NRECA Medical Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

PPO Plan

COASTAL ELEC COOPERATIVE INC

01-41030-001

EFFECTIVE DATE: January 1, 2024

NRECA

America's Electric Cooperatives

Introduction

Summary Plan Description

This summary plan description (SPD), also known as the *Benefits Booklet,* describes the benefits provided to Participants by the National Rural Electric Cooperative Association (NRECA) Medical PPO Plan (the Plan).

Your Responsibilities

You are responsible for reading the SPD and related Plan materials distributed by NRECA or by your Employer, such as premium contribution notices, summary of material modifications, and Employer benefits eligibility rules, completely and complying with the rules and Plan provisions described herein. The provisions applicable to the specific benefit options under this benefit Plan determine what services and supplies are eligible for benefits; however, you and your provider are ultimately responsible for determining what services you will receive.

While reading this SPD, be aware that:

- The Plan is provided as a benefit to persons who are eligible to participate, as defined in the *Eligibility and Participation Information* chapter. Plan participation is not a guarantee or contract of employment with NRECA or with member cooperatives. Plan benefits depend on continued eligibility; and
- Frequently used and Plan-specific terms are capitalized and defined in *Appendix A: Key Terms.*

In case of a conflict between this SPD (or any information provided) and the official Plan document, the official Plan document governs.

Table of Contents

Plan Information

Plan Name

The NRECA Medical Plan, which is a component Plan of the NRECA Group Benefits Program.

Plan Number:	501
Plan Type:	Medical PPO Plan
Year End:	December 31
Plan Effective Date:	January 1, 2024

Plan Funding

Plan coverage is self-insured and funded in whole or in part through contributions made by participating Employers or Participants to the:

NRECA Group Benefits Trust
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Arlington, VA 22203-1860

Plan Administration

Except where pre-empted by ERISA or other U.S. laws, the Plan's validity and any other provisions will be determined under the laws of the Commonwealth of Virginia. The Plan administration type is sponsor administration. Plan records are kept on a calendar-year basis.

Named Fiduciary

The named fiduciary of the NRECA Group Benefits Program (Program) is the Insurance and Financial Services Committee (I&FS Committee) of the NRECA Board of Directors (Board), whose members are appointed by the President of the Board from members of the Board. The I&FS Committee has both the central fiduciary responsibility for the Program and is vested with the discretion to select providers for the Program, including the Plan Administrator, investment managers, and trustee. It is charged with management of the Program and the NRECA Group Benefits Trust. The I&FS Committee delegates authority to various entities and individuals to carry out required Plan operations and then actively monitors its delegates to help ensure compliance with complex federal laws and regulations governing employee benefit plans.

Plan Sponsor

National Rural Electric Cooperative Association
4301 Wilson Boulevard
Arlington, VA 22203-1860

Plan Sponsor's Employer Identification Number: 53-0116145

NRECA, as the Plan Sponsor, must abide by Plan rules when making decisions about how the Plan operates and how benefits are paid.

Plan Administrator

Senior Vice-President, Insurance and Financial Services
National Rural Electric Cooperative Association
4301 Wilson Boulevard, Mailstop IFS7-355
Arlington, VA 22203-1860

703.907.5500

The Plan Administrator has discretionary and final authority to interpret and implement Plan terms, resolve ambiguities and inconsistencies, and make all decisions about eligibility and entitlement to coverage or benefits.

In addition to the Senior Vice-President of the Insurance and Financial Services department, the person listed below has certain administration responsibilities for your Employer:

Benefits Administrator
COASTAL ELEC COOPERATIVE INC
2269 JEFFERIES HIGHWAY
WALTERBORO, SC 29488-3903

Plan Trustee

State Street Bank and Trust Company
1200 Crown Colony Drive, 5th Floor
Quincy, MA 02169

Agent for Service of Legal Process

The agent of service of legal process is the Plan Administrator. The Plan Administrator receives all legal notices on behalf of the Plan Sponsor regarding claims or suits filed with respect to this Plan. Such legal process may also be served upon the Plan Trustee.

Claims Administrator (Medical Benefits)

Cooperative Benefit Administrators, Inc. (CBA)
P.O. Box 6249
Lincoln, NE 68506

Claims Administrator (Prescription Drug Benefits)

CVS Caremark
P.O. Box 686005
San Antonio, TX 78268-6005

Chapter 1: Contact Information

For Information About	Contact
Preauthorization for medical procedures and services	**Simplified Hospital Admissions Review (SHARE)** UMR P.O. Box 8042 Wausau, WI 54402-8042 Medical Review Coordinators 800.526.7322 (8 am to 7 pm ET Monday through Friday)
Medical claims and provider information	**United Medical Resources (UMR)** P.O. Box 30515 Salt Lake City, UT 84130-7105
Teladoc General Medical Consultations	800.Teladoc (800.835.2362) Teladoc.com/NRECA or Teledoc App
Teladoc Mental Health Consultations	Teladoc.com/NRECA or Teladoc App
• **Clinical policy guidelines** • **Explanation of benefits (EOB)** • **General Medical Plan questions**	**Participants** Cooperative Benefit Administrators, Inc. (CBA) 866.673.2299, Option 1 contactcenter@nreca.coop cooperative.com **Providers** UMR 877.233.1800
Prescription drug benefits	**CVS Caremark** P.O. Box 686005 San Antonio, TX 78268-6005 888.796.7322 customerservice@caremark.com (available 24/7) caremark.com
General benefit questions • Eligibility • Enrollment • When coverage begins or ends • Cost of coverage • Family and Medical Leave Act (FMLA)	**Benefits Administrator** COASTAL ELEC COOPERATIVE INC 2269 JEFFERIES HIGHWAY WALTERBORO, SC 29488-3903
COBRA administrator	**UMR** **COBRA Administration** P.O. BOX 1246 Wausau, WI 54402

Benefits questions, including creditable coverage for Medicare	**Member Contact Center** P.O. Box 6007 Lincoln, NE 68506 866.673.2299 Fax: 402.483.9300 contactcenter@nreca.coop
Transplant and cancer treatment programs	**Centers of Excellence (COE)** 800.526.7322
Bariatric program	**Centers of Excellence (COE)** 888.936.7246
Health and lifestyle issues and concerns	**FutureMe coaches** 888.321.1521
Joint and spine surgery program	**Centers of Excellence (COE)** Transcarent Surgery Care 855.435.5790
Personal life concerns	**Life Strategy Counseling Program** 888.225.4289
Pregnancy support and resources	**First Steps Maternity** 800.526.7322
Designating a personal representative	**NRECA Privacy Officer** 4301 Wilson Boulevard Arlington, VA 22203-1860 Telephone: 703.907.6601 Fax: 703.907.6602 privacyofficer@nreca.coop
Find Care & Costs	Cooperative.com > My Benefits > My Insurance > Find Care & Costs

Chapter 2: PPO Plan Highlights

This chapter summarizes the Plan's medical and prescription drug benefits. Full details, including coverage amounts, limitations, and exclusions, appear in the chapters that follow.

Retirees and their dependents who are 65 or older are not eligible to participate in the Medical Plan (including prescription drug benefits). For details, read the *Coverage Under Medicare* section in the *Prescription Drug Benefits* chapter.

Notwithstanding the cost share amounts listed herein, all cost share (including any consultation fees, copays, or coinsurance) for Teladoc General Medical Consultations and Teladoc Mental Health shall be waived effective January 1, 2023 through December 31, 2024.

Overview of Your Cost-sharing

Deductible[1,2]	
Individual Annual Deductible (in-network)	$750
Individual Annual Deductible (out-of-network)	$1,500
Family Aggregate Deductible (in-network/out-of-network)	$1,500 / $3,000
Coinsurance	
Coinsurance Level (in-network/out-of-network)	100% / 80%
Individual Annual Out-of-pocket Coinsurance Maximum (in-network)	$0
Individual Annual Out-of-pocket Coinsurance Maximum (out-of-network)	$1,200
Family Aggregate Out-of-pocket Coinsurance Maximum (in-network/out-of-network)	$0 / $2,400

Copayment	
Physician's Office Visit	$40
Teladoc General Medical Consultation	$0 per consultation
Teladoc Mental Health Consultation	Teladoc is paid at 100% after you pay your office copayment.

Laboratory Coverage	Preventive laboratory services are paid at 100%. Laboratory services charges are paid as part of the medical benefit and are subject to your annual Deductible, Coinsurance, and Copayments.
Emergency Room Copayment or Coinsurance	$100 Copayment, after Deductible and Coinsurance.
Prescription Drugs	Waived for covered generic drugs filled at an Exclusive Choice pharmacy (including CVS Caremark Mail Service). See the *Prescription Drug Benefit Cost-sharing* chart in this chapter.

Total Cost-sharing Out-of-Pocket Limit	
Medical and Prescription Drug Expenses	**In-network:** There is a combined in-network total cost-sharing out-of-pocket limit for medical and prescription drug expenses (Deductibles and Copayments). The Plan's total cost-sharing out-of-pocket limits are **$7,150** for individual coverage and **$14,300** for family coverage. Also, the individual limit of **$7,150** will apply to each covered person, whether enrolled for individual or family coverage. **Out-of-network:** There is no out-of-network total cost-sharing out-of-pocket limit.

[1]The Deductible does not apply to charges for preventive services.
[2]Under this Plan, covered services are not reimbursed for you and your covered dependents until the family Deductible is met (if applicable). Amounts that count toward satisfying an in-network Deductible also count toward satisfying an out-of-network Deductible and vice versa.

Medical Benefit Highlights

Medical Service		Coinsurance[1,2] Level	
		In-network	Out-of-Network
Preventive Care for Adults		100%	80%
Well-child Care		100%	80%
Physician Services (includes services for Mental Health and Substance-related Disorders)	Office visits, second surgical opinions, outpatient Mental Health services	100% after a $40 Copayment	80% after Deductible
	Surgeon and anesthesiologist services	100% after Deductible	80% after Deductible

Medical Service		Coinsurance[1,2] Level	
		In-network	Out-of-Network
	Inpatient, outpatient, and emergency room Physician services		
	Allergy Immunization shots		
Diagnostic Lab and x-ray	Diagnostic services	100% after Deductible	80% after Deductible
	Preventive tests and screenings	100%	80% after Deductible
Hospital Services (includes services for Mental Health and Substance-related Disorders)		100% after Deductible	80% after Deductible
Emergency Room Services (includes services for Mental Health and Substance Related Disorders)[3]		100% after Deductible and $100 Copayment	100% after Deductible and $100 Copayment
Ambulance Services		100% after Deductible	100% after Deductible
Convalescent Nursing Home Care		100% after Deductible	80% after Deductible
Hospice Care		100% after Deductible	100% after Deductible
Rehabilitation Services and Other Medical Services		100% after Deductible	80% after Deductible

[1]Eligible expenses may be subject to Reasonable and Customary (R&C) Rates, Coinsurance maximum, total cost-sharing limits, and other service and/or benefit maximums. Please review the remainder of this SPD for full details about cost-sharing and maximums in this Plan.

[2]The Plan pays eligible expenses for covered services at the Coinsurance level.

[3]For emergency room charges only (excludes Hospital charges. Emergency room visits for actual emergencies are paid at the in-network benefit level.

Prescription Drug Benefit Highlights

Prescription Drug Benefit Cost-sharing[1,2,3,4,5,6,7]		
Traditional Prescription Drug Benefit Options		**You Pay…**
Network[3] Pharmacies	Generic drugs at an Exclusive Choice[1, 7] pharmacy	$0
	Generic drug at other in-network retail pharmacies	$15
	Preferred brand-name[4] drug	$30

Prescription Drug Benefit Cost-sharing[1,2,3,4,5,6,7]		
Traditional Prescription Drug Benefit Options		**You Pay…**
	Non-preferred brand-name[4] drug	$50
CVS Caremark Mail Service	Generic drug	$0
	Preferred brand-name[4] drug	$60
	Non-preferred brand-name[4] drug	$100
	Specialty drugs: Maximum 30-day supply *(must be ordered through CVS Caremark Specialty Pharmacy Mail Service)*	Generic: 30% (max $100) Preferred Brand: 30% (max $300) Non-Preferred Brand: 30% (max $500)

[1]Exclusive Choice is a pharmacy network designed to help lower your prescription costs. For additional information, see the Prescription Drug Benefits chapter.

[2]Subject to the dispense as written (DAW) feature (see the Prescription Drug Benefits chapter).

[3]"Network" means any participating retail network pharmacy. Contact CVS Caremark at the website address listed in the Contact Information chapter to find a participating retail network. If you go out-of-network, must pay your portion of the cost-sharing plus any amount exceeding the cost at a participating retail network pharmacy.

[4]You pay less for brand-name drugs included on the preferred drug list.

[7]The Extended Day Supply (EDS) Network replaces Exclusive Choice in Oklahoma. It includes chain and independent retail pharmacies willing to participate in the network, including the CVS Caremark Mail Service.

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

To be eligible to participate in this Plan, you must:

- Be part of a benefits-eligible classification;
- If you are an active Employee, satisfy one of the Hours of Service Requirements for active Employees described in the section below; and
- Have satisfied the Eligibility Waiting Period, if applicable.

Listed below are the Plan's eligible and excluded classes. See your benefits administrator if you have specific questions about eligibility.

Benefits-eligible Classifications

These Employee classifications are eligible to participate in this Plan:

- Active Employees;
- Dependents of Employees;
- Directors;
- Dependents of Directors;
- Disabled Employees receiving Employer-sponsored long-term disability (LTD) benefits;
- Dependents of disabled Employees receiving Employer-sponsored LTD benefits;
- Under age 65 retired Employees (if covered by the Plan at the time of retirement);
- Under age 65 dependents of retired Employees (if covered by the Plan at the time of retirement);
- Active Employees eligible and enrolled in Medicare Part A on or after January 1, 2023, due to disability or kidney dialysis treatment or a kidney transplant;
- Dependents of Active Employees where the dependent is eligible and enrolled in Medicare Part A on or after January 1, 2023, due to disability or kidney dialysis treatment or a kidney transplant;
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) beneficiaries; and
- Employees on approved leave of absence (see *Your Benefits During a Leave of Absence* chapter for details).

Your Employer treats Employees who are on long-term disability (LTD) (as defined by your Employer's LTD plan) as active Employees for purposes of eligibility to participate in this Plan.

For purposes of Plan eligibility, your Employer defines "retiree" as a former Employee who is under age 65 and has met the following criteria:

- Other: 30 years of service or age 62: Normal Retirement Age 55 and 12 years of service: Early Retirement

These Employee classifications are not eligible to participate in this Plan:

- Directors who joined the Board after the following date: 01/01/2012
- Employees of any subsidiary (including employees of affiliated business)
- Intern (including student intern, work-study student)
- Part-time employee
- Seasonal worker
- Temporary employee

Hours of Service Requirement for Active Employees

As a **full-time active Employee**, you must satisfy one of these Hours of Service Requirements:

- Upon hire (or status change), you are expected to work at least 1,000 hours for your Employer as an active Employee during your first 12 months of employment;
- Upon hire (or status change), you had worked at another participating Employer within the past six months and had met the eligibility requirements at the prior participating Employer; or
- At the time of annual enrollment, you had worked at least 1,000 hours for your Employer in the preceding calendar year.

Coverage for Your Dependents

If you are eligible to participate, then each of your dependents who individually satisfies one of the following requirements may also participate in the Plan. For certain dependents, you may be required to provide documentation to NRECA to support eligibility (see *The Plan's Right to Audit* section in this chapter).

Eligible dependent(s) must be:

- Your spouse (spouse means the person to whom a Participant is legally married under applicable state law, provided that such marriage is recognized as a legal marriage by the state in which the Participant's Employer has its principal place of business);
- Your domestic or civil union partner, if your domestic partnership or civil union is registered in any state (consult your personal tax advisor about the tax consequences of covering your domestic or civil union partner);
- Your child[1] (married or unmarried), up to age 26 who is:
    - Your biological child;
    - Your stepchild by marriage or registered domestic or civil union partnership;
    - A child adopted by you (or placed for adoption with you); or
    - A child for whom you have legal guardianship;
- Your child[1] who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under your group health plan (if the child is eligible as stated above); or
- Your incapacitated adult child[1].

