Mental Health/Substance Abuse Services and EAP Plan of
Progress Energy Florida, Inc.

HRI-PGNF-00002

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

Keywords: human resources information; benefits booklets

Mental Health/Substance Abuse and EAP 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 Mental Health/Substance Abuse and EAP Plan of Progress Energy Florida, Inc. (the "Plan"). The Plan is sponsored by Progress Energy, Inc. and is available to eligible employees as follows:

- Employee assistance services are available to regular, full-time, temporary and retired bargaining unit employees of Progress Energy Florida, Inc. and their eligible dependents.

- Mental health and substance abuse services administered by ValueOptions are available to regular full-time and retired bargaining unit employees of Progress Energy Florida, Inc. and their covered dependents who are enrolled in one of the Progress Energy, Inc.-sponsored medical options.

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

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

Call ValueOptions at 1-800-662-8800 for questions regarding Mental Health/Substance Abuse and EAP services.

Reference Form
FRM-SUBS-01112, ValueOptions – Health Insurance Claim Form
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The Progress Energy, Inc.-sponsored Employee Assistance Plan (EAP) helps employees and their families deal with personal issues, such as stress, grief, legal and financial matters, substance abuse, or marital and family difficulties that may be affecting their lives at work or at home. ValueOptions, an outside administrator, provides confidential assessments, short-term counseling, referral services, and treatment monitoring under the EAP.

Mental health and substance abuse services are integrated with the EAP and are also administered by ValueOptions.

The Plan covers bargaining unit 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.
Eligibility
Regular, full-time and temporary bargaining unit employees and all members of their households are eligible to receive EAP services on the first day of employment or reclassification date (i.e., change from non-bargaining classification to bargaining unit classification) with Progress Energy Florida, Inc. Progress Energy Florida, Inc. pays the full cost of coverage for EAP services.

Leaves of absence
You and the members of your household will continue to be eligible to receive EAP services while you are on 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

Retired employees
If your employment status changes and you are reclassified as a retired employee of Progress Energy Florida, Inc., eligibility for EAP services will continue.

Employees whose employment terminates, other than for retirement, are not eligible to receive EAP services except under COBRA.

Surviving dependents
Surviving dependents are not eligible for EAP services, except under COBRA.

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

When eligibility ends
Your eligibility for EAP services will end if one of the following events occurs:
- Your employment status changes and you no longer meet the employee eligibility criteria and you are not reclassified as a retired employee.
- Your employment terminates, for any reason other than retirement.
- Your employment status changes from a bargaining unit employee of Progress Energy Florida, Inc. to a non-bargaining unit employee of one of the Progress Energy, Inc. participating subsidiaries. (Certain Progress Energy non-bargaining employees are eligible for benefits under the Choice Benefits program.)
- The Plan is terminated (eligibility for services will end on the date of such termination).

When your eligibility for EAP services ends, your household members’ eligibility for EAP services also ends.
Access to counseling
You may request counseling services for yourself or members of your household. You should call ValueOptions directly at 1-800-662-8800 to set up an appointment with a counselor for a face to face visit or you may talk with a counselor over the phone. In case of an emergency, a ValueOptions staff clinician can be reached 24 hours a day, seven days a week by calling this number.

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

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

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

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

- If information is disclosed that ValueOptions considers imminently life threatening to you or others, ValueOptions will take prudent steps to prevent the threatened danger.

- If instances of juvenile or elder care abuse or neglect are disclosed, state law may require that this information be reported to the appropriate state office.

- When you are within the scope of the NRC Fitness for Duty rule and it has been determined that your condition constitutes a hazard to yourself or others, ValueOptions must disclose this information to your employer's EAP staff, who will report it to your management.

- Pursuant to a subpoena, court order, regulatory order, or as otherwise required by law.
Eligibility
Regular, full-time bargaining unit employees who are enrolled in one of the Progress Energy, Inc.-sponsored medical options are eligible for mental health and substance abuse services on the first day of employment or reclassification date with Progress Energy Florida, Inc.

Dependents
Dependents of eligible plan participants who meet the dependent eligibility requirements are eligible to receive mental health and substance abuse services if the dependent is also covered under one of the Progress Energy, Inc.-sponsored medical options. Each eligible dependent to be covered must be listed by name, Social Security number, and date of birth on the enrollment form or through the online web enrollment. Eligible dependents are:

- 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
  - 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.
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.

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.

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.

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

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

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 injury or illness, 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.

