15) 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.

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 in selecting or changing a general dentist, call CompBenefits to obtain a provider directory or visit the CompBenefits website www.compbenefits.com. If your general dentist should leave 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.**

**Benefit questions**
Any questions you may have regarding benefits provided by CompBenefits (Select 15) should be directed to CompBenefits customer service at 1-800-342-5209.
### CompBenefits (Select 15) Plan Benefit Summary

<table>
<thead>
<tr>
<th>CompBenefits (Select 15) Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Deductible (annual)</td>
<td>None</td>
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<tr>
<td>Plan maximum (annual)</td>
<td>Unlimited</td>
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<tr>
<td>Preventive</td>
<td>You pay a $5 copayment for each office visit (fluoride treatments to age 16)</td>
</tr>
<tr>
<td>Basic restorative Fillings</td>
<td>You pay a $5 copayment for each office visit</td>
</tr>
<tr>
<td>Single tooth extractions</td>
<td></td>
</tr>
<tr>
<td>Major restorative Crowns Bridges Dentures</td>
<td>You pay the applicable copayment $^1$</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Plan provides a 25% discount</td>
</tr>
<tr>
<td>Coverage for Lifetime Maximum</td>
<td>Children and adults</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

$^1$ Refer to the CompBenefits (Select 15) Schedule of Benefits and Subscriber Copayments for a complete listing.
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.

If the Plan should be terminated, coverage ends on the date of such termination.

Eligibility for benefits under the FlexPower Benefits program will also end if your employment status changes from a bargaining unit employee of Progress Energy Florida, Inc. to a non-bargaining employee of a company within the controlled group of Progress Energy, Inc. (Certain Progress Energy non-bargaining employees are eligible for benefits under the Choice Benefits program.)

Terminated employees
Dental coverage will end if your employment terminates. Coverage will end on the last day of the base pay period in which your employment terminates. Terminated employees are not eligible to continue coverage unless they qualify for COBRA coverage as described in the COBRA section.

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 delete the dependent from your coverage within 30 days of the loss of eligibility. Coverage will terminate on the date your dependent loses eligibility status. Employees who cover ineligible dependents are in violation of the Company’s Code of Ethics. In addition, if a dependent becomes ineligible, you must notify the Plan Administrator with 60 days in order for the dependent to be eligible for COBRA coverage.

Surviving dependents
If you die as a regular full-time bargaining unit employee, your eligible dependents may be eligible to elect to continue coverage as described in the COBRA section.

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

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

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

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

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

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

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

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

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

Your responsibility to notify your employer
If health coverage is lost because of a divorce, termination of domestic partner relationship, legal separation or a dependent no longer meets the dependent definition, you, your spouse or your domestic partner must notify your employer within 60 days to drop the dependent from your Progress Energy, Inc.-sponsored coverage by submitting a FlexPower Benefits Change Form (FRM-PGNF-00008) to the Employee Service Center. The Employee Service Center may be contacted at 1-800-546-5705 to request forms and assistance. After being notified that a 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.
Cost of COBRA coverage
The cost of continuing coverage under COBRA is 102% (100% of the full cost of the coverage plus a 2% administration fee). For example, if the total cost of employee coverage is $50 per month (employee and employer contributions combined), the cost for COBRA coverage would be $51 per month. During the 11-month extension period for disabled qualified beneficiaries, the cost increases to 150% of the total cost of the coverage beginning with the 19th month of COBRA coverage.

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

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

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

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

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

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

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

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

If a qualified beneficiary is eligible for the 18 months of coverage and is disabled (as determined by the Social Security Administration) on the date of the qualifying change, or at any time during the first 60 days of continued coverage, the 18-month coverage period may be extended by an additional 11 months for a total of up to 29 months of COBRA coverage from the date of the first qualifying event. This extension is designed to permit the individual to continue coverage until becoming entitled to Medicare.
A disabled qualified beneficiary who becomes eligible for the special 11-month extension must notify the COBRA administrator within 60 days of the Social Security determination of disability and prior to the end of the 18-month continuation period. The employer can charge up to 150% of the applicable premium during the 11-month disability extension. If coverage is extended to 29 months, coverage will cease upon a final determination that the qualified beneficiary is no longer disabled. The disabled individual must notify the employer within 30 days of any final determination that he or she is no longer disabled.

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

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

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

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

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

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

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

Other COBRA Information
Multiple qualifying events
Should your dependents experience more than one qualifying event while COBRA coverage is still active, they may be eligible for an additional period of continued coverage, not to exceed a total of 36 months from the date of the first qualifying event. For example, if you terminate employment, you and your dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the plan (a second qualifying event) your child may be eligible for an additional period of coverage not to exceed a total of 36 months from the date of your termination.
To be eligible for extended coverage after a second qualifying event, you or your dependent must notify the COBRA administrator within 60 days of the second qualifying event.

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

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

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

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

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

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

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

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

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

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

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

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

Submitting an appeal

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

If your claim is denied on review, you will receive written notice of the denial. The notice will include the specific reason(s) for the denial, refer to the specific Plan provisions on which the denial is based, state that you are entitled to receive upon request, and without charge, copies of all documents, records and other information relevant to your claim, describe the Plan’s voluntary review procedures, state your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, and state that you and the Plan may have other, voluntary alternative dispute resolution options.