---

[1]A dependent child's coverage ends at 11:59 pm on the last day of the month in which he or she reaches age 26.

Eligibility Requirements for Incapacitated Adult Children

Coverage for a child may continue past the age limit if the child is incapable of self-sustaining employment because of a mental or physical disability, and if your child:

- Is at least 26 years of age;
- Is unmarried;
- Qualifies as your tax dependent on an annual basis because he or she is permanently and totally disabled (as defined by the Internal Revenue Service [IRS] in Publication 501); **and**
- Has been continually covered as your eligible dependent under the NRECA Medical Plan on the date just prior to the date participation would have ended due to age or another insurer prior to attaining age 26.

If all above criteria are met, then you may enroll your incapacitated adult child at one of the following times:

- During your designated enrollment period for newly hired and newly eligible Employees;
- During annual benefits enrollment; or
- Within 31 days of a life or employment event.

When you initially request dependent coverage for an incapacitated adult child (and each year thereafter during annual enrollment), you must fill out the *NRECA Statement of Dependency (SOD)* form. This form provides proof of the dependent's incapacity, prior coverage, and tax dependency. NRECA reviews the form and approves or denies coverage. At any time, the Plan may ask for additional documentation to verify one or more of your dependents' eligibility.

Subject to the *Date Your Insurance for Your Spouse and Child Ends section*, your child's coverage continues:

- While such child remains incapable of self-sustaining employment because of a mental or physical disability;
- If the SOD form is completed and approved when required; and
- While such child continues to qualify as a child, except for the age limit.

You and Your Spouse or Child Work for Participating Employers

One person cannot be simultaneously covered by the Plan as 1) an Employee, Director, or retiree; and 2) a spouse, domestic partner, civil union partner, or child. Also, the same individual may not be covered under more than one NRECA group Medical Plan at one time.

Current Spouse or Domestic or Civil Union Partner

If both you and your current spouse or domestic or civil union partner work for a participating co-op and are eligible for coverage separately (as an Employee, Director, or Retained Attorney), you will each be covered individually at your respective Employers. However, if you wish to cover eligible dependent children, **four** options are available:

- You enroll in individual coverage while your spouse or domestic or civil union partner and dependent children enroll in Employee plus child(ren) or family coverage;
- Your spouse or domestic or civil union partner enrolls in individual coverage while you and your dependent children enroll in Employee plus child(ren) or family coverage;
- You enroll in family coverage (including your spouse or domestic or civil union partner and eligible-dependent children), and your spouse or domestic or civil union partner has no coverage under his or her own employment record; or
- Your spouse or domestic or civil union partner enrolls in family coverage (including you and your eligible dependent children), and you have no coverage under your own employment record.

Former Spouse or Domestic or Civil Union Partner

If both you and your former spouse or domestic or civil union partner work for a participating Employer and are eligible for coverage separately (as an Employee, Director, or Retained Attorney), you will each be covered individually at your respective Employer. However, if you wish to cover eligible dependent children, **two** options are available:

- **Your** enrollment election includes your jointly eligible dependent children. Therefore, your former spouse's (or your domestic or civil union partner's) enrollment election must **exclude** your jointly eligible dependent children; or
- Your **former spouse's or domestic or civil union partner's** enrollment election includes your jointly eligible dependent children. Therefore, your enrollment election must **exclude** your jointly eligible dependent children.

If You Are Both a Retiree and an Employee

If you are a retiree **and** an Employee of a participating Employer and are eligible for coverage separately (as an Employee, retiree, Director, or Retained Attorney), you are not permitted to be

covered under more than one NRECA Group Medical Plan at a time. Rather, you must choose to be covered as an Employee, retiree, Director, or Retained Attorney.

If both you and your spouse or domestic or civil union partner (or former spouse or domestic or civil union partner) work for or are retired from a participating Employer and are eligible for coverage separately (as an Employee, retiree, Director, or Retained Attorney), you each must choose whether to be covered as an Employee or retiree at your respective Employer. If you wish to cover eligible dependent children, **two** options are available:

- **Your** enrollment election includes your jointly eligible dependent children. Therefore, your former spouse's (or your former domestic or civil union partner's) enrollment election must **exclude** your jointly eligible dependent children; or
- Your **former spouse's or former domestic or civil union partner's** enrollment election includes your jointly eligible dependent children. Therefore, your enrollment election must **exclude** your jointly eligible dependent children.

If Your Dependent Child Is Also an Employee

If your child is employed by a participating Employer and is also eligible for coverage as your dependent, then he or she must choose to:

- Be covered as your dependent;
- Be covered as your former spouse's dependent; or
- Enroll in coverage as an individual Employee.

Eligibility Waiting Period

Upon meeting the requirements described in the *Eligibility to Participate* section of this chapter, you must satisfy your Employer's Eligibility Waiting Period.

The Eligibility Waiting Period is the length of time you must have worked for your Employer before you may enroll in the Plan. Day one of your Eligibility Waiting Period corresponds with the first day you are Actively at Work in a benefits-eligible status.

If you contribute any portion of the premium for coverage, you may enroll in insurance coverage by enrolling in benefits with your Employer using their enrollment process or completing and returning the *NRECA Employee Worksheet* form to your benefits administrator within **31 days** of satisfying your Employer's eligibility waiting period. The form is available from your benefits administrator.

Your Plan's Eligibility Waiting Period

An active employee is eligible to participate in the Plan after: 90 days.

Eligible Directors and Retained Attorneys do not need to satisfy the Plan's Waiting Period. Coverage begins on the date that a Director's term commences or, for a Retained Attorney, on the attorney's hire date. A Director or Retained Attorney who does not enroll within 31 days of such term commencement or date of hire must wait for the next life event, employment event, or annual enrollment period.

Moving from Part-time to Full-time Employment Status During the Year

If you move from part-time to full-time status during the calendar year and:

- If your Employer **excludes** part-time Employees from eligibility for benefits, then your Eligibility Waiting Period begins the date you move into an eligible status; or
- If your Employer **includes** part-time Employees in eligibility for benefits, then your Eligibility Waiting Period began the first day you were Actively at Work in a benefits-eligible status. If you have already met the Eligibility Waiting Period, then you are eligible for coverage immediately.

Rehired Former Employees and Rehired Retirees

A retiree who is rehired into a full-time position is eligible to participate in the Plan on the **date of rehire** if he or she:

- Has been continuously enrolled in the Plan as a retiree since retirement;
- Has maintained COBRA continuation coverage for the duration of the break in service; or
- Incurred a break in service of less than six months immediately preceding rehire.

A former Employee (or retiree) who is rehired into a full-time position **must satisfy the Employer's Eligibility Waiting Period** if he or she:

- Has not been continuously enrolled in the Plan as a retiree since retirement;
- Has not maintained COBRA continuation coverage for the entire break in service; or
- Incurred a break in service of six months or longer immediately preceding rehire.

Note: If part-time employment is a benefits-eligible status at your Employer and you are rehired into a part-time position, then you must also satisfy the 1,000 Hours of Service Requirement as a part-time active Employee.

Health ID Card

After you enroll in this Plan, you will receive a health identification (ID) card. You can also go to cooperative.com > My Benefits > My Insurance to print a health ID card or order a new health ID card. Present your card each time you visit a provider.

When Coverage Begins (Participation Date)

You are covered under this Plan on either the Plan's effective date or the date you meet the eligibility criteria, whichever is later. See the *Eligibility to Participate* and *Eligibility Waiting Period* sections in this chapter.

Cost of Coverage

You and your Employer share the cost of your coverage and, if applicable, your dependents' coverage as follows:

- **Active Employees:** The employer pays 100% of the cost of your coverage.
- **Dependents of Employees:** You and the employer share in the cost of the coverage.
- **Directors:** You and the employer share in the cost of the coverage.
- **Dependents of Directors:** You and the employer share in the cost of the coverage.
- **Disabled Employees:** The employer pays 100% of the cost of your coverage.
- **Dependents of disabled Employees:** You pay the entire cost of your coverage.
- **Under age 65 retired Employees:** The employer pays 100% of the cost of your coverage.
- **Under age 65 dependents of retired Employees:** You pay the entire cost of your coverage.

Your Employer will give you specific information about the cost of your coverage before you enroll in the Plan, whether at your initial enrollment, annual enrollment, or special enrollment. The cost of this coverage is subject to your Employer's policies and can change at any time.

Making Changes During the Year and Special Enrollment

If you experience one of the events listed below, you may be able to add, change, or drop coverage for yourself or your dependents. Also, if you decline coverage during your initial enrollment period and later experience one of the events listed here, you may qualify to add coverage for yourself and

your eligible dependents. If you experience a qualifying event, you have 31 days from the date of the event to request enrollment or disenrollment. You may enroll new dependents as indicated if they satisfy the requirements for Plan eligibility.

Events include:

- Marriage;
- Divorce or annulment;
- Birth, adoption, placement for adoption, or court-appointed legal guardianship of your dependent child;
- Death of your spouse or dependent child;
- Loss of or enrollment in other group or individual health plan coverage (see *Losing Other Coverage* below);
- Changes in your employment status (e.g., part-time to full-time, completion of an Employer trial work period or Waiting Period, going on or returning from an Employer-approved leave of absence, going on or returning from long-term disability leave, termination of employment, or retirement) that would make you eligible to participate in the Plan or to make a change to your Plan elections; or
- Annual enrollment, if offered by your Employer.

If you use your Employer's Internal Revenue Code Section 125 plan to make premium payments for coverage on a pre-tax basis, **the requested election change must be consistent with one of the change-in-status events listed above.** For example, if an employee divorces, the employee may drop coverage for the spouse and stepchildren, if applicable, but not for himself or herself or other covered dependents.

Coverage changes in this Plan, if elected on a timely basis, are effective retroactively to the date of the divorce, marriage, birth, adoption, placement for adoption, or legal guardianship. If you (as an Employee) or your spouse are not currently enrolled, you may enroll yourself and your spouse when you enroll a new dependent child.

If you do not enroll new dependents within **31 days**, you must wait until the next event in the list above, change in employment status, or annual enrollment to obtain coverage for the new dependent.

Contact your benefits administrator if you have questions about qualifying events.

Note: If you are an active Employee (or the dependent of an active Employee) who is covered under this Plan and you become eligible for Medicare but this Plan does not provide creditable prescription drug coverage, you may be eligible to elect an alternate NRECA Medical Plan (if your Employer offers one). Mid-year changes from a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) to a non-HDHP may result in excess HSA contributions. The excess HSA contributions may result in imputed income on your personal federal income tax return. You must elect coverage under the alternate Plan within 31 days of Medicare eligibility. If you believe you qualify, contact NRECA Employee Benefit Services at 866.673.2299 for further information and eligibility requirements.

Losing Other Coverage

If you 1) declined medical coverage for yourself or your dependents because you have other medical coverage and 2) either you or your dependents later lose the other medical coverage, those who lost coverage may qualify for **special enrollment** in this Plan. Your new enrollment form must be completed within 31 days of the date medical coverage was lost.

A loss of other medical coverage qualifies for special enrollment treatment **only** if **one** of the following conditions is met:

- You, as an Active Employee, or your dependents were covered under another group or individual medical plan or another group or individual medical insurance policy (through or

outside of a Health Insurance Marketplace) at the time you were eligible for medical coverage under this Plan, and you or your dependents lose such coverage through no fault of your/their own; or

- You, as an Active Employee, or your dependents lost the other group medical coverage because you exhausted COBRA continuation coverage, and either you were no longer eligible under that plan or an Employer's contributions under that plan stopped.

Note: You and your spouse do not have special enrollment rights if your coverage ended either because you failed to pay premiums on time or because your coverage was terminated for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact.

Special Rules for Retirees and Their Covered Dependents

If you are a covered retiree, you may drop your coverage or your dependents' coverage at any time during the year without a life or employment event. To do so, you must notify your benefits administrator within **31 days** of the requested date of coverage change. However, if you drop your coverage or your dependents' coverage, you are not permitted to re-enroll yourself or your dependents in such coverage.

If you are a retiree who is currently enrolled in the Plan and you are under age 65, and you acquire a new dependent through marriage, adoption, birth, placement for adoption, or legal guardianship, you may enroll the new dependent within 31 days of acquiring such dependent to the extent such new dependent is otherwise eligible.

Note: Retirees and dependents of retirees are not eligible for special enrollment opportunities that arise from their loss of other coverage.

Special Rules for Covered Directors

Directors who are covered under this Plan may drop coverage for themselves or their dependents at any time during the year for any reason. To drop coverage you must notify your benefits administrator within **31 days** of the desired date of coverage change. Directors who drop coverage for themselves or their dependents may re-enroll in this Plan during their Employer's annual enrollment period or within 31 days of a qualifying life or employment event.

If you are a Director and your Employer offers retiree coverage, you must be covered on the day your Directorship ends to be eligible to continue coverage as a retired Director.

Special Enrollment Rights Under CHIP

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, you and your dependents who are covered by this Plan may be eligible for a special opportunity to enroll in (or withdraw from) the Plan, as applicable, under the following conditions:

- If you or your dependents lose coverage under your state's CHIP or Medicaid program, you may be able to enroll yourself and your dependents in this Plan, provided that you request enrollment within 60 days after the termination of your state's CHIP or Medicaid coverage;
- If you or your dependents become eligible for a premium assistance subsidy under your state's CHIP or Medicaid coverage, you may be able to enroll yourself and your dependents in this Plan, provided that you request enrollment within 60 days after eligibility is determined; or
- If you or your dependents become eligible for coverage under your state's CHIP or Medicaid program, you and your dependents have the right to withdraw from this Plan the first day of the month after you give notice to your Employer.

Qualified Medical Child Support Order (QMCSO)

The Plan extends benefits to an Employee's noncustodial child, as required by any QMCSO, under the Employee Retirement Income Security Act of 1974 (ERISA) §609(a), to the extent such child is otherwise eligible to be covered under the Plan. The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

When Coverage Ends

Your coverage ends at termination of employment.

Your coverage (and your dependents' coverage) ends if:

- You fail to pay your share of the premium;
- Your hours worked drop below the required eligibility threshold;
- You are no longer in a status that is eligible to participate in the Plan;
- **You retire after age 65**, your coverage ends on your last day of employment if you do not elect retiree coverage. If you elect retiree coverage, your coverage will end on the last day of the month;
- **You retired prior to age 65**, coverage ends on the last day of the month prior to when you turn 65 unless your birthday falls on the first day of the month. In that case, your coverage ends on the last day of the second month prior to your 65th birthday. If Medicare becomes your primary payer prior to age 65, you are no longer eligible for prescription drug coverage under the Plan unless the Plan, in its sole discretion, determines that comparable Medicare Part D prescription drug plan coverage is not available. If you are not able to obtain comparable replacement Medicare Part D prescription drug coverage, you must contact your benefits administrator or the Member Contact Center so that they can contact the Plan to request your continued prescription drug coverage under the Plan;
- **You are the dependent spouse of a retiree**, your coverage ends the last day of the month prior to when you turn 65 unless your 65th birthday falls on the first day of the month. In that case, your coverage ends on the last day of the second month prior to your 65th birthday. If Medicare becomes your primary payer prior to age 65, you are no longer eligible for prescription drug coverage under the Plan unless the Plan, in its sole discretion, determines that comparable Medicare Part D prescription drug plan coverage is not available. If you are not able to obtain comparable replacement Medicare Part D prescription drug coverage, you must contact your benefits administrator or the Member Contact Center so that they can contact the Plan to request your continued prescription drug coverage under the Plan;
- **You are the dependent child of a retiree**, your coverage ends when you no longer meet the Plan's dependent child eligibility requirements. If Medicare becomes your primary payer, then you are no longer eligible for prescription drug coverage under the Plan unless suitable replacement Medicare prescription drug coverage is not available. You must contact your benefits administrator or the Member Contact Center if you are not able to obtain suitable replacement prescription drug coverage to retain your prescription drug coverage under the Plan;
- **You are an Active Employee that becomes entitled to Medicare**, and you request to discontinue your coverage under this Plan due to Medicare enrollment. Under these circumstances, your coverage shall terminate at the end of the month in which notification of your request has been provided to the Plan;
- **You are a Medicare-disabled Employee** for whom Medicare becomes the primary payer, and request to discontinue coverage under this plan because you enrolled in Medicare Part D prescription drug coverage or other comparable coverage;
- **You are the Medicare-eligible dependent spouse or a Medicare-eligible dependent child of an Employee** for whom Medicare becomes the primary payer, and request to discontinue coverage under this plan because you enrolled in Medicare Part D prescription drug coverage or other comparable coverage;
- You or your dependents submit false claims or misuse health ID cards;
- You or your dependents 1) intentionally misrepresent a material fact concerning eligibility for Plan coverage or benefits or 2) commit fraud to obtain Plan coverage or benefits. (In either case, coverage termination will be retroactive to the date of ineligibility and you, or your dependents, will receive 30 days' advance written notice of coverage termination. See the *Rescission of Coverage* section below. An intentional misrepresentation of fact includes, but is

not limited to, your failure to report a divorce, a change in your dependent's eligibility status, or any other change in eligibility status in accordance with Plan terms.); and

- Your uncompensated leave of absence exceeds the thresholds outlined in the *Your Benefits During a Leave of Absence* chapter.