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 medical 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 medical 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

You and your eligible dependents will continue to be eligible to receive mental health and substance abuse services if you elect to continue medical coverage under one of the Progress Energy, Inc.-sponsored medical options while you are on 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
Retired employees
If your employment status changes and you are reclassified as a retired employee and you meet the eligibility requirements to continue medical coverage under one of the Progress Energy, Inc.-sponsored medical options, you and your covered dependents will remain eligible for mental health and substance abuse services if you continue medical coverage under one of the specified medical options. (See the Medical booklet for eligibility requirements.)

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

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

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

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

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

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

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

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

ValueOptions' role
ValueOptions' role in administering the mental health and substance abuse services under the Plan includes conducting a brief assessment, providing network referrals, certifying care based on medical necessity, claims adjudication and payment services as well as facilitating member appeals.
How to use the services
To receive mental health and substance abuse services, you should call ValueOptions at 1-800-662-8800 before beginning treatment. For emergency services, you may call at any time. ValueOptions is staffed by trained professionals 24 hours a day, seven days a week.

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

Precertification of treatment is required for all outpatient mental health and substance abuse services regardless of whether they are rendered by an in-network or out-of-network provider. Out-of-network mental health and substance abuse services for hospital, inpatient or alternative programs must be authorized within 48 hours of admission or initiating treatment. Failure to contact ValueOptions within 48 hours shall render such services ineligible for coverage under the Plan.

In case of emergency
A mental health or substance abuse emergency is a condition in which the patient is a danger to him or herself or others. If an emergency arises and you cannot call ValueOptions, go immediately to any convenient hospital emergency facility. If you are admitted to the hospital on an emergency basis, you must call ValueOptions (1-800-662-8800) within 48 hours of admission to the hospital. If you cannot call, have a family member, friend or the hospital make the call.

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

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

Claims
When you use a provider in the ValueOptions network, you will not have to file a claim. In-network providers file directly with ValueOptions. With in-network providers, you pay only the copayment portion of the bill. In-network providers may not bill you for the difference between their usual charges and the ValueOptions discounted rate.

If you choose to use a non-network provider you will be required to file your own claims with ValueOptions. All out-of-network claims must be submitted within 180 days of the date of service to be eligible for reimbursement under the Plan. ValueOptions – Health Insurance Claim Form (FRM-SUBS-01112) is available from ValueOptions (1-800-662-8800) or the Employee Service Center (VoiceNet 770-5705 or 1-800-546-5705) and should be submitted to:

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

If you have claim questions, you may call ValueOptions at 1-800-662-8800.
**Benefit summary**

- The EAP benefit allows three visits per issue and visits are covered at 100% each calendar year, if services are precertified with ValueOptions.
- A per visit copayment applies for outpatient mental health & substance abuse services if they are precertified by ValueOptions.
- Inpatient and alternative levels of mental health and substance abuse treatment are required to be precertified by ValueOptions to be covered. The proposed treatment plan must be approved as medically necessary and rendered by a licensed and accredited facility. This plan’s alternative levels of care include partial hospital programs and intensive outpatient treatment programs. Note: residential treatment programs are not a covered benefit.
- ValueOptions must be notified within 48 hours of emergency admissions to both in-network and out-of-network facilities. If ValueOptions is not notified, benefits will not be provided and you will be responsible for treatment cost.
- Outpatient mental health and substance abuse treatment is covered if the provider is either a psychiatrist, psychologist, or masters level clinician who is licensed to practice independently without supervision. ValueOptions will certify services with Developmental Behavioral Pediatricians (medical doctors and pediatricians) who have completed a three-year fellowship in developmental behavioral pediatrics to provide outpatient services to members who are 18 and under. A higher level of benefits will apply if the treatment is precertified by ValueOptions and a network provider is seen. Practitioners must bill a DSM-IV diagnosis to be assigned plan benefits.
- Usual and customary limits will apply to covered inpatient services received from an out-of-network provider. Usual and customary is the rate most providers typically charge for that service in that geographic area under similar circumstances. Benefits will not be paid for any amount over the usual and customary limit.
- Methadone maintenance services require pre-certification and are considered under the outpatient benefit.