If your claim is denied on review, you also have the opportunity for a voluntary second appeal. You must request a second appeal within 180 days of the time you receive the notice of denial from the first review. This request must be submitted in writing to the Plan Administrator for the BU Dental Plan (Comprehensive Dental Plan) and the Insurance Company for the CompBenefits (Select 15) Plan and should include any additional information you believe may affect the outcome of the review. You and your legal representative will have the right to examine all relevant documents and to submit written issues and comments about your claim. The Plan waives any right to assert that you failed to exhaust administrative remedies if you do not elect this second, voluntary level of appeal, and the Plan agrees that any statute of limitations or defense based on timeliness will be waived during the time that any voluntary appeal is pending.

The claim will be reviewed, including all information submitted with the original claim and review requests. A final decision will be made as soon as possible but not later than 30 days after the second review request is received. You will receive a written notice of the results of this review. The notice will include the reasons for the decision, will refer to the Plan provisions on which the decision is based and will include the additional information included in your first notice of denial upon review described above.
Acts of third parties
In the event you suffer an injury or illness caused by a third party, you assign to Progress Energy, Inc. any rights against the third party to recover benefits received under a Progress Energy, Inc.-sponsored dental plan for that injury or illness. You should notify the Plan Administrator that a third party is responsible for dental costs. In addition, you grant Progress Energy, Inc., on behalf of the Plan, an equitable lien, on a first-dollar basis, against any recovery that you have against any party, up to the amount of medical expenses advanced to you by the Plan.

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

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

This provision also applies to maintenance of benefits. For example, if you receive dental services and receive benefits from the Plan and later another group plan pays for the same charges, the Plan may recover the overpaid or duplicated benefits from you, the dental provider, or the other plan. Common law doctrines such as the “make whole” rule, the “common fund” rule, “comparative fault,” and similar doctrines are inapplicable to benefits paid under this Plan.
Qualified medical child support order
A qualified medical child support order (QMCSO) is an order issued by a court or through a state administrative process established under state law. In addition, national medical support notices will be treated as QMCSOs. A QMCSO directs the Plan Administrator to cover a child for benefits under the health care plan. Upon receipt of the order, the Plan Administrator will review the order to determine whether or not it is a QMCSO. During this review period the Plan Administrator will hold all claims that may be payable for the children named in the order. The Plan Administrator will notify in writing all persons named in the order of the determination. If the Plan Administrator determines the order is a QMCSO, its terms must be followed to the extent required by law. You must pay the appropriate cost of coverage as for any dependent coverage. If the Plan Administrator determines the order is not a QMCSO, a revised order may be prepared for submission and review. The Plan Administrator will discontinue holding claims at the time an order is determined not to be a QMCSO. If a revised order is submitted and determined to be a QMCSO, the Claims Administrator will pay any claims on behalf of the child to the extent required by the revised order.

Health Insurance Portability and Accountability Act (“HIPAA”)

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

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

The Privacy and Security Officials may be contacted by phone at 1-800-546-5705 or email privacy.official@pgnmail.com.
Plan identification
The official name of the Plan is the Dental Plan of Progress Energy Florida, Inc. This Plan is part of the Progress Energy, Inc. Welfare Benefit Plan, Plan number 526. The employer identification number (EIN) issued by the Internal Revenue Service for Progress Energy, Inc. is 56-2155481.

The Plan Sponsor’s address is:
Progress Energy, Inc.
PO Box 1551, PEB 16ESC
Raleigh, NC 27602-1551

Costs and funding
Benefits under the Plan are funded through contributions from participating employees.

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. Except as noted below the Plan Administrator has the exclusive right in its sole discretion to interpret the Plan and to decide any and all matters arising thereunder, including but not limited to matters related to eligibility for benefits, application of Plan limitations, and the amount of any required contributions by or on behalf of any participants.

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

The Plan Administrator has delegated to the Claims Administrator/Insurance Company overall responsibility for the operation and administration of the applicable portion of the Plan. The Claims Administrator/Insurance Company has the exclusive right in its sole discretion to interpret the applicable portion of the Plan and to decide any and all matters arising thereunder, including but not limited to matters related to eligibility for benefits and application of Plan limitations.

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

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

The Employee Service Center provides administrative services for Plan participants and can be reached at the address above, by calling 1-800-546-5705 or by email at employee.service@pgnmail.com.
Claims Administrator/Insurance Company
The Plan Administrator has arranged for dental claims to be administered as follows:
   BU Dental Plan (Comprehensive Dental Plan) (Claims Administrator)
       UMR
       P. O. Box 8014
       Wausau, WI 54402-8014
       Telephone Number: 1-800-842-6475
       www.fhs.umr.com

   CompBenefits (Select 15 DHMO) (Insurance Company)
       CompBenefits (Select 15 DHMO)
       P.O. Box 769649
       Roswell, GA  30076
       Telephone Number: 1-800-342-5209
       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.
Receiving information about your Plan and benefits
As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine without charge at the Plan Administrator's office and at other specified locations such as worksites, all Plan documents governing the Plan, including insurance contracts and collective bargaining agreement, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health plan coverage for yourself, spouse, domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Enforcing your rights
Under ERISA, there are steps that you may take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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