Your coverage ends on the date your Employer no longer offers the Plan. Your coverage also ends if:

- The Plan terminates;
- The Employer terminates its participation in the Plan;
- You voluntarily make a permitted election to drop coverage; or
- You die.

In all of the above cases, coverage for your spouse and children ends when your coverage ends with one exception. If you voluntarily make an election to drop coverage due to Medicare enrollment at open enrollment or initial Medicare enrollment, your spouse and dependent may continue coverage for as long as they otherwise remain eligible. Dependent coverage also ends:

- For a spouse, upon divorce at 11:59 pm the last day before your divorce is official. Your official divorce date is your first day without coverage under the Plan;
- For a domestic or civil union partner, when the partnership terminates at 11:59 pm the last day before your partnership terminates. Your first day as non-partners is your first day without coverage under the Plan;
- For any dependent, when he or she no longer meets dependent eligibility requirements (i.e., a step-child in the event of a divorce or death of the natural parent);
- When you voluntarily make a permitted election to drop a dependent's coverage; or
- When your covered dependent dies.

Rescission of Coverage

Rescission of Coverage means cancellation, termination, or discontinuance of coverage effective as of a past date on which you became ineligible. The Plan will rescind your (or your dependents') coverage with 30 days' advance written notice if, in its sole discretion, the Plan determines that your fraud against the Plan or your intentional misrepresentation of a material fact resulted in eligibility for you or your dependents when in fact you (or your dependents) were not eligible.

An *intentional misrepresentation of fact* includes, but is not limited to, your failure to report a divorce, a change in your dependent's eligibility status, or any other change in eligibility status in accordance with Plan terms. Enrolling an ineligible individual or failure otherwise to comply with the Plan's eligibility requirements constitutes fraud or an *intentional misrepresentation of material fact*.

The following coverage terminations are **not** Rescissions of Coverage and do not require the Plan to give you 30 days' advance written notice of coverage termination:

- The Plan terminates your (and your dependents') coverage retroactive to your employment termination date or the date you made a change in coverage election when 1) there is a delay in your Employer's administrative recordkeeping that results in your Employer's failure to notify the Plan of your termination of employment or of a change in coverage election in a timely manner, 2) you paid no Plan premiums or contributions after your employment termination date or the date you made a change in coverage election, and 3) no claims have been paid by the Plan;
- You failed to pay timely, required premiums or contributions for Plan coverage and, as a result, the Plan terminates your (and your dependents') coverage as of the last coverage date for which you did pay required Plan premiums or contributions on time; or
- The Plan retroactively terminates coverage for either your former spouse or your stepchildren, as of your divorce date, when 1) the Plan is not notified of the divorce in a timely manner and 2) the full COBRA premium has not been paid by your former spouse.

When the Plan's coverage of you (or your dependents) should not have occurred because of an unintentional mistake or error, the Plan will terminate that coverage prospectively—going forward—once the mistake or error is identified. Because such termination is not a Rescission of Coverage, the Plan will not give you 30 days' advance written notice.

Moving from Full-time to Part-time Employment Status During the Year

Your Employer **excludes part-time Employees** from benefits eligibility. If you move from full-time to part-time status during the calendar year:

- Coverage will end at 11:59 pm on the last day you are considered full-time.

Misuse of Plan Health ID Card

The health ID card issued by the Plan to you and your dependents is for identification purposes only and must be used only by you and your covered dependents. Possession of a health ID card confers no right to services or benefits under this Plan. Misuse of the card is grounds for termination of your coverage, as described above.

Continuation of Coverage

You must be covered on your last day of employment to be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For details, see the *Continuing Coverage Under COBRA* chapter.

Note: If you are covered by this Plan as an active Employee, Director, or Retained Attorney and you voluntarily drop coverage because you become eligible for Medicare, you and your dependents cannot elect COBRA coverage to continue coverage under this Plan.

Continuation and reinstatement rights may be available if you are absent from employment to perform uniformed service governed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For details, review the section about USERRA in the *Your Benefits During a Leave of Absence* chapter.

The Plan's Right to Audit

The Plan reserves the right to audit your eligibility (and your dependents' eligibility) by requesting substantiating documentation. In the event either you or your dependent(s) are later found to be ineligible for coverage, coverage may be canceled retroactively to the date of ineligibility and the Plan will seek to recover any claims paid on your behalf or on behalf of the ineligible dependent(s). Enrollment of an ineligible individual, whether yourself or your dependent, will be treated by the Plan as an intentional misrepresentation of material fact or fraud.

Chapter 4: Your Benefits During a Leave of Absence

General Information

A leave of absence means time away from work, as permitted by your Employer, for reasons such as military duty, family care, disability, or personal needs. **Time away from work does not include time off as a result of disciplinary suspension.**

Depending on the types of leaves your Employer offers, you may remain eligible to participate in this Plan while you are on a leave of absence. How you (or your Employer) pay for your Plan premiums during a leave of absence may vary. **Remember that the specific Plan provisions described in the individual chapters of this SPD continue to govern the administration of benefits during your leave of absence**.

Your leave of absence may be protected under either the **Family and Medical Leave Act** (FMLA) or the **Uniformed Services Employment and Reemployment Rights Act of 1994** (USERRA). Specific sections later in this chapter describe each of these leave types in more detail.

If you have questions about your own leave of absence, contact your benefits administrator.

Compensated and Uncompensated Leave of Absence

Your approved leave of absence may be **compensated** or **uncompensated** based on the sources of income you receive during your leave of absence.

Compensated leave means the period of time that you are **not** Actively at Work and you **are** receiving one or more of the following sources of income:

- Base wages (pay) for time worked;
- Accrued, unused paid time off (such as sick leave, vacation leave, or personal leave);
- Holiday pay (including pay for floating or variable holidays);
- Pay by your Employer for other time away from work (e.g., bereavement, community service, general election voting, jury duty, weather closings);
- Remuneration for your services as a Director;
- Short-term Disability benefits from your Employer;
- Long-term Disability benefits from your Employer;
- Military supplement pay; or
- Salary continuation programs and extended illness benefits.

Uncompensated leave means the period of time that you **are not** Actively at Work and **are not** receiving one or more of the income sources listed above.

Eligibility to Participate During Your Leave of Absence

If your employment continues and you are on an Employer-approved **compensated** leave of absence, eligibility to participate in this Plan generally continues as long as the required applicable premium is paid.

If you are on an Employer-approved **uncompensated** leave of absence, eligibility to participate in this Plan may continue for up to 90 calendar days as long as the required applicable premium is paid. If you obtain other employment during your uncompensated leave of absence, your eligibility to participate may end before 90 calendar days.

Note: If you participate in your Employer's long-term disability (LTD) plan and either you have a claim pending with that plan (an initial claim, a claim for which an appeal is pending, or a claim for which the appeals filing deadline has not expired) or you are waiting for the LTD plan's Benefit Waiting Period to end, then your eligibility to participate in this Plan continues as long as the required premium is paid. If your LTD claim is approved, continued eligibility to participate in this

Plan depends on your Employer's policy. If your LTD claim is denied, then your eligibility to participate in this Plan ends on either the date your initial claim is denied or the date your claim is denied on appeal.

Annual Benefits Enrollment

When you are on a leave of absence and are eligible to continue to participate in this Plan, you may generally make benefit elections (subject to all Plan enrollment provisions) during the annual benefits enrollment period for the upcoming Plan year. Benefits elected during the annual benefits enrollment period and corresponding costs for coverage (subject to late enrollee requirements where applicable) become effective January 1 of the following year.

Paying for Benefits During Your Leave of Absence

You or your Employer must make the required premium payments for your benefit coverage while you are on a leave of absence. If your benefits coverage terminates due to nonpayment of premiums, reinstatement or re-enrollment options will vary when you return to work in a benefits-eligible position immediately following your leave. See the *Returning from a Leave of Absence* section below for details.

Returning from a Leave of Absence

If your premiums were paid while you were on a leave of absence and you return to work in a benefits-eligible position immediately afterward, then your benefit elections will continue on your return.

If you return to work immediately following the end of your approved leave, you are eligible to re-enroll in this Plan. Your coverage is effective on the date you return to work. For additional information, contact your benefits administrator or see the *Making Changes During the Year and Special Enrollment* section in the *Eligibility and Participation Information* chapter.

Different requirements may apply when you return from a leave of absence that is protected under FMLA or USERRA. For additional information, see the sections in this chapter about FMLA and USERRA.

If You Terminate Employment While on a Leave of Absence

If your employment ends either during or at the end of your leave of absence and your benefits coverage was not terminated during the leave, you or your Employer must make any required premium payments that did not occur. If you do not pay for all elected benefit coverages by the due date, your coverage will end **on the date of termination**. If your coverage terminates due to premium nonpayment, you may lose eligibility for COBRA continuation coverage.

Workers' Compensation

Your period of workers' compensation may be either compensated (paid) or uncompensated (unpaid), depending on whether you receive income from any source listed in the *Compensated and Uncompensated Leave of Absence* section in this chapter. If you receive one of these income types, then you are eligible to continue your benefits until your compensated leave ends. If your workers' compensation is considered an uncompensated leave, your coverage will end on the last day worked.

Family and Medical Leave Act (FMLA)

Basic Leave Entitlement

FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees. The following leaves of absence are protected under FMLA:

- Incapacity due to pregnancy, prenatal medical care, or childbirth;
- To care for the Employee's child after birth or placement for adoption or foster care;
- To care for the Employee's spouse, son, daughter, or parent who has a serious health condition; or
- A serious health condition that makes the Employee unable to perform his or her job.

If your leave is protected under FMLA, then until you return to work your Employer will continue to maintain your benefits if you elect to continue coverage and make the required premiums. If you do not choose to continue coverage during your FMLA leave, when you return to work your Employer will reinstate your coverage to the extent required by FMLA.

If you and your Employer are covered by FMLA and you do not return to work at the end of your FMLA leave of absence, you may be entitled to elect COBRA, even if you withdrew from coverage under this Plan during the leave.

Military Family Leave Entitlements

Eligible Employees whose spouse, son, daughter, or parent is on (or called to) covered active duty may use their 12-week FMLA entitlement for certain related purposes. Examples include attending certain military events, arranging for alternative child care, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

Under FMLA, eligible Employees may also take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

- A current member of the armed forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list for a serious injury or illness; or
- A veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA leave to care for the covered veteran and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.

For specific information about your co-op's benefits during an FMLA-covered leave, contact your benefits administrator.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under USERRA, if you begin an authorized military leave of absence to serve on active duty in 1) the U.S. Armed Forces or 2) the National Guard of a state that is called to federal service, you have certain employment and Employee benefit rights during and after your duty.

Military Leave of 31 or Fewer Days

There is no impact to this Plan's benefits coverage for you or your covered dependents.

Military Leave Longer than 31 Days

Your Plan coverage can continue through the first 24 months of an approved military leave to the extent required by USERRA, as long as you do not voluntarily drop coverage and continue to pay your portion of the premiums.

You may drop your Plan coverage when you begin military leave. Coverage stops if you stop paying your contributions or portion of the premiums or if you cancel coverage, as allowed under USERRA. The change in coverage will generally be effective the date your military leave begins.

If you drop your coverage when you start military leave, or if your coverage lapses or terminates due to nonpayment, and you later return to work in a benefits-eligible position within the applicable job reinstatement period, then your coverage and contributions can be reinstated to the extent

required by USERRA. Coverage is effective upon your reemployment. If you do not reinstate your coverage within 31 days of your reemployment, then you may not re-enroll until the next annual enrollment period, unless you have an applicable special enrollment right, life event, or employment event. For more information, see the *Special Enrollment Rights Under CHIP* and *Making Changes During the Year and Special Enrollment* sections in the *Eligibility and Participation Information* chapter.

For specific information about your co-op's benefits and premium requirements during military leave, contact your benefits administrator.

Chapter 5: Medical Plan Benefits

How the Plan Works

This Plan provides medical benefits and services to eligible Employees and their covered dependents. Your Plan benefits include medical and surgical services and supplies, medications, Mental Health, and Substance-related Disorder benefits, along with certain other services and programs (such as chiropractic care) as elected by your Employer and described in detail later in this chapter.

Medical benefits are administered by Cooperative Benefit Administrators (CBA) and prescription drug claims by CVS Caremark.

Cost-sharing

You will share in your health care costs through certain cost-sharing features that are described in detail in this chapter and defined in *Appendix A: Key Terms.*

- A **Deductible** is the amount of eligible health care expenses that you must pay in a calendar year before the Plan begins to pay benefits. The annual Deductible counts toward your annual out-of-pocket maximum.
- A **Copayment** is a flat dollar amount that you must pay for a specific covered service, such as a Physician's office visit.
- **Coinsurance** is a percentage of an eligible expense that you pay for covered health services, generally after you have met your Deductible. Your Coinsurance amount may vary depending on the provider you visit.
- **Eligible expenses** (or covered charges) are the charges for services that are covered and provided by the Plan, subject to the claims administrator's guidelines.

The Deductible

All services except preventive services count toward the annual Deductible. Copayments (for office visits, prescription drugs, etc.) do not count toward your Deductible.

Your in-network and out-of-network Deductibles (see the *Plan Highlights* chapter) are actually a combined Deductible. Amounts that count toward the in-network Deductible also count toward the out-of-network Deductible and vice versa.

Each individual covered under the Plan must satisfy his or her annual Deductible (or contribute to the family Deductible) before the Plan will begin to pay benefits for that person in a calendar year.

If you are enrolled in family coverage, then you will have a **family Deductible**. Eligible expenses for all family members count toward the family aggregate Deductible. For each family member, the maximum applied is the individual annual Deductible.

Here is an example of how Michelle and her family can meet their family Deductible. In this example, Michelle's individual Deductible is $800 and her family Deductible is $1,600. The family Deductible could be met as shown below. **Once the family Deductible is met, individual family members are no longer subject to the individual Deductible amounts.**

Family Member	Deductible Paid
Michelle	$800 (meets individual Deductible)
Michelle's Spouse	$550
Michelle's Child	$250

Family Member	Deductible Paid
Total	**$1,600** (meets family Deductible)

Coinsurance and Copayments

For most covered medical treatments and services, you and the Plan will share the cost of medical expenses once your Deductible is satisfied. You will pay a percentage, and the Plan will pay the remaining percentage. This is called Coinsurance.

Generally, in-network providers are reimbursed for covered services at a higher Coinsurance level than out-of-network providers.

In other cases (such as for Physician's office visits), you may need to pay a specific-dollar amount toward the cost. This is known as a Copayment.

See the *Plan Highlights* for a list of the Coinsurance percentages and applicable Copayment amounts for the medical treatments and services covered under the Plan.