<table>
<thead>
<tr>
<th>Services</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Assistance</td>
<td>• Up to three visits (per issue) covered at 100%</td>
<td>• Not covered</td>
</tr>
<tr>
<td></td>
<td>• Precertification required</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copay</td>
<td>• $10 copay visits 1-20;</td>
<td>• $30 copay visits 1-20;</td>
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<tr>
<td></td>
<td>• $25 copay visits 21-45</td>
<td>• $50 copay visits 21-45</td>
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<tr>
<td></td>
<td>• 45 visits per year</td>
<td>• 45 visits per year</td>
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<tr>
<td></td>
<td>• Yes</td>
<td>• Yes</td>
</tr>
<tr>
<td>Maximum visits</td>
<td></td>
<td></td>
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<tr>
<td>Precertification required</td>
<td></td>
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<tr>
<td>Inpatient Mental Health &amp; Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>• - 0 -</td>
<td>• - 0 -</td>
</tr>
<tr>
<td>Maximum days</td>
<td>• 30 days per year</td>
<td>• 30 days per year</td>
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<tr>
<td>Coinsurance</td>
<td>• - 0 -</td>
<td>• 25% U&amp;C (employee responsibility)</td>
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<tr>
<td></td>
<td>• Yes</td>
<td>• Yes</td>
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<tr>
<td>Precertification required</td>
<td></td>
<td></td>
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<tr>
<td>Detoxification in connection with substance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>abuse</td>
<td>Two episodes of treatment over a calendar year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and three episodes over the lifetime (subject</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to inpatient and outpatient calendar year limits)</td>
<td></td>
</tr>
<tr>
<td>Lifetime Plan maximum</td>
<td>Unlimited (except detoxification – see above)</td>
<td></td>
</tr>
</tbody>
</table>

1 Includes in-network and out-of-network Mental Health & Substance Abuse.

2 Two days of PHP (partial hospitalization program) equals one day of inpatient and three days of IOP (intensive outpatient program) equals one day of inpatient towards the 30 day maximum.
Pre-approval requirements
The following services require pre-approval by ValueOptions even if treatment has already been pre-authorized. For example, your therapist or hospital may have received approval to begin treatment; however, you must also get pre-approval from ValueOptions to assure coverage for any of the specialized services listed below:

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

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

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

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

- Acupuncture
- Accommodations, services, supplies, or other items determined as neither clinically nor medically necessary
- Administrative psychiatric services when these are the only services rendered
- Any service or supply listed under general exclusions of the Medical Plan
- Bioenergetics therapy
- Carbon dioxide therapy
- Chart review
- Confrontation therapy
- Consultation with a mental health professional for adjudication of marital, child support, or custody cases
- Crystal healing treatment
- Cult deprogramming
- Custodial care
- Durable Medical Equipment for light box or photo-stimulation therapy
- Eating disorder and gambling programs based solely on the 12-step model
- Educational evaluation and therapy, including testing
- Educational treatment including reading clinics and special schools for mentally retarded or behaviorally impaired individuals
- Environmental ecology treatment
- EST (Erhard) or similar motivational services
- Examinations or treatments exclusively required as a part of legal proceedings if not medically necessary
- Experimental or investigative treatments
- Expressive therapies (art, poetry, movement, psychodrama) as separately billed services
- Guided imagery
- Hemodialysis for schizophrenia
- Hyperbaric or normobaric oxygen therapy
• Items specifically for personal comfort, hygiene or convenience, such as television, telephone, or private room for inpatient care; housekeeping, homemaker or meal services for outpatient care
• L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with a diagnosis of nutritional deficiency
• Marathon therapy
• Megavitamin therapy, nutritional formulas, food supplements, or special diets
• Narcotherapy with LSD
• Orthomolecular therapy
• Outpatient prescriptions
• Primal therapy
• Private duty nursing
• Private rooms (except when required for infection control)
• Psychological ‘camps’ for treatment of ADHD or weight management
• Rolfing
• Sedative action electrostimulation therapy
• Sensitivity training
• Services not authorized by ValueOptions
• Sex therapy (without a DSM IV diagnosis)
• Speech therapy
• Substance Dependency treatment programs not using a medical model detox protocol (if indicated) in collaboration with ASAM (American Society of Addiction Medicine) treatment protocol staging
• Supervision of clinical treatment practitioners or team
• Training analysis (Tuitional or Orthodox)
• Transcendental meditation
• Travel, whether or not recommended or prescribed as part of treatment
• Treatment for chronic, intractable pain at a pain control center or through a pain control program
• Treatment of sexual addiction, co-dependency, or any other behavior that does not have a DSM IV diagnosis
• Vocational assessment/school assessment
• Z therapy
Primary and secondary responsibility for claims

Primary and secondary responsibility for claims under the Mental Health/Substance Abuse Services Plan of Progress Energy Florida, Inc. follows the same rules as the Progress Energy, Inc.-sponsored medical plans.