Annual Out-of-Pocket Coinsurance Maximum

The limit on how much you and your family must pay toward covered medical treatments and services each calendar year is called the annual Out-of-Pocket (OOP) Coinsurance Maximum.

The following amounts do not count toward the annual OOP Coinsurance Maximum:

- Amounts above R&C Rates;
- Any 20% reduction in eligible expenses for failure to Preauthorize through SHARE (see the *Services and Supplies that Require Preauthorization by SHARE* section for details); and
- Expenses for services not covered by the Plan.

If you are enrolled in family coverage and you have reached the annual family OOP Coinsurance Maximum, the Plan will pay covered expenses at 100% for all covered family members for the remainder of the calendar year. Amounts that count toward the in-network OOP Coinsurance Maximum also count toward the out-of-network OOP Coinsurance Maximum and vice versa.

Note: The family annual OOP Coinsurance Maximum equals the total out-of-pocket expenses incurred by all family members. Each family member never has to meet more than the individual annual OOP Coinsurance Maximum.

Total Cost-sharing Out-of-Pocket Maximum

The limit to how much you and your family must pay toward covered medical treatments and services in a calendar year is called the total Cost-sharing Out-of-Pocket (OOP) Maximum.

Once you have reached your total Cost-sharing Out-of-Pocket Maximum for medical and prescription drug expenses, the Plan pays your eligible expenses for the remainder of the calendar year as outlined in the *Overview of Your Cost-sharing* chart.

Because medical claims are processed by Cooperative Benefit Administrators (CBA) and prescription drug claims by CVS Caremark, the Plan’s records may not immediately reflect your total cost-sharing out-of-pocket expenses. For this reason, you may need to pay for a medical or a prescription drug expense even though you have met the annual OOP Coinsurance Maximum. If this occurs, CBA will issue you a refund.

Provider Networks and Reimbursement Rates

The Plan will pay covered charges for Physician’s visits and for Hospital, surgical, and other medical services and supplies (including prescription drugs) at the Coinsurance level listed in the *Overview of Your Cost-sharing* chart (in the *Plan Highlights* chapter). Under the Plan, you may

choose to visit any Physician; however, visiting preferred providers may mean lower costs for you because those providers have agreed to accept set fees for their services.

Find Care & Costs

Find Care & Costs is an interactive online resource that enables you to make more optimal choices when seeking care for you and your family.

The Find Care tool enables NRECA Medical Plan participants to search for participating network providers by service and specialty.

The Find Cost Estimates tool provides a range of the average costs for medical procedures in your area. You can search using simple, intuitive terms like ‘knee pain’ or ‘baby’ and see a list of services/care paths that you can select from and drill down for further details.

You can also use the tool to identify covered services and items and provide cost estimates that will also take into account your Plan cost-sharing accumulators including Copayments, Deductibles, and/or Coinsurance.

In addition to serving participants better, these enhancements make price comparison information available to you highlighting provider-specific cost and quality of care information as required by federal law.

NRECA Medical Plan participants can access Find Care & Costs on the NRECA Employee Benefits website by going to cooperative.com > My Benefits > My Insurance > Find Care & Costs. Once there, you will see links for Find Care and Find Cost Estimates.

Surprise Billing and the No Surprises Act

Emergency Services

For covered health care services that are Emergency Services provided by an out-of-network provider, you are not responsible for amounts in excess of your applicable co-pays, deductibles and/or coinsurance, based on the lesser of the amount billed or the Qualifying Payment Amount as defined in this SPD. The Plan shall calculate any cost-sharing payments for Emergency Services toward any applicable in-network deductible or out-of-pocket maximum as if your or your family’s cost-sharing payments applied to an in-network provider or in-network emergency facility.

Note: You could receive balance bills for post-stabilization services after the receipt of Emergency Services if your attending Physician or treating provider determines that you can travel to an in-network facility using nonmedical or nonemergency transportation, but you chose to stay at the out-of-network facility, if the notice and consent requirements have been satisfied, and the provider or facility acts in compliance with applicable state laws.

Coverage of Non-Emergency Services Performed by Out-of-Network Providers

For covered health care services that are not for Emergency Services furnished to you or your dependent by an out-of-network provider with respect to any covered item or service at an in-network health care facility, you are not responsible for amounts in excess of your applicable Copayment, Deductible and/or Coinsurance, based on the lesser of the amount billed or the Qualifying Payment Amount as defined in this SPD, unless such charges are permitted to be waived through your notice and consent and the out-of-network provider’s notice meets certain criteria. The Plan shall calculate any cost-sharing payments for these covered items or services toward any in-network Deductible or out-of-pocket maximum as if your or your family’s cost-sharing payments applied to an in-network provider or in-network health care facility.

The following charges are **not permitted** to be balance billed by the provider to you even if the provider obtains your notice and consent:

- Items or services furnished as a result of an unforeseen, urgent medical need arising at the time an item or service is furnished;
- Ancillary charges, including:
    - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-physician practitioner;
    - Items and services provided by assistant surgeons, hospitalists, and intensivists;
    - Diagnostic services, including radiology and laboratory services; and
    - Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Coverage of Air Ambulance Services

For otherwise covered Air Ambulance services furnished by an out-of-network provider, you are not responsible for amounts in excess of your applicable Copayment, Deductible and/or Coinsurance, based on the lesser of the amount billed or the Qualifying Payment Amount. The Plan shall calculate any cost-sharing payments for covered out-of-network Air Ambulance toward any in-network Deductible or out-of-pocket maximum as if your or your family's cost-sharing payments applied to an in-network provider or in-network health care facility.

Reasonable and Customary (R&C) Rates

The R&C Rate for any service or supply is the amount usually charged by providers in the same general area for the same service or supply. The R&C Rate for any service or supply is the usual charge for the service or supply in the absence of insurance, but not more than the prevailing charge for a like service or supply in the geographic area.

A **like service** is a service of the same nature and duration that requires the same skill and is performed by a provider of similar training and experience.

A **like supply** is a supply that is identical or substantially equivalent.

Area means the municipality (or, in the case of a large city, the subdivision of it) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service or supply.

When determining applicable R&C Rates, CBA in its sole discretion consults industry-wide databases, which may include, without limitation, Fair Health and a factor of Medicare rates, and relies on the methodologies of third parties, whether or not such databases and third parties are listed in the Plan. CBA may also consider factors such as:

- The nature and duration of the service;
- The skills required to perform that service;
- The training and experience of the provider who performs the service; and
- The medical supplies necessary for the treatment or service.

R&C Rates do not apply to services you receive from providers in your primary Preferred Provider Organization (PPO) network because in-network providers have pre-negotiated contracted fees for their services. Charges from providers who are not in your primary PPO network(s) (also called non-participating providers) are subject to R&C Rates. If your provider charges more than the R&C Rates, you must pay any amounts over those limits. In addition, the Plan may require a Copayment when you visit a Physician or an emergency room. See *Appendix A: Key Terms* for the definition of R&C Rates.

Evaluation of Services

When evaluating submitted or billed charges to determine which are eligible, the Plan also reviews how each procedure or service is coded. The Plan will pay benefits based on industry coding standards when procedures and services commonly considered to be incidental or combined are instead billed or listed separately. Although each Physician has a right to determine how much to charge for his or her services, the Plan will cover the industry standard valuation for the services provided.

Preferred Provider Organization (PPO) Network Discounts

This Plan provides a discount to Participants who use PPO network medical services. Although you may visit any health care provider, you will receive greater discounts when you see providers who are in the Plan's PPO network (known as preferred providers). When you visit preferred providers, you also do not have to fill out claim forms.

Your Plan's PPO network(s) are shown on the front of your health ID card. In some cases, you will have a local PPO and an out-of-area PPO network.

You can find providers who participate in the Plan's local or out-of-area PPO networks in these ways:

- Refer to the logo(s) on the front of your health ID card;
- Log in to cooperative.com and go to My Benefits > Find a Doctor; or
- Call CBA (see the *Contacts Information* chapter) for assistance.

The list of preferred providers changes frequently. Call ahead to verify that your provider or facility still participates in the network.

Remember these facts about primary PPO networks:

- The medical Plan pays 100% of eligible preventive care services received from in-network providers (there is no annual Deductible to satisfy);
- PPO in-network Physicians and Hospitals are not affiliated with, and have not been selected, by your Employer. (In-network providers have no contract with your Employer. The Plan pays PPO in-network providers according to contracted rates that apply only to such in-network providers.);
- Neither the Plan nor your Employer provides or guarantees the quality of the health care that you or a covered dependent receive under the Plan;
- You always have the choice of what services you receive and who provides your care, regardless of what the Plan covers or pays; and
- Even if a Hospital is a PPO in-network provider, some Physicians and other health care providers who practice in that Hospital may not be PPO in-network providers, and vice versa. Services provided by out-of-network providers are not covered at the in-network benefit level except in the situations discussed in the section below.

When In-network Benefits Are Paid for Out-of-Network Providers

The Plan covers eligible inpatient or outpatient Hospital services rendered by ancillary providers (such as surgical assistants, anesthesiologists, hospitalists, and radiologists) at the in-network benefit level. Benefits for covered services from all other specialists (such as cardiologists and oncologists) are paid based on their participation status with the PPO network.

Eligible emergency room charges for an actual Medical Emergency are covered at the in-network benefit level. Emergency surgery or procedure(s) directly related to an emergency room episode of care are covered at the in-network benefit level.

All eligible expenses are subject to possible reduction due to R&C Rates.

When Medicare is your primary plan (and this Plan is secondary), for purposes of coordinating benefits with Medicare, medical charges covered under this Plan are always covered at the in-network benefit level. In all other cases, the benefit level is determined by the PPO network participation status of the provider rendering the service.

Even if a Hospital is a PPO in-network provider, the Physicians and other health care providers who practice at that Hospital may not be, and vice-versa. This Plan covers services provided by out-of-network providers at the out-of-network benefit level, except in the situations discussed in the section above

Transition of Care

If your PPO provider network changes, you can apply for a Transition of Care exception if you have certain medical conditions. If approved by CBA (in its sole discretion), the Plan will provide continued in-network coverage with your current provider for up to six months. A Transition of Care exception will be granted only if:

- Your local PPO network was discontinued or changed; or
- Your employer transferred from another health insurer to the NRECA group medical plan.

Medical conditions or treatments that may be eligible for a Transition of Care exception include, but are not limited to:

- Second or third trimester of pregnancy (up to eight weeks postpartum);
- Moderate or high-risk pregnancies;
- Active courses of cancer treatment (e.g., Chemotherapy, Radiation Therapy);
- Organ transplant patients awaiting a donor or under active treatment; or
- In-patient Hospital admission at the time of the network change.

Treatment of stable conditions, minor illnesses, routine procedures, and elective surgical procedures are not eligible for a Transition of Care exception.

To apply for a Transition of Care exception, contact CBA for a Transition of Care form. Complete the form and return it to CBA. CBA will review the request and approve or deny it based on the Plan's applicable criteria for Transition of Care. If you have questions, contact the Member Contact Center (MCC) at 866.673.2299

Continuity of Care

If your provider ceases to be an in-network provider during your ongoing course of treatment, the Plan will provide you notice of your right to elect Continuity of Coverage for certain ongoing medical conditions or treatments up to 90 days to allow you to receive benefits provided under the Plan under the same terms and conditions as would have applied if your provider didn't cease to be an in-network provider.

If you have the following medical conditions or treatments, you may be eligible for continued coverage under this section:

- You are undergoing a course of treatment for a serious and complex condition;
- You are undergoing a course of institutional or inpatient care;
- You are scheduled to undergo nonelective surgery, including postoperative care;
- You are pregnant and undergoing a course of treatment for the pregnancy; or
- You are or were determined to be terminally ill and is receiving treatment for the illness.

To apply for a Continuity of Care exception, contact UMR for a *Continuity of Care Request* form. Complete the form and return it to UMR. UMR will review the request and approve or deny it based on the Plan's applicable criteria for Continuity of Care. If you have questions, contact the Member Contact Center (MCC) at 866.673.2299.

Secondary Networks

NRECA partners with selected medical provider networks to help you obtain discounted medical services from certain providers who are not in the primary provider network. These additional networks are known as secondary networks.

Each secondary network has a group of participating acute-care Hospitals, ancillary providers, and practitioners. The secondary network logo that appears on the back of your health ID card lets the provider know that you qualify for a discount. Secondary network providers agree to accept the discounted amount as the total eligible charge. Benefits for visits to secondary network providers are paid at the out-of-network level. You are not responsible for balances more than the discounted charge for covered services; however, you must pay any part of the discounted amount that is applied to your out-of-network Deductible and Coinsurance.

Note: The Plan will pay the lesser of the secondary network discounted amount or the R&C Rate. If the Plan pays the R&C Rate, the provider may bill you for the amount more than the R&C Rate in addition to your out-of-network Deductible and Coinsurance. The EOB you receive from CBA will show either the secondary network discount or the R&C Rate.

Negotiated Discounts

NRECA may also negotiate directly with an out-of-network provider to obtain a discount on the provider's standard billed charge. Providers must agree to accept the negotiated amount as payment in full. You are not responsible for balances more than the negotiated discounted charge for covered services; however, you are responsible to pay any part of the discounted amount that is applied to your out-of-network Deductible and Coinsurance.

Note: The Plan will pay the lesser of the negotiated discounted amount or the R&C Rate. If the Plan pays the R&C Rate, the provider may bill you for the amount more than the R&C Rate in addition to your out-of-network Deductible and Coinsurance. The EOB you receive from CBA will reflect either the negotiated discount or the R&C Rate.

Important Facts About Secondary Networks and Negotiated Discounts

- Providers who agree to provide a negotiated discount are not affiliated with and have not been selected by your Employer. These providers have no contract with your Employer. The Plan pays providers the lesser of the negotiated rate or the R&C Rate.
- Secondary network providers are not affiliated with, have not been selected by, and have no contract with your Employer. The Plan pays network providers according to contracted rates and these rates apply only to secondary network providers.
- Neither the Plan nor your Employer provides or guarantees the quality of the medical care that you or a covered dependent receive under the Plan.
- You always have the choice of the services you receive or who provides your care, regardless of what the Plan covers or pays.
- To identify which providers participate in the secondary network, call the contact number for the secondary network on the back of your health ID card.

Coverage While Traveling Outside the United States

For the Plan to cover services obtained outside the United States, these requirements must be met:

- The service must be a recognized service in the United States;
- All provider billings and records must be translated into English;
- Bills must clearly show the patient's name, the provider's name, the date of service, the diagnosis, and a description of the services rendered; and

- The current currency exchange rate must be provided with the bill, showing the daily exchange rate for the dates the services were rendered. If you pay for services using a credit card, the card service will automatically translate the expenses into U.S. currency at the prevailing rate.

Benefits for covered services received outside of the United States will always be paid to the Plan Participant. Participants must pay for all foreign services up front before submitting a claim for charges to the Plan.

The Simplified Hospital Admission Review (SHARE) Program

Coping with an illness or Injury that requires hospitalization can be stressful, confusing, and costly. Understanding your treatment options and which expenses your insurance will cover is important. To help reduce the confusion and costs associated with hospitalization and other medical services, the Plan includes the SHARE program. SHARE is responsible to Preauthorize certain services and supplies for Medical Necessity. Specific services for which you must contact SHARE are listed in the section *What the Plan Covers* of this chapter.

Four Benefits of SHARE

The SHARE program offers the following four medical review services to help you make informed health care decisions:

Hospital Confinement Review

The SHARE program will contact your Physician to perform a Hospital Confinement review as soon as it is notified that a hospitalization has been prescribed.

The SHARE medical review coordinator will discuss with your Physician the reason for your hospitalization and an appropriate length of confinement. The coordinator will evaluate the proposed treatment plan to be sure that the length of your Hospital stay and any recommended convalescent treatments or facility stays are medically appropriate. The coordinator will then mail a Hospital admission confirmation to both you and your Physician.

Although the Hospital admission confirmation approves the medical appropriateness of the proposed hospitalization, it does not guarantee either the payment or amount of benefits. Eligibility for and payment of benefits are subject to all Plan terms. A Hospital admission confirmation is binding, unless the information furnished to the SHARE medical review coordinator was incorrect.

Under the Plan terms, expenses for services or supplies that are not Medically Necessary and for days of inpatient Hospital Confinement that are not Medically Necessary are not eligible expenses. For this reason, all or some days of inpatient Hospital Confinement may not be eligible expenses.

If needed for your condition, SHARE may extend the approved number of days of inpatient Hospital Confinement. To arrange for your Physician to request an extension, you must call the SHARE medical review coordinator before the previously approved length of stay is over. Once you request an extension, the SHARE medical review coordinator determines the need based on the Physician's information. The coordinator then tells the Physician how many days, if any, are approved and sends a written notice to you, the Physician, and the Hospital.

If your Preauthorization review for Medical Necessity or determination of need is not approved by SHARE, you have a right to appeal the decision. See the *Medical Claims and Appeals* chapter for more about the appeals process.

Medical Case Management

If a Hospital admission could require long-term care, a SHARE case manager will be assigned to provide guidance and information about available resources. The patient and family select the most appropriate treatment plan and the SHARE case manager coordinates and implements the Plan.

Medical case management is a voluntary service. Your benefits are not reduced and you are not penalized if you choose not to participate. Medical decisions are made by you and your Physician and do not involve the Plan.

Discharge Planning

SHARE monitors your progress in the Hospital and, through discharge planning, monitors your treatment and progress throughout recovery. When you need continuing care after your release, SHARE works with the Hospital to arrange your transfer to an extended-care facility, a nursing home, or your own home. For the Plan to cover transportation services, CBA must determine that transportation to one of the previously listed destinations is Medically Necessary. SHARE also arranges for wheelchairs, Hospital beds, home care nurses, pharmaceuticals, and other health aids.

First Steps Maternity Program

The Plan's First Steps Maternity Program is a highly specialized program designed to monitor low-risk pregnancies and to identify complications early so Plan Participants can locate and receive proper prenatal care to identify a high-risk pregnancy.

The First Steps Maternity Program also provides expectant mothers and fathers with access to experienced OB/GYN nurses who can provide individualized one-on-one telephone consultations and act as a trusted resource for pregnancy-related questions and support. As an incentive to enroll, mothers-to-be may receive:

- Up to $150 in MasterCard gift cards (dependent on the trimester enrolled);
- Prescription prenatal vitamins (with a doctor's prescription) at no cost for up to 12 months after enrollment;
- Choice of a free pregnancy book from a number of best-selling titles;
- Access to online educational content; and
- An NRECA Willie Wiredhand baby blanket.

These and more free items are included in the First Steps Maternity Welcome Package.
To enroll in the confidential First Steps Maternity Program at no additional cost, call 800.526.7322.

Services and Supplies that Require Preauthorization by SHARE

As described earlier, the SHARE program reviews and coordinates medical treatment, helping Plan Participants make informed decisions about both treatment and Plan use. SHARE must Preauthorize these services and supplies for **Medical Necessity:**

- All inpatient Hospital admissions, including non-emergency, behavioral health admissions, skilled nursing facilities, and extended-care stays;
- All outpatient, non-emergency high-end radiology (e.g., CT, MRI, MRA, PET, and nuclear cardiology scans);
- Home health care;
- Durable Medical Equipment (not braces and orthotics), including equipment purchases over $1,500, prosthetics over $1,000, and Equipment rentals over $500;
- Clinical trials; and
- Maternity services if the Hospital stay exceeds the 48-hour or 96-hour guidelines (including stays for a newborn that continues after the mother has been discharged).

SHARE helps you reduce the risks and costs of unnecessary hospitalization and medical care by choosing the safest, most appropriate course of treatment. However, medical decisions do not involve the Plan and are ultimately made by each patient with his or her Physician. When planning and coordinating your care, remember:

- If SHARE does not Preauthorize services or supplies for Medical Necessity when required, the amount of your eligible expenses that the Plan would normally cover will be reduced by 20%. You will be responsible for these ineligible expenses. **For example**, if you incur $10,000 in Hospital charges that would normally be eligible expenses under the Plan but you failed to call SHARE, then those eligible expenses would be reduced by 20% ($2,000), making your eligible expenses for the Hospital stay $8,000 ($10,000 minus $2,000). You would have to pay the

$2,000 in uncovered Hospital expenses out-of-pocket. In addition, that $2,000 would not be applied to your annual OOP Coinsurance Maximum or Deductible.

- If services or supplies are not Preauthorized and the Plan later finds that they were not Medically Necessary, the Plan will not cover those services or supplies. You will be responsible for the entire cost of the service or supply.

Clinical Trials

Participation in a clinical trial must be Preauthorized for Medical Necessity. Once Preauthorized, the Plan covers Routine Patient Costs for items and services furnished in conjunction with participation in the Approved Clinical Trial. If a covered individual is accepted in a Preauthorized clinical trial, the Plan requires all items and services related to the clinical trial to be provided by participating in-network providers.

Clinical Policy Guidelines

The Plan determines whether services, supplies, tests, or procedures are Medically Necessary (and thus covered) using a foundation of evidence-based medicine and generally accepted standards of good practice in the medical community. See *Appendix A: Key Terms* for a full definition of Medical Necessity.

To help determine Medical Necessity, the Plan may consult a number of industry resources, including Aetna Clinical Policy Bulletins, UnitedHealthcare Medical Policies and Coverage Determination Guidelines, Centers for Disease Control and Prevention (CDC) Guidelines, U.S. Preventive Services Task Force (USPSTF) Guidelines, and NRECA Plan Clinical Policy Guidelines. The Plan may consult additional resources at any time. Any such resources consulted by the Plan are intended solely to help administer Plan benefits and are not intended to constitute a description of Plan benefits.

How and When to Contact SHARE

For services within the Choice Plus network, the provider or facility must obtain Preauthorization for an inpatient admission. When using facilities that aren't part of the Choice Plus network, the patient or a member of the patient's family must notify SHARE.

Contact SHARE during normal business hours (8 am to 7 pm ET Monday through Friday) to speak with a SHARE medical review coordinator. Use the phone number provided in the *Contact Information* chapter or call the Preauthorization contact number on the back of your health ID card. Outside of normal business hours, callers with urgent or life-threatening situations have the option to speak to a live representative. All others will be asked to call back on the next business day. The SHARE medical review coordinator will ask for the:

- Patient's name;
- Attending Physician's name, address, and phone number;
- Group insurance coverage number; and
- Member ID number

In non-emergency situations, call SHARE about two weeks prior to a scheduled admission or procedure.

In emergency situations, notify SHARE within two business days after a Hospital admission. This includes non-business hours but excludes weekends and U.S. government holidays. For example, if you are admitted to a Hospital for an emergency at 7 pm on Friday, you must call SHARE by 7 pm on Tuesday.

Predetermination of Services

For services that do not require Preauthorization, you and your provider may instead request a Predetermination. A Predetermination is a request for the Plan to review planned services in advance to determine Medical Necessity and to verify that the charges for such services are eligible for coverage. Predetermination helps avoid any misunderstanding about what the Plan will cover.

The Predetermination request must be submitted by a provider to CBA in writing. It must include:

- The provider's recommended services, including billing codes; and
- Medical records that support the Medical Necessity of the services.

CBA will review the submission and respond in writing to you and your provider with the Plan's Predetermination in advance of the services. Any payment for an expense that is not covered under the Plan is the patient's responsibility.

Centers of Excellence (COE) Programs and Services

Transplant Centers of Excellence Program

If you are a transplant candidate or need Ventricular Assist Device (VAD) services, you are required to use the NRECA Transplant Centers of Excellence (COE) Program. **If you choose not to use the COE Program, the Plan will not cover the cost of the services.**

As soon as a medical practitioner indicates that you or your covered dependent needs a transplant, an implantation, or an evaluation, contact CBA. CBA will put you in contact with a dedicated case manager at the Plan's contracted vendor for these services.

The Plan will cover solid organ transplants, bone marrow transplants, peripheral stem cell transplants, and implantation (when used as a bridge-to-transplant) provided these charges are deemed Medically Necessary and you use the Transplant COE Program. The Plan will cover charges for implantation used as a lifesaving or life-prolonging treatment (destination therapy) for persons who are not viable candidates for heart transplantation, provided these charges are deemed Medically Necessary and you use the COE Program.

When a live donor is used, the Plan will cover health services associated with removal of the organ, tissue, or both when performed at the recipient's selected Transplant COE facility. Donor expenses may be subject to coordination of benefits with the donor's primary medical plan.

Deductible, Copayment, and Coinsurance provisions (if applicable to your Plan) also apply to transplant services. The Plan covers charges for services provided by a Transplant COE facility, subject to all other Plan limitations and provisions. Benefits for transplants and implantations, regardless of whether the Plan is the primary or secondary payer, are available only from practitioners within the Transplant or COE Program's designated COE network with case management by the Plan's contracted vendor for these services.

COEs are state-of-the-art medical facilities. The Transplant and COE networks include Hospitals and other medical centers that specialize in solid organ and tissue transplants or implantations and post-surgical maintenance. Some facilities specialize in one kind of transplant procedure, while others have multiple specialties. The Plan will cover Medically Necessary transplants or services only when provided by facilities that are designated by the Plan's contracted vendor as COEs for the applicable transplant procedure. The practitioners within the Transplant and COE Programs emphasize quality and improved outcomes for transplant procedures. These programs include dedicated case managers who serve as patient advocates throughout the process and work with the patient to determine the most appropriate COE facility. Prescription drugs provided in connection with the Transplant COE Programs are managed through your prescription drug benefits outside the Plan's medical benefits.

The Transplant COE will register the patient with United Network for Organ Sharing (UNOS), which places the patient on the UNOS regional transplant list. If the needed organ is rarely donated or difficult to procure or if the patient has a critical need for an organ to sustain life, the Transplant COE Program case manager may refer the patient to a COE facility in a second UNOS region to be placed on the transplant list.

The transplantation period begins the day of transplantation and ends 365 days following the surgery. When CBA deems that a transplant is Medically Necessary (and the Transplant COE Program is used), transplant benefits begin with the first appointment with the Physician or COE facility and continue through the transplantation period.

Note that patients must not have used drugs or alcohol for a minimum of six months before the Plan will begin covering transplant-related expenses. The Plan will not cover transplant-related expenses during the six-month period prior to drug or alcohol sobriety.

If the patient is referred to a facility that loses its COE status for any reason prior to or during the benefit period, the patient will be directed to another facility that is in the COE network. This means that the patient may need to relocate to be near the COE facility.

The Plan's transplant travel benefits begin when the patient is referred to a COE facility for evaluation and ends 365 days after the surgery. In the case of an implantation (including any future heart transplant), the lifetime travel benefit is $10,000.

If the transplant recipient travels more than 50 miles from home for care at a COE facility, the patient and one companion traveling on the same day and time to and from the facility (two companions if the patient is a minor) are eligible for travel benefits of up to a maximum of $10,000 for the benefit period. This benefit is subject to reimbursement limitations described in the *Centers of Excellence Travel Benefits* section of this chapter.

A live transplant donor and one companion traveling on the same day and time to and from the Transplant COE (two companions if the donor is a minor) are eligible for travel benefits. These travel benefits will be deducted from the transplant recipient's maximum $10,000 travel benefit for the benefit period and are subject to the reimbursement limitations described in the *Centers of Excellence Travel Benefits* section of this chapter.

Bariatric Centers of Excellence Program

The NRECA Bariatric Centers of Excellence (COE) Program is a designated COE Program provided by the Plan's contracted vendor. The Bariatric COE Program is **mandatory** for Plan Participants who obtain bariatric surgery. Benefits for bariatric surgery are available **only** for charges from practitioners and facilities within the Bariatric COE Program's designated COE network with case management provided by the Plan's contracted vendor. The Plan will cover charges for services provided by a Bariatric COE practitioner or facility, subject to all other applicable Plan limitations and provisions, including Deductible, Copayment, and Coinsurance.

To inquire about the NRECA Bariatric COE Program, contact the contracted vendor, OptumHealth Bariatric Resource Services (BRS), at 888.936.7246. The Bariatric COE Program case manager's role is to discuss the bariatric surgery process, answer questions about COE referrals, and outline the specific criteria and requirements for program eligibility. Only the COE surgeon determines whether a patient is a surgical candidate.

Once the decision is made to pursue bariatric surgery, OptumHealth BRS will begin coordinating pre-surgery and case management services.

Once a Participant has been approved for bariatric surgery, the vendor will provide:

- A choice of credentialed facilities across the country in which the bariatric surgery may be performed;
- Personalized case management support before and during surgery; and
- Continued support during the post-surgical recovery period.

The Plan may also cover meals, lodging, and transportation for the patient and one companion during the patient's evaluation, surgery, and follow-up care when traveling a distance of more than 50 miles from the patient's home to the facility. The travel benefit period begins once the patient is referred to a COE facility. **The lifetime maximum travel benefit is $2,500, subject to expense reimbursement limitations** (see the *Centers of Excellence Travel Benefits* section in this chapter).

The Plan does not cover these services at any time:

- Services for surgical follow-up care for a bariatric surgery not covered by the Plan;
- Bariatric surgery for a patient who has had previous bariatric surgery, whether or not the previous bariatric surgery was covered by the Plan;
- Bariatric surgery for a patient under the age of 18;

- Unapproved bariatric surgeries;
- Surgeries performed at facilities other than those designated as COEs by the Plan's contracted vendor; and
- Surgeries that are not coordinated or managed by the Plan's contracted vendor.

Cancer Centers of Excellence Program

The Cancer Centers of Excellence (COE) Program is an **optional** program provided to Plan Participants by the Plan's contracted vendor(s). The Cancer COE Program covers all cancer diagnoses and is strongly recommended for Participants who have complex or rare types of cancer. Treatment that is experimental, investigational, or both will not be covered under the Plan unless it is part of the COE.

To be eligible for the Cancer COE Program, your primary insurance plan must be the NRECA Medical Plan. If Medicare or another insurance carrier is your primary plan, then the coverage of cancer care and treatments will be managed either by Medicare or by your primary insurance carrier.

When a Participant has been approved for cancer treatment, the Plan's contracted vendor will provide personalized case management support during a 365-day continuous treatment period. As part of the case management services, the Plan's contracted vendor will provide the opportunity for the patient to enroll in the Cancer COE Program and information about the many Cancer COE Program-credentialed medical centers across the country at which cancer treatments may be performed.

The Plan covers charges for services provided by a Cancer COE facility at the in-network level, subject to all other Plan limitations and provisions. Coverage for charges incurred at facilities other than a Cancer COE is subject to the Plan's otherwise applicable in-network and out-of-network provisions. The benefit period begins when the patient is enrolled in the Cancer COE Program and continues for up to 365 days, until the patient goes into remission, or until the patient ceases active treatment, whichever occurs first. When active treatment continues beyond 365 days, the Plan will consider continuing benefits on a case-by-case basis.

If traveling more than 50 miles from the patient's home for care at a Cancer COE, the patient and one companion (two companions if the patient is a minor) who are traveling on the same day and time to or from the Cancer COE will be eligible for travel benefits of up to a lifetime maximum of $5,000, subject to guidelines and reimbursement limitations described in the *Centers of Excellence Travel Benefits* section of this chapter. Travel benefits require all of the following:

- Active participation in the case management services provided by SHARE;
- Use of a Cancer COE to initiate and develop a cancer treatment plan; and
- That the patient be newly diagnosed or in active treatment, which includes:
  - Diagnosis/evaluation visit;
  - Active cancer treatments at a Cancer COE facility; and
  - Follow-up visits to the treating Physician during the course of cancer treatment.