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

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

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

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

Dependent children

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

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

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

Medicare

Active employees

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

- For you, if you are covered by both the Progress Energy, Inc.-sponsored plan and Medicare.
- For your dependent, if you have a Medicare-eligible dependent covered under a Progress Energy, Inc.-sponsored plan.
- For you or your dependent, during the first 30-months of eligibility or entitlement to Medicare based solely on end stage renal disease (ESRD). After 30 months, Medicare will be primary.

Retired employees or surviving dependents

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

- For you, if you are retired or a surviving dependent and are age 65 or over.
- For you, if you are disabled when you retire and are entitled to Medicare (regardless of your age).
- For you, if you are eligible for LTD benefits and have received Social Security benefits for 24 months (regardless of your age).
- For your dependent, if you have a Medicare-eligible dependent covered under a Progress Energy, Inc.-sponsored plan and you are retired or eligible for LTD benefits (regardless of your age).
- Pre age 65 – for you or your dependent, after the first 30 months of eligibility or entitlement to Medicare based solely on end stage renal disease (ESRD).
• Post age 65 – Medicare will remain primary for you or your dependent even if you become eligible for Medicare based on end stage renal disease (ESRD).

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

You should apply for and purchase Medicare Part B when you or your dependent first become eligible for Medicare. The Progress Energy, Inc.-sponsored plan will assume you have purchased Medicare Part B and coordinate benefits accordingly, regardless of whether or not you are actually covered under Part B.
Non-certification determinations

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

Level I appeal
If a ValueOptions peer advisor (Psychiatrist or Ph.D licensed Psychologist) determines that care cannot be certified, you or the participating provider may request a Level I appeal within 180 calendar days of receipt of the notification of non-certification. This level of appeal provides the participating provider an opportunity to review the patient's clinical condition with a peer advisor who was not involved in the non-certification determination. Under usual circumstances, a decision is completed within 30 calendar days of receipt of the appeal request and medical records for a standard Level I appeal.

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

Level II appeal
If a Level I appeal upholds the non-certification determination, the participating provider may request a Level II alternative appeal within 180 days of the Level I appeal recommendation. This level of appeal involves referral to an independent outside review organization. (i.e., peer review analysis).

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

Level II appeal determinations are made within 30 calendar days of the receipt of the Level II appeal request. Level II appeals are typically standard appeals, not expedited. The independent reviewer will render a decision in writing and the review organization will transmit the results to ValueOptions Regional/Unit Medical Director. ValueOptions will notify the treatment provider and the patient of the results. ValueOptions will certify those services that are found to be medically/psychologically necessary by the independent reviewer.

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

Plan appeal
The Level II Appeal is the final level available to you through ValueOptions. If you disagree with this decision, you may request that the Plan Administrator reconsider this adverse benefit determination. Requests for reconsideration must be submitted, in writing, within 180 days of receipt of the appeal decision.

You may obtain further information regarding your appeal rights by contacting the Progress Energy Employee Service Center at 1-800-546-5705 or VoiceNet 770-5705.

If you request a review of your benefit determination, the Progress Energy Compliance Committee will complete its review not later than 30 days upon receipt of appeals records.

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

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

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

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

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

You and/or your eligible dependents have 60 days from the date you would lose coverage because of one of the events described above, or 60 days from the date you are notified of your right to elect continuation coverage under COBRA, if later, to make an election under COBRA. If a COBRA election is not made during this 60-day election period, continuation of coverage will not be available.

Cost of COBRA coverage
The cost of continuing coverage under COBRA is 102% (100% of the full cost of the coverage plus a 2% administration fee). For example, if the total cost of employee coverage is $300 per month (employee and employer contributions combined), the cost for COBRA coverage would be $306 per month. During the 11-month extension period for disabled qualified beneficiaries, the cost increases to 150% of the total cost of the coverage beginning with the 19th month of COBRA coverage.

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

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

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

Maximum period of coverage
Your covered dependents may be eligible for COBRA coverage for up to 36 months if coverage is lost because of one of the following qualifying events:
- Death of a participating employee.
You 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.

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

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

The law also says that, at the end of the 18-month, 29-month or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if such an individual conversion health plan is otherwise generally available under the group health plan. Conversion to an individual policy is not available under the Progress Energy health plans.
If a qualified beneficiary's COBRA coverage is terminated for any of the above-referenced reasons, or the qualified beneficiary elects to discontinue coverage before the end of the applicable maximum period of coverage, the qualified beneficiary will not be eligible to re-elect coverage at a later date. If COBRA coverage is denied or terminated, qualified beneficiaries and eligible dependents will be notified in writing as to why coverage was denied or is being terminated.