Joint and Spine Surgery Centers of Excellence Program

The Joint and Spine Surgery Centers of Excellence (COE) program is an **optional** program provided to Plan Participants by the Plan's contracted vendor Transcarent Surgery Care. The COE Program covers most types of joint and spine surgery, such as a knee and hip replacement, carpal tunnel release, spinal fusion and shoulder and ankle repair for both inpatient and outpatient procedures. If Participants do not use the program, they will still have access to NRECA Medical Plan benefits for covered expenses related to joint and spine surgery.

To be eligible for the Joint and Spine Surgery COE, your primary insurance plan must be the NRECA Medical Plan. If Medicare or another insurance carrier is your primary plan, then the coverage and treatments will be managed either by Medicare or by your primary insurance carrier.

When a Participant has been approved for treatment, NRECA's Centers of Excellence vendor, Transcarent Surgery Care, will administer the Joint and Spine Surgery COE program and provide a dedicated Care Coordinator to:

- Answer questions related to the program
- Help Participants select the right facility for treatment
- Make travel and lodging arrangements; and
- Obtain medical records and release forms.

The Plan covers charges for services provided by the Joint and Spine Surgery COE at 100% once the Deductible is met, subject to all other Plan limitations and provisions. Coverage for charges incurred at facilities other than a Joint and Spine Surgery COE are subject to the Plan's otherwise applicable in-network and out-of-network provisions. The benefit period begins when the patient is referred to a Joint and Spine Surgery COE and continues for up to 365 days after the surgery or until the patient has transitioned to local care. When active treatment continues beyond 365 days, the Plan will consider continuing benefits on a case-by-case basis.

The travel, meal and lodging benefit for the Joint and Spine Surgery COE Program is administered by the Plan's contracted vendor Transcarent Surgery Care.

Travel expenses, including transportation and lodging, are covered at 100% if traveling more than 50 miles from the patient's home for care at a Joint and Spine Surgery COE. The patient and one companion (two companions if the patient is a minor) who are traveling on the same day and time to or from the Joint and Spine Surgery COE will be eligible for travel benefits. Additionally, patients who drive to a facility for care receive mileage reimbursement as allowed by the IRS guidelines. The travel benefit period begins once the patient travels to a COE facility.

A meals and incidental benefit is included with the Joint and Spine Surgery COE. Transcarent Surgery Care will provide the benefit with a debit card issued to the patient in advance of the surgery. The maximum reimbursement for the patient when not admitted as an inpatient for meals and incidentals is $50 per day. The maximum reimbursement for the companion is $50 per day. If the patient is admitted longer than 15 days, the maximum reimbursement for the companion for meals and incidentals is $125 per week.

To inquire about the Joint and Spine Surgery (COE) Program or to enroll, contact Transcarent Surgery Care at 855.435.5790.

Centers of Excellence Travel Benefits: Bariatric, Organ and Transplant, Ventricular Assist Device, and Cancer Services and Treatment

The Plan pays travel benefits for bariatric services, organ and tissue transplant services, Ventricular Assist Device (VAD) implantation services, or treatment at a Cancer COE. The travel benefit covers round-trip transportation expenses for the evaluation, COE procedure, and follow-up visits to the treatment facility that are completed within the applicable benefit period, subject to the Deductible and Coinsurance.

The travel benefit also covers reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion (two if the patient is a minor) during the applicable benefit period subject to the Deductible and Coinsurance. Follow-up care and medical appointments after the benefit period has ended are not included in COE benefits.

Travel benefits are not applicable unless the patient is actively participating in the travel, meals, and lodging. Expenses for companion(s) traveling separately or alone are ineligible for reimbursement.

Travel benefits are limited in the following ways:

- If traveling to the COE treatment location **by automobile**, the patient will be reimbursed for the actual mileage completed from the patient's home to and from the COE treatment location at a rate per mile equal to the then-current IRS standard mileage allowance for medical reimbursement. Tolls, parking, gas, car rental, and tips will not be reimbursed. Mileage will be

reimbursed only for the most direct route between the patient's home and the COE treatment location.

- When traveling by **airplane or train**, the patient and one companion (two if the patient is a minor) who is traveling to and from treatment on the same day and time with the patient should request coach (economy) seating. If the patient and companion(s) wish to upgrade, the Plan will not cover the cost difference between the economy and upgraded fares. The Plan will reimburse fees for up to two checked bags. Personal amusement expenses during air or train travel (e.g., reading materials, in-flight movies, games) will not be reimbursed. Travel also includes taxi or ground transportation to and from the airport or train station to the COE location. To be reimbursed, you must submit original (or legible copies of) itemized receipts with the transportation expense report.
- The maximum combined reimbursement for the patient and companion(s) meals and lodging is $200 per day.
- The lodging benefit for a patient and one companion covers hotel, motel, campgrounds, extended-stay residences, and Hospital-affiliated residences. Lodging is limited to one room, double occupancy. The Plan does not reimburse for personal expenses. The original or a legible copy of the lodging receipt must be attached to the expense report to be reimbursed.
- The meals benefit covers food and non-alcoholic beverages for the patient and one companion (two companions if the patient is a minor) on the days that the patient is traveling to and from treatment and on the days that the patient is receiving treatment at the COE treatment location. If the patient chooses lodging with facilities for self-preparation of meals, the benefit will pay for groceries from the following food groups: meat, dairy, grain, and fruits and vegetables. Original or legible copies of itemized meal receipts must be attached to the expense report to be reimbursed.
- Examples of personal expenses that are not covered as meal and lodging expenses include alcoholic beverages, snack foods (e.g., sports drinks, bottled soft drinks, candy, desserts), haircuts, movies, internet access, massages, laundry, tips, toothbrushes, toothpaste, cleaning supplies, personal hygiene supplies, **and** health club access.

The travel, meal, and lodging benefit for these three programs is administered by CBA.

What the Plan Covers

The Plan covers eligible expenses for the categories of medical services and supplies listed in the *Plan Highlights* chapter. Each category may be subject to varying cost-sharing amounts that you pay out of your own pocket. These categories include:

- Preventive services, including well-child care;
- Physician services;
- Teladoc Consultations;
- Diagnostic lab and x-ray services;
- Hospital services;
- Emergency room and ambulance services;
- Convalescent Nursing Home and hospice services;
- Rehabilitation Services; and
- Other miscellaneous medical services and supplies.

The remainder of this chapter describes in detail the specific services within each of these categories.

Preventive Care

The Affordable Care Act requires the Plan to cover a range of preventive services. A Plan may not impose cost-sharing (such as Copayments, Deductibles, or Coinsurance) for preventive services **if they are administered by an in-network provider**.

This Plan covers adult physical examinations; well-child care; women's preventive services; and screenings, tests, and Immunizations that are age and gender appropriate. Preventive medical care benefits and screenings from in-network providers are covered by the Plan at 100%. All out-of-network preventive medical care benefits and screenings are subject to Coinsurance and R&C Rates. The list of covered and excluded preventive services are subject to change pursuant to changes in the applicable recommendations or guidelines issued by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration, or Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention (CDCP) in accordance with the Affordable Care Act. A current listing of covered and excluded preventive services and items can be found at cooperative.com > My Benefits > My Insurance > Preventive Benefits Basics. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you.

Adult Physical Examinations and Well-child Care

The Plan covers at 100% one physical exam every calendar year for you, your spouse, and your eligible dependents ages 19 and older. For women, this benefit covers both an annual physical and a well-woman exam.

The preventive benefit also covers standard preventive screenings, tests, and Immunizations that are considered appropriate for the patient's age and gender. These services must be done on an outpatient basis and may be performed at the same time as an annual physical exam.

Well-child (or baby) examinations include, but are not limited to, establishing and maintaining medical history; height, weight, and body mass index measurements; developmental screenings (including autism); behavioral assessments; and Immunizations. The Plan does not cover physical exams (including Department of Transportation exams) that are a condition of employment for aviation or for certain other situations. The adult physical examination benefit covers comprehensive checkups for the purpose of monitoring your health.

Women's Preventive Services

The Plan covers certain preventive services for women's health and well-being at 100% when they are provided by in-network providers.

In-network Women's Preventive Services Covered at 100%		
Service[1]	**Coverage**	**Frequency and Limitations**
Well-woman visits	Covered annually for adult women to obtain age and developmentally appropriate services, including preconception and prenatal care	Annually. Several visits may be needed to obtain all necessary recommended preventive services, depending on health status, needs, and other risk factors.
Gestational diabetes screening	Screening for gestational diabetes	In all pregnant women at 24 to 28 weeks of gestation and at first prenatal visit for pregnant women at high risk for diabetes
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results	Once every three years at age 30 and older

In-network Women's Preventive Services Covered at 100%		
Service[1]	**Coverage**	**Frequency and Limitations**
Counseling for sexually transmitted infections	Counseling for all sexually active women	Annually. Must be provided by an in-network trained provider licensed in the state where provided.
Counseling and screening for human immunodeficiency virus	Counseling and screening for all sexually active women	Annually. Must be provided by an in-network trained provider licensed in the state where provided.
Counseling and screening for preeclampsia	Counseling and screening for pregnant women	Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Contraceptive methods and counseling	All Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, patient education, and counseling for all women with reproductive capacity	As prescribed; • Oral generic contraceptives covered at 100% under the Plan's prescription drug benefit • Brand-name oral contraceptives subject to brand-name prescription drug Copayment and Coinsurance, as applicable[2] • Over-the-counter methods and supplies not covered • Services for male contraceptive methods (e.g., vasectomy) covered based on normal coverage provisions and subject to applicable Copayments and cost-sharing provisions
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling by a trained provider during pregnancy or in the postpartum period; costs for renting breastfeeding equipment	For each birth: • Breast pump and supplies must be purchased at an in-network Durable Medical Equipment supplier. One manual or electric-grade breast pump per pregnancy. • Other breastfeeding supplies (e.g., maternity bras, nursing pads, bottles) are not covered • Lactation counseling and classes must be provided by an in-network, licensed International Board-certified Lactation Consultant (IBCLC)

In-network Women's Preventive Services Covered at 100%		
Service[1]	**Coverage**	**Frequency and Limitations**
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence	Annually. Counseling must be provided by an in-network trained provider licensed in the state where provided.

[1]All services in this table should be included with the well-woman visit where appropriate.

[2] Plan covers certain brand-name oral contraceptives without cost sharing in certain situations in accordance with Affordable Care Act.

This Plan's medical benefit covers some in-network preventive benefits and your prescription drug benefit covers others. The Plan's **prescription drug benefits** cover birth control pills, patches, and rings. The Plan's **medical benefit** covers:

- Physician visits and follow-up care;
- Counseling for natural family planning services;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for breastfeeding and contraceptive methods;
- Counseling and screening for human immunodeficiency virus;
- Counseling for sexually transmitted infections;
- Diaphragms and cervical caps (device and fitting);
- Implants, such as implanon (drugs, insertion, and removal);
- Injections, such as depo-provera (drug and administration);
- Intrauterine device (device, insertion, and removal);
- Pre-exposure prophylaxis (PrEP) for the prevention of Human Immunodeficiency Virus (HIV), plus items and services that the USPSTF recommends prior to being prescribed anti-retroviral and for ongoing follow-up and monitoring, including HIV testing, hepatitis testing, pregnancy testing, and adherence testing, among other items and services, as described in more detail in Appendix B: Preventive Drugs and Services; and
- Tubal ligation (surgical procedure and related services when performed as the primary procedure).

Age- and Gender-appropriate Screenings, Tests, and Immunizations

Certain screenings, tests, and Immunizations are covered by the Plan if they are recommended based on age and gender, if they are preventive in nature, and if they are coded appropriately by the billing provider. Examples include colon cancer screening for Participants ages 45 to 75 and mammograms, including 3-D mammography, for women ages 40 and older. In some cases, where family history warrants a screening earlier than recommended for a particular health problem, an eligible screening may be covered. Call CBA to verify.

Some preventive screenings are not covered due to the lack of clinical evidence for effectiveness (e.g., routine chest x-rays, full-body x-rays). Details about the Plan's preventive benefits, including charts listing key recommended preventive services based on age and gender, are subject to change. A current listing of covered preventive screenings, tests and immunizations can be found at cooperative.com > My Benefits > My Insurance > Prevention / Immunizations > Preventive Benefits Basics. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you.

Preventive Services Excluded from Coverage

Some services are not recommended or covered either for the general population or for those who do not exhibit symptoms that demonstrate need. Diagnostic testing may be appropriate and covered, but not under the Plan's preventive care provisions.

The following screenings, tests, and Immunization services are **not covered** under the Plan. This list is not all-inclusive and may change based on evidence and recommendations of the USPSTF and ACIP of the Centers for Disease Control and Prevention (CDC). If you have questions about coverage for these or other preventive services, call CBA.

Excluded Preventive Services			
Service	**Gender**	**Age**	**Policy**
Abdominal aortic aneurysm (routine radiology procedure for detection)	Female	All	Not covered
Abdominal aortic aneurysm (routine radiology procedure for detection)	Male	0 to 64 65 to 75 76 and older	Not covered One per lifetime Not covered
Breast cancer gene test (BRCA)	Both	All	Covered subject to Medical Necessity and the Clinical Policy Bulletin
Carotid Artery Stenosis (CAS) (stroke-screening using duplex ultrasonography, digital subtraction angiography, or magnetic resonance angiography)	Both	All	Not covered
Chronic obstructive pulmonary disease (COPD) screening using spirometry	Both	All	Not covered
Employment-related physical exams such as Department of Transportation	Both	All	Not covered
Executive physicals (often includes multiple high-dollar tests that are not age or gender appropriate)	Both	All	Not covered
Peripheral artery disease (screening using ankle brachial index)	Both	All	Not covered

Excluded Preventive Services			
Service	**Gender**	**Age**	**Policy**
Synagis[1] shot to prevent respiratory syncytial virus (RSV) infection	Both	Infants under age 2	Not covered under medical benefits unless billed by the Hospital during a premature infant's initial inpatient confinement May be covered under the prescription drug benefit, subject to Medical Necessity review by CVS Caremark

[1]Synagis, a special Immunization occasionally given to premature babies, is not covered under the medical benefits of this Plan unless the Plan is billed by the Hospital during the initial inpatient confinement for a premature newborn. In certain other situations, the drug will be covered if it is Preauthorized by the Plan and filled through CVS Caremark Specialty Pharmacy Services. Synagis is not included in the American Academy of Pediatrics' recommended childhood Immunization schedule.

Preventive Services with Coverage Limitations

The following screenings, tests, and Immunization services are **covered only under certain circumstances**. This list is not all-inclusive and is subject to change. If you have questions about coverage for any preventive service, call CBA.

Preventive Procedures with Policy Limitations			
Service	**Gender**	**Age**	**Policy** (age limit applies)
Colonoscopy (including prescribed preparations)	Both	45 to 75	Every 10 years
Double contrast barium enema	Both	50 and older	Every five years
Flexible sigmoidoscopy and sigmoidoscopy	Both	50 to 75	Every five years
Herpes Zoster (shingles) vaccination	Both	50 and older	Once per lifetime
Human papillomavirus vaccination	Both	9 to 45	Three doses total
Mammogram (including 3-D mammography)	Women	40 and older; under 40 with risk factors such as a certain family history of breast cancer	Every year
Osteoporosis	Women	60 and older	Every year

Preventive Procedures with Policy Limitations			
Service	**Gender**	**Age**	**Policy** (age limit applies)
Prostate-specific Antigen (PSA) blood test	Men	50 and older	Every year

The Plan includes the following services and supplies as preventive care **only** when prescribed to an individual diagnosed with a listed chronic condition.

Preventive Care Condition	Required Diagnosis
Blood pressure monitor	Hypertension
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease

Physician Services

The Plan covers Physician services in a variety of settings to evaluate and manage health conditions, including charges for Physician services rendered during:

- **Office visits:** Visits to a Physician's office or an Urgent Care Clinic. Covered charges include evaluation, x-ray, and laboratory charges billed by the same Physician or the Urgent Care Clinic on the same day of service.
- **Surgery, Hospital visits, and Hospital services:** The Plan will pay benefits toward surgeon and anesthesiologist fees (inpatient or outpatient); inpatient, outpatient, and emergency room and Urgent Care Physician charges; and second surgical opinions.
- **Allergy Immunizations:** Physician's charges for allergy Immunization shots.

Teladoc General Medical Consultations

The Plan covers medical consultations provided by a Teladoc Physician for evaluating and treating health conditions. Teladoc provides telephone or online video medical consultations for acute non-emergency medical issues such as:

- Sinus infections;
- Cold and flu symptoms;
- Allergies;
- Bronchitis; and
- Minor eye, ear, skin, and respiratory infections.

Teladoc is available 24 hours a day, seven days a week, 365 days a year, and provides access to a national network of U.S. board-certified Physicians who can resolve many acute non-emergency

medical issues via telephone or online video consultations. Regulations in the state where the patient is located at the time of the Teladoc Consultation determine the availability and the delivery method (phone, video, or both). Teladoc Physicians can prescribe drugs to treat a variety of acute non-Emergency Medical Conditions by calling in a prescription for pickup from the pharmacy you choose. Prescription drugs prescribed by a Teladoc Physician are subject to the Plan's prescription drug Copayment and Coinsurance provisions. All consultation fees you pay to Teladoc count toward your annual out-of-pocket maximum.

To use the consultation services, eligible Participants must register with Teladoc either online or by calling 800.Teladoc (800.835.2362). You must then provide a brief medical history. To set up an account online, go to Benefits.cooperative.com/Teladoc or Teladoc.com/NRECA or use the Teladoc app and click "Set up account," and then provide the requested information.

Teladoc Mental Health Consultations

The Plan covers Mental Health consultations provided by Teladoc for Plan participants 13 and older. Teladoc Mental Health providers (licensed psychiatrists for participants age 18 and older, and therapists) can help support a wide range of short-term and long-term needs such as:

- Depression;
- Anxiety;
- Stress;
- Family or work relationships; and
- Substance Abuse.

Mental Health appointments are available 7 days a week by phone or video, 7 am to 9 pm local time, but are not available on-demand. The first available visit time will always be no less than 72 hours from the current day/time. Appointments are scheduled online and cannot be scheduled by telephone.

To use the Teladoc Mental Health services you must be 13 years old or older. Minors will need parent/guardian consent. Individuals 18 years and older must be registered with Teladoc and have completed a brief medical history. (For adolescents a consent form must be signed by at least one parent/guardian of the Adolescent and uploaded into the system before the initial MH Consultation can be scheduled for the Adolescent. An intake form must be completed and uploaded into the system before the initial MH Consultation can be scheduled for the Adolescent. A parent/guardian must be present at the start and conclusion of each initial MH Consultation for an Adolescent with a MH Practitioner.)

To register you can go online or call 1-800-Teladoc (800.835.2362). To register online go to Benefits.cooperative.com/Teladoc or Teladoc.com/NRECA or use the Teladoc app and click "set up account" and then provide the requested information.

To schedule an appointment with a Mental Health provider, go online via benefits.cooperative.com/Teladoc or Teladoc.com/NRECA or the Teladoc app and select "Mental Health." Scheduling an appointment will require completion of a brief online mental health assessment questionnaire.

A Teladoc psychiatrist can prescribe a limited Formulary of medications if Medically Necessary to treat non-emergency Mental Health conditions. Medications can be prescribed only by a psychiatrist. Prescriptions are sent electronically to the pharmacy of your choice. Prescription drugs prescribed by a Teladoc psychiatrist are subject to the Plan's prescription drug Formulary and Copayment and Coinsurance provisions.

Treatment of Complications from Non-covered Procedures

Treatment for complications from medical or surgical interventions is a covered expense subject to benefit levels for Physician services (for surgery, Hospital visits, and services) and subject to the following coverage rules:

- The treatment itself must be a service that the Plan covers;
- If the original medical or surgical intervention was not (or would not have been) a covered service under the Plan, benefits are limited to treatment of the complication only, if such treatment is a service that is covered under the Plan;
- Treatment for complications resulting from experimental or investigational medications or procedures is a covered benefit; however, the cost of administration or use of an investigational drug or procedure is not a covered charge under the Plan; and
- The Plan may require a full medical review of the non-covered procedure, the complications, and the subsequent treatment before claims may be paid for treatment of the complications.

Diagnostic Lab and X-ray Services

The Plan covers the cost of diagnostic x-ray and laboratory services that are Medically Necessary for the treatment of Sickness or Injury. However, you must call SHARE for Preauthorization before obtaining all non-emergency, outpatient CT, MRI, MRA, PET, and nuclear cardiology scans. When you call, SHARE will need a diagnosis code and procedure code(s) for any radiological procedure, along with the patient's name, member number, group number, and Employer name, as well as the provider's contact information.

Preauthorization for Medical Necessity is required for the Plan to cover the following high-end radiology services on a non-emergency, outpatient basis:

- Computed tomography (CT);
- Magnetic resonance imaging (MRI);
- Magnetic resonance angiogram (MRA);
- Positron emission tomography (PET); and
- Nuclear cardiology scans.

For additional information about Preauthorization through SHARE, review the *Services and Supplies that Require Preauthorization by SHARE* section in this chapter**.**

Hospital and Surgical Services

All non-emergency Hospital admissions require Preauthorization for Medical Necessity. For additional information, review the *Services and Supplies that Require Preauthorization by SHARE* section in this chapter**.** If you access the Choice Plus network, the provider or facility is responsible for Preauthorization of an inpatient admission. The Plan covers a variety of treatments that you or a covered dependent may receive in the Hospital, including:

- Inpatient care and surgical expenses;
- Outpatient surgical expenses; and
- Outpatient services.

The Plan may cover additional expenses you or a covered dependent incur during a Hospital Confinement, subject to the following:

- The Plan covers payment for room and board only up to the Hospital's standard rate for a semi-private room;
- An emergency admission means an admission to the Hospital for a condition that, unless promptly treated on an inpatient basis, would put the patient's life in danger or cause serious damage to a bodily function of the patient; and

- The Partial Hospitalization Program (PHP) provides a short-term, intermediate level of care for the treatment of Mental Health Conditions and Substance Abuse. PHPs are typically offered within a psychiatric Hospital or behavioral health department of a Hospital. Patients generally participate on weekdays for six to eight hours at a time as prescribed by their Physician. The Plan counts a partial day as one inpatient day.

Inpatient Care and Surgical Expenses

Inpatient Hospital care requires Preauthorization for Medical Necessity. The Plan covers the following for inpatient Hospital care:

- **Room and board:** The Plan will cover eligible charges for room and board in a semi-private room. Any charges more than the semi-private room rate will not be paid by the Plan. If the Hospital does not have semi-private rooms, the limit will be the daily charge for its lowest-rate private room.
- **Other Hospital services:** The Plan covers these services in the same manner as room and board charges:
  - Services and supplies that are furnished by the Hospital, such as operating rooms, x-rays, laboratory tests, and medicines (not services such as Physician's visits and second opinions, which are covered as Physician charges);
  - Ambulance service to the nearest appropriate facility; and
  - Pre-admission x-ray and laboratory tests.

Eligible Surgical Expenses

The Plan covers a wide variety of Physicians' surgical services. For example, the following surgical procedures are covered (excluding oral surgery):

- Incision, excision, or electro-cauterization of any organ or body part;
- Reconstruction of any organ or body part or the suture repair of lacerations;
- Reduction of a fracture or dislocation by manipulation under general anesthesia;
- Use of endoscope to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or ureter;
- Puncture and aspiration;
- Injection for contrast media testing;
- Laser surgery;
- Treatment of burns; and
- Application of casts.

The Plan also covers assistance for surgical procedures when Medically Necessary. Coverage of surgical assistants' charges are limited to 20% of the surgeon's rate allowance.

Outpatient Surgical Expenses

Outpatient surgical procedures may be performed in a Hospital, a freestanding surgical facility, or an Ambulatory Surgical Center. The Plan covers outpatient facility fees when a surgical procedure is performed by a Physician on an outpatient basis. The Plan will consider benefits as described in the *Plan Highlights* chapter toward the cost of the facility's fees.

Childbirth Services

Charges for childbirth services must be Preauthorized by SHARE for Medical Necessity. The Plan pays Hospital and surgical benefits for a pregnant mother in the same way that it pays any non-maternity benefits. The Plan also covers Birthing Center expenses, provided the services and supplies you receive at a Birthing Center would have been covered if furnished in a Hospital.

Hospital charges for a newborn baby are separate from the mother's expenses. The Plan covers charges for the newborn only if the newborn is an eligible dependent. You have 31 days following

the birth of the child to add the newborn to your coverage. If you request coverage for a newborn (whether your natural child or one for whom adoption is being processed) within 31 days of the child's birth, coverage will automatically be effective on the date of birth provided that you have met any Eligibility Waiting Period.

Length of Maternity Hospital Stay

Group health plans and health insurance issuers generally may not, under the Newborn and Mother's Health Protection Act of 1996 (NMHPA), restrict a mother or newborn child's benefits for any childbirth-related Hospital stay to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, federal law generally does not prohibit an attending provider, after consulting with the mother, from discharging the mother or her newborn earlier. Under federal law, plans and issuers cannot require providers to obtain Plan or insurer authorization for a length of stay that is shorter than 48 hours (or 96 hours as applicable). This Plan conforms to the requirements of the NMHPA. However, to avoid a possible reduction in benefits, the provider should get approval from SHARE in advance for the patient to stay beyond the 48-hour and 96-hour limits.

Mastectomy Expenses

For more information about the mastectomy expenses that the Plan must cover, see the *Women's Health and Cancer Rights Act (WHCRA)* section of the *Important Notifications and Disclosures* chapter.

Ambulance Services

The Plan covers ambulance services subject to the Deductible and Coinsurance. Ambulance service must provide transportation to the nearest appropriate medical facility qualified to treat the covered patient's Sickness or Injury. Use of the ambulance must be Medically Necessary and must be the most reasonable method of transportation available, as determined by CBA. This includes air ambulance service to facilitate immediate admission to a medical facility for a Life-threatening Condition.

Emergency Room Services

The Plan provides benefits (as described in the *Plan Highlights* chapter) for the use of a Hospital's emergency room. Emergency room services, however, are very expensive and should be used only in a Medical Emergency. Any Copayment required by the Plan for an emergency room visit will be waived if the covered individual is later admitted to the Hospital.

Emergency Services extend to medical screening examinations and further medical treatment required to stabilize a patient, provided that those further services are within the capabilities of the staff and facilities available at the Hospital.

Mental Health and Substance-related Disorder Benefits

Mental Health and Substance-related Disorder benefits are designed to help you and your covered dependents receive the appropriate care for Mental Health Conditions and Substance Abuse. The Plan covers charges you incur to treat mental disorders, psychoneurotic and personality disorders, and Substance Abuse, subject to Physician, Hospital, or emergency room benefit levels depending on the type of service(s) received (see the *Plan Highlights* chapter).

The Partial Hospitalization Program (PHP) provides a short-term, intermediate level of care to treat Mental Health Conditions and Substance Abuse. PHPs are typically offered at a psychiatric Hospital or within the behavioral health department of a Hospital. Patients typically participate on weekdays for six to eight hours at a time as prescribed by their Physician. The Plan considers a partial day to be one inpatient day, subject to the Plan's inpatient Hospital benefit limitations.

Notwithstanding anything else contained in this SPD, the Plan does not impose any visit limits on outpatient Mental Health and Substance-related Disorder office visits, although all visits are subject to Medical Necessity.

Hospital admissions under the Plan's Mental Health and Substance-related Disorder benefits must be Preauthorized by SHARE for Medical Necessity, as described in *The Simplified Hospital Admission Review (SHARE) Program* section in this chapter. You can read about Mental Health and Substance-related Disorder appeals in the *Medical Claims and Appeals* chapter.

Convalescent Nursing Home Care

The Plan covers Convalescent Nursing Home care following certain hospitalizations. Convalescent Nursing Home care must be Preauthorized by SHARE for Medical Necessity. A 90-day limit applies to coverage for all Convalescent Nursing Home care due to the same or related causes. The Plan does not cover Custodial Care.

The Plan covers eligible expenses incurred during a covered Convalescent Nursing Home care confinement that follows a covered inpatient Hospital stay lasting at least one day. The confinement must start within 15 days after release from the Hospital and must be recommended by the Physician who attended the condition that caused the hospitalization. The Plan covers two types of expenses:

- **Room and board:** charges for Convalescent Nursing Home room and board, but not more than 80% of the standard (most common) semi-private room rate of the Hospital stay that immediately preceded transfer to skilled nursing care; and
- **Ancillary services and supplies:** services and supplies (other than personal items) furnished by a Convalescent Nursing Home for Medically Necessary care while the patient is under the continuous care of a Physician and requires 24-hour skilled nursing care.

Hospice Care

A Hospice Care Program is a formal program directed by a Physician to help care for a terminally ill person. The Plan provides both hospice and bereavement benefits (see the *Plan Highlights* chapter for coverage details).

A hospice team is a group of professionals and volunteer workers who provide care to:

- Reduce or abate pain or other symptoms of physical or mental distress; and
- Meet the special needs caused by Terminal Illness, death, and bereavement.

The team includes at least a Physician and registered nurse and may also include a social worker, a clergy member or counselor, volunteers, a clinical psychologist, a physiotherapist, and an occupational therapist.

Covered Hospice Services

The Plan covers a hospice stay or hospice services if they are:

- Provided while the terminally ill person is covered under the Plan;
- Ordered by the supervising Physician as part of a Hospice Care Program;
- Billed by the Hospice Care Program; and
- Provided within six months of the terminally ill person's entry or re-entry (after a remission period) into the Hospice Care Program.

The Plan pays Hospice Care benefits as outlined in the *Plan Highlights* chapter, up to a lifetime maximum of $50,000. Eligible hospice charges may be for either inpatient or outpatient care.

The Plan will cover bereavement counseling services (up to a maximum of $200) for the family unit, if:

- Ordered and received under the Hospice Care Program; and
- Incurred within three months after the terminally ill patient's date of death.

A family unit consists of the terminally ill person and other covered dependents. Bereavement benefits will be paid if, on the day prior to his or her death, the terminally ill person was in the Hospice Care Program, was a member of the family unit, and was a covered individual.

Excluded Hospice Services

The Plan does not cover these services:

- Charges for the treatment of a diagnosed Sickness or Injury for you or your dependent when the benefits are payable under another benefit of the Plan (if benefits for such coverage are expressed as a percentage of charges, this exclusion applies at a rate of 100%);
- Charges for services provided by you (or your spouse or someone related to you or your spouse by blood or marriage); and
- Charges incurred during a remission period. This applies if, during remission, the terminally ill person is discharged from the Hospice Care Program.

Outpatient Rehabilitation Services

Outpatient Rehabilitation Services must be Medically Necessary and are subject to a 25-visit annual limit. **In addition, CBA must Preauthorize these services for Medical Necessity once the 25-visit limit has been reached:**

- Physical therapy, occupational therapy, massage therapy, and acupuncture;
- Restorative Speech Therapy; and
- Chiropractic care.

Physical Therapy (PT), Occupational Therapy (OT), Massage Therapy, and Acupuncture Services

PT, OT, massage therapy, and acupuncture services are covered only when they are Medically Necessary and when the practitioner is licensed in your state. CBA requires you to provide a Physician's written prescription for massage therapy with your first claim and again annually if the massage therapy treatment is ongoing.

The 25-visit limit applies to a combination of all PT, OT, massage therapy, and acupuncture visits for the same or unrelated conditions. If a covered individual has more than 25 combined PT, OT, massage therapy, and acupuncture visits within a calendar year, any additional visits must be Preauthorized by CBA to ensure Medical Necessity. Failure to obtain Preauthorization will result in denial of services.

Restorative Speech Therapy

The Plan covers eligible charges for Restorative Speech Therapy. If a covered individual has more than 25 visits within a calendar year, additional visits must be Preauthorized by CBA to ensure appropriate Medical Necessity. Failure to obtain Preauthorization will result in denial of services.