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

Other COBRA Information

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

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

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

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

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

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

You must notify the employer within 60 days of the event to change your coverage under COBRA. If you provide notice within 30 days of the date of your status change, your change in coverage will be effective on the date of your status change. If you provide notice after 30 days but within 60 days, your change will be effective on the date you notify the employer. In the case of a domestic relations judgment, decree or order, the child will be covered from the date specified in the judgment, decree or order.
If you are on a Family and Medical Leave (FMLA)
If you have taken a leave of absence under the Family and Medical Leave Act (FMLA), and you do not return to work at the end of your FMLA leave, you may elect COBRA coverage. You will experience a qualifying event on the last day of your FMLA leave, which is the earliest of:

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

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

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

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

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires employers to issue certificates of coverage to employees and their dependents when coverage is lost under the employer’s plan due to termination of employment or loss of dependent eligibility. The certificate may be used to reduce or eliminate the length of time coverage may be excluded for pre-existing conditions under a new employer’s plan. Certificates of coverage are automatically issued to employees and their dependents following their coverage termination.
Provider compensation
The relationship between the Plan’s Claims Administrator and participating providers is contractual. Compensation for participating providers is based on a variety of payment mechanisms. For example, some providers receive a fee each time they provide covered services to a plan participant and others are paid a fee for their service based on filing of standard industry insurance procedure codes which define the professional services they have rendered to a plan beneficiary. For additional information on participating provider compensation, contact the Claims Administrator.

Qualified medical child support order
A qualified medical child support order (QMCSO) is an order issued by a court or through a state administrative process established under state law. In addition, national medical support notices must be treated as QMCSOs. A QMCSO directs the Plan Administrator to cover a child for benefits under the health care plan and also meets the criteria set forth in Section 609(a) of the Employee Retirement Income Security Act (ERISA). Upon receipt of the order, the Plan Administrator will review the order to determine whether or not it is a QMCSO. During this review period the Plan Administrator will hold all claims that may be payable for the children named in the order.

The Plan Administrator will notify in writing all persons named in the order of the determination. If the Plan Administrator determines the order is a QMCSO, its terms must be followed to the extent required by law. If you are subject to a QMCSO, you must pay the appropriate cost of coverage as for any dependent coverage. If the Plan Administrator determines the order is not a QMCSO, a revised order may be prepared for submission and review. The Plan Administrator will discontinue holding claims at the time an order is determined not to be a QMCSO. If a revised order is submitted and determined to be a QMCSO, the Plan Administrator will pay any claims on behalf of the child to the extent required by the revised order.

Health Insurance Portability and Accountability Act (“HIPAA”)

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

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

The Privacy and Security Officials may be contacted by phone at 1-800-546-5705 or email privacy.official@pgnmail.com.
Plan Identification
The official name of the Plan is the Mental Health/Substance Abuse and EAP Plan of Progress Energy Florida, Inc. This Plan is a component plan under 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 and operating expenses for the mental health and substance abuse services under the Plan are funded through contributions from Progress Energy Florida, Inc. and participating employees. Benefits and operating expenses for employee assistance services under the Plan are paid from the general assets of Progress Energy Florida, Inc.

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

Plan Administrator
A Plan Administrator has been appointed, as required by law, to be responsible for the operation of the Plan. The Plan Administrator has overall responsibility for the operation of the Plan and controls the administration of the Plan. The Plan Administrator has the exclusive right in its sole discretion to interpret the Plan and to decide any and all matters arising thereunder, including but not limited to matters related to eligibility for benefits, application of Plan limitations, and the amount of any required contributions by or on behalf of any participants.

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

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

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
The Claims Administrator is:
ValueOptions
PO Box 12438
3800 Paramount Parkway
Morrisville, NC 27560-6901
1-800-662-8800
Agent for service of legal process
Legal process may be served upon the Plan's agent, Sponsor, or Administrator.

The Plan’s agent for service of legal process is:
   Vice President - Human Resources
   Progress Energy Service Company, LLC
   PO Box 1551
   Raleigh, NC 27602-1551

Continuation of the Plan and Plan amendments
The Plan Sponsor reserves the right to amend or terminate the Plan or any Plan benefit at any time based on the cost of the benefits or other considerations without prior approval of or notification to any party.
The following statement is provided in compliance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

**Receiving information about your Plan and benefits**
As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

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

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

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

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

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

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

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