Chiropractic Care

Chiropractic services are covered only if they are Medically Necessary and the practitioner is licensed in your state. If a covered individual has more than 25 visits within a calendar year, any additional visits for that individual must be Preauthorized by CBA to ensure appropriate Medical Necessity. Failure to Preauthorize chiropractic services will result in denial of services.

Habilitation Services

Habilitation Services are health care services delivered by a licensed or certified provider to help a person learn, improve, or maintain skills that were never previously learned or acquired and are necessary for daily living. Habilitation and Rehabilitation Services can be similar but are performed for different purposes. While Rehabilitation Services help a patient regain function that he or she has lost, **Habilitation Services** help someone learn skills they need to perform daily living functions

but did not learn or acquire (often in childhood) due to a developmental, cognitive, or other condition. See the definitions for both Habilitation and Rehabilitation Services in *Appendix A: Key Terms.* Examples include therapy for a child who is not walking or talking at the expected age. Other services may include physical and occupational therapy, speech-language therapy, and services for people with disabilities in a variety of inpatient and outpatient settings.

The Plan will cover Habilitation Services if those services are both Preauthorized by CBA and found to be Medically Necessary. Failure to obtain Preauthorization will result in a denial of services.

Custodial Care Services

Custodial Care services are not covered under this Plan. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Custodial Care helps people perform daily living activities such as walking, getting in and out of bed, bathing, dressing, eating, and performing normal bodily functions. Other examples include preparation of special diets and help taking medication that can usually be self-administered.

Other Medical Services

The Plan will cover the following services as specified in the *Rehabilitation Services and Other Medical Services* section of the *Medical Benefit Highlights* table, which is located in the *Plan Highlights* chapter.

Chemotherapy and Radiation Therapy

The Plan covers eligible charges for Chemotherapy and Radiation Therapy. Oral drugs purchased at a pharmacy are not covered under medical benefits. However, they may be covered under the Plan's prescription drug benefits (see the *Prescription Drug Benefits* chapter for details).

Dental Anesthesia Services and Facility Charges

Under specific circumstances and subject to prior review by CBA, the Plan may cover deep sedation or general anesthesia for oral and maxillofacial surgery along with dental services provided either in an office or in a Hospital-based environment. This includes oral rehabilitation in toddlers with baby bottle syndrome, as well as treatment for children, adolescents, or adults with severe physical or behavioral disabilities who require sedation for dental care. When required, the use of a short procedure unit or a Hospital stay for such procedures may also be covered under the Medical Plan, subject to Preauthorization. Anesthesia for any dental Cosmetic Procedure is not covered. The Plan may cover anesthesia and facility charges even when the dental procedure itself is not covered; however, such coverage is subject to all the Plan's usual coverage requirements, including Preauthorization.

The Plan covers deep sedation or general anesthesia under the following circumstances:

- Radical excision of lesions in excess of 1.25 centimeters (1/2 inch.);
- Radical resection or ostectomy with or without bone graft;
- Patients who exhibit physical, psychological, intellectual, or medical conditions and for whom dental treatment under local anesthesia (with or without additional adjunctive techniques and modalities) cannot be expected to provide a successful result and for whom treatment under anesthesia can be expected to produce a superior result (such conditions include, but are not limited to, cerebral palsy, epilepsy, cardiac problems, and hyperactivity, as verified by appropriate medical documentation);
- Patients with a chronic disability that 1) is attributable to a mental or physical impairment or combination of both; 2) is likely to continue indefinitely; and 3) results in substantial functional limitations in one or more of the following: self-care, respective and expressive language, learning, mobility, capacity for independent living, or economic self-sufficiency (as verified by appropriate medical documentation);
- Patients who have sustained extensive oral-facial or dental trauma, for whom treatment under local anesthesia would be ineffective or compromised;

- A child 6 years old or younger who has a dental condition (such as baby bottle syndrome) that requires repairs of significant complexity (e.g., multiple amalgam or resin-based composite restorations, pulpal therapy, extractions, or combinations of these or other dental procedures); or
- When local anesthesia is ineffective because of acute infection, anatomic variation (e.g., due to previous surgery, trauma, or congenital anomaly), or an allergy to local anesthesia.

Diabetic Retinopathy Screening

The Plan covers a diabetic retinopathy exam, diagnostic diabetic retinopathy testing, or both to monitor the eye health of a person diagnosed with diabetes.

Diabetes Self-care Programs

Participation in a diabetes outpatient medical self-care program is a covered expense under the Plan (subject to the frequency, duration, and coverage limitations described in this section) when the program satisfies the following criteria:

- The program is specifically ordered by the Physician treating the Participant's diabetes;
- The program's services are provided by health care professionals who are licensed, certified, or qualified by professional credentials or degrees (e.g., Physicians, registered nurses, registered pharmacists, registered dieticians); and
- The program is designed to educate the Participant about Medically Necessary aspects of diabetes self-care.

To be covered, the expense for participation in a diabetes outpatient medical self-care program must be incurred:

- When the patient has been newly diagnosed with diabetes;
- Once every three years after initial diagnosis; or
- When a change in the patient's condition warrants a significant adjustment in treatment modality. Such changes may include:
    - Introducing new medications that may affect blood glucose levels, including medications used to treat other conditions (e.g., corticosteroids);
    - Introducing a new class of anti-diabetic medications (e.g., adding insulin to oral anti-diabetic medications);
    - Diagnosis with a separate chronic condition that may affect blood glucose levels;
    - Stress;
    - Hospitalization or acute illness;
    - Gestational diabetes;
    - Surgery; or
    - Significant change in body mass index (BMI).

The Medically Necessary portion of a diabetes outpatient medical self-care program will vary depending on the program's goals and objectives, but may not exceed 10 visits within a 12-month period, up to a yearly maximum of $1,000 in eligible charges. After the initial training year, a maximum of one day of follow-up training with not more than $250 in eligible charges is allowed annually when recommended by a Physician. Covered charges for diabetes outpatient medical self-care programs are subject to both the annual Deductible and the in-network and out-of-network benefit levels for Physician benefits for this Plan.

Participants are strongly encouraged to contact a health coach through FutureMe for help managing their diabetes (for details, see the *FutureMe coaching* section of the *FutureMe Benefits and Resources* chapter).

Durable Medical Equipment

The Plan will cover charges for eligible Durable Medical Equipment. Purchases over $1,500 and equipment rentals over $500 per month must be Preauthorized.

Hearing Aids

Hearing aids are medical equipment, subject to Plan requirements such as Medical Necessity, Deductible(s), and cost-sharing. The Plan will cover a lifetime maximum of $10,000 in eligible hearing aid expenses for each covered person for wearable hearing aids and hearing aid maintenance. Hearing aid maintenance includes ongoing fitting, orientation, checking, repair, and modification but does not include replacement batteries. Hearing aid exams are covered under the Plan as an office visit for a non-preventive service and are not subject to the hearing aid maximum benefit.

Hearing aids that are not wearable (such as implanted hearing aids) are subject to the Plan's Medical Necessity requirement and are not covered under the hearing aid maximum benefit. Assistive listening devices are considered Durable Medical Equipment, not hearing aids, and are covered only when Medically Necessary.

Home Health Care Agency Benefits

The Plan covers home health care services if those services are both Preauthorized and Medically Necessary. The Plan does not cover home health care services that are:

- Rendered by you, your spouse, or someone related to your or your spouse by blood or marriage;
- Provided by home health aides; or
- Considered to be Custodial Care.

The following limits apply to eligible charges from a Home Health Care Agency:

- Benefits will be paid for up to 100 visits in one calendar year furnished directly to a person during Home Health Care Agency visits;
- A visit of four hours or less counts as one visit. Each four hours of service (or fraction thereof) is counted as a separate visit; and
- For other services and supplies, the benefit cannot exceed the amount that would have been paid had they been furnished by a Hospital during an inpatient confinement. For this purpose, a Hospital Confinement is considered a continuous period during which inpatient care in a Hospital, Convalescent Nursing Home, or skilled nursing facility would be required were it not for the home care.

Miscellaneous Benefits

The Plan also provides benefits for the following miscellaneous medical treatments, services, and supplies:

- **Blood and blood plasma** not replaced by or for the patient;
- **Medical devices** such as artificial limbs, eyes, and larynx; electronic heart pacemaker; and surgical dressings, casts, splints, trusses, braces, prosthetics, crutches, oxygen, and rental of equipment for its administration. Medical devices costing over $1,000 during one calendar year must be Preauthorized. Failure to Preauthorize medical devices costing more than $1,000 will result in denial of coverage;
- **Contact lenses or eyeglasses** needed because of and obtained immediately after a cataract operation. Benefits will not exceed the R&C Rate and no benefit will be payable unless Medically Necessary. No benefits will be paid to replace contact lenses or eyeglasses due to loss, breakage, or prescription change; and
- **Implantable contraceptive devices,** including their insertion and removal.

Private Duty Nursing

The Plan will cover a maximum of $10,000 in eligible private duty nursing charges for any covered individual in a calendar year. The following conditions must also be met:

- The patient cannot be in a Hospital or other institution that provides nursing services;
- The services must be required to treat an acute illness or Injury; and
- The nursing services must be provided by a registered graduate nurse and cannot be provided by you, your spouse, or anyone related to you or your spouse by blood or marriage.

This benefit covers professional nursing care for persons whose health and welfare would be endangered without the skill and training of a registered graduate nurse.

Benefits will not be paid for any services that are primarily Custodial Care or for services that:

- Are mainly to assist the patient with the functions of daily living or to dispense oral medication; and
- Could be properly furnished by someone without the professional qualifications of a registered graduate nurse.

Travel Vaccinations

If you or your dependents plan to travel to a country outside the United States where certain vaccinations, consistent with current CDC guidelines (cdc.gov/travel), are recommended by your Physician, any such vaccinations are covered at 100% if provided in-network (if applicable). If the vaccinations are provided out-of-network (if applicable), the Plan will pay the Coinsurance level specified in the *Overview of Your Cost-sharing* chart in the *Plan Highlights* chapter.

General Exclusions

The Plan does not provide benefits for services or supplies that are:

- Not Medically Necessary, including tests or checkup exams that are not Medically Necessary;
- Cosmetic Procedures;
- Covered under another benefit plan for which your Employer pays all or part of the cost;
- For a supply that your Employer is required to furnish;
- For the treatment of Injury or illness incurred as a result of declared or undeclared war, an act of war, or resistance to armed aggression;
- For the treatment of Injury or illness incurred in the commission of an assault, felony, strike, civil disorder, or riot (however, this exclusion does not apply to otherwise eligible charges to treat Injury or illness incurred by victims of domestic violence);
- For treatment while you are confined to jail, prison, or another house of correction as a result of conviction for a criminal or other public offense;
- For services or supplies that the covered person would not otherwise have the responsibility to pay. (e.g., for coordination of benefit purposes, this Plan, as the secondary payer, will not cover charges that have been denied by the primary plan and for which the patient is not responsible);
- For the charges and all supporting materials for a claim received more than 12 months after the services or supplies are provided;
- Higher than R&C Rates; or
- For services rendered by yourself or by anyone related to you or your dependents by blood or marriage.

Specific Exclusions

Blood

The Plan will not cover charges for blood or blood plasma that is replaced by or for the patient.

Dental Expenses

The Plan does not cover dental expenses, including charges for Physician's services or x-ray exams involving one or more teeth, the tissue or the structure around teeth, or the gums. This exclusion for dental expenses applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of temporomandibular joint disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning teeth.

The Plan's dental expense exclusion does not apply to charges for:

- TMJD when the Plan determines that internal derangement or degeneration exists, that treatment is appropriate for the existing condition, that a suitable long-term prognosis can be achieved by TMJD treatment, and that there is no alternative, less-invasive treatment;
- Treatment by a Physician, dentist, or dental surgeon of injuries (except injuries that result from chewing) to sound natural teeth, including replacement of such teeth and related x-rays received within 12 months after an Accident; and
- Removal of un-erupted impacted teeth, or removal of a tumor, cyst, or incision, and drainage of an abscess or cyst.

Dietary supplements

Nutritional supplements such as Ensure, Limbrel, and Vanachol or specialized infant formula.

Elective Abortions

Elective abortions are not covered under the Plan unless Medically Necessary.

Eye Care

Eye care charges (such as radial keratotomy or similar procedures such as LASIK) not specifically outlined in the Plan will not be covered by the Plan.

Foot Conditions

The Plan does not cover charges for Physician's services in connection with weak, strained, or flat feet; instability or imbalance of the foot; or any metatarsalgia or bunion, unless the charges are for an open cutting operation that is otherwise covered. Further, the Plan will not cover charges for treating corns, calluses, or toenails unless the charges are for removal of nail roots or unless the services are Medically Necessary to treat a metabolic or peripheral-vascular disease.

Government Plan Charges

In most cases, the Plan will not cover charges for a service or supply that is furnished under any government program. Contact CBA for more information.

Impregnation or Fertilization

The Plan will not cover charges related to or for actual or attempted impregnation or fertilization that involves either a covered person or a surrogate as a donor or recipient.

Manipulation Therapy

The Plan will not cover charges incurred in connection with treatment of a chronic maintenance condition by manipulation therapy.

Occupational Injury, Sickness, or Disease

In most cases, the Plan does not cover charges incurred in connection with:

- Injury, sickness, or disease that arises out of or in the course of any employment for wage or profit; or
- Injury, sickness, or disease that is covered by any workers' compensation law, occupational disease law, or similar law.

Charges for occupational injury, sickness, or disease that would otherwise be excluded from Plan coverage may be, in CBA's sole discretion, advanced by the Plan, if:

- The party responsible for paying occupational injury, sickness, or disease charges has not made payment;
- There is a dispute between you and the party responsible for paying occupational Injury, sickness, or disease charges as to 1) whether the charges are payable by such party or 2) the amount that should be paid by such party;
- You have exhausted your administrative remedies under applicable workers' compensation law, occupational disease law, or similar law by requesting every available claim denial review or appeal; and
- You (or, if incapable, your legal representative) agree in writing on forms provided by CBA to repay to the Plan any benefits advanced to you by the Plan within 30 days after you receive any future payments made by or on behalf of the party responsible for paying occupational Injury, sickness, or disease benefits. If you do not repay the Plan within 30 days of your receipt of such benefits, the Plan may take legal action to pursue repayment plus interest on any unpaid principal amount of the advance that is not repaid within 30 days of your receipt of the other benefits. Interest will be calculated at a rate equal to the prime rate plus 3% (compounded annually from the date that is 30 days after you receive the other benefits). The Plan may also seek to recover its costs and attorney's fees incurred to enforce this repayment provision.

For purposes of this provision, "you" includes Participants, their covered dependents, COBRA beneficiaries, and any other person who may recover under this Plan on your behalf (e.g., your estate).

Prescription Drugs

Outpatient prescription and non-prescription drugs are not covered under the Plan's medical benefit. Outpatient prescriptions should be filled through CVS Caremark (the Plan's pharmacy benefit manager, described in the *Prescription Drug Benefits* chapter).

Infusion nursing services for select specialty medications that are administered in the home or in an ambulatory infusion center are covered through the pharmacy benefit and are coordinated through and dispensed by the CVS Caremark Specialty Pharmacy. For non-oncology infused specialty medications that require administration by a medical professional, a CareTeam nurse will work with you and your provider to assess your clinical history and determine clinically appropriate options for clinician-infused specialty medications, such as a location for your infusion. Options may include home care, an ambulatory infusion center, a Physician's office, and so on. CareTeam nurses will contact all affected members to provide assistance and guidance.

Generally, specialty drugs are **not covered** under the medical benefit and will not be filled by any pharmacy except for CVS Caremark Specialty Pharmacy, regardless of Medical Necessity. Prior Authorization of specialty drugs may be required regardless of the benefit that covers the drug or the identity of the Provider who administers the drug.

However, specialty drugs **may be covered** under the medical benefit in these limited circumstances:

- When billed by a facility as part of an inpatient Hospital stay or an emergency room visit. Preauthorization by CVS Caremark is not required.
- When Medicare or a non-NRECA provider is the primary carrier. Preauthorization by CVS Caremark is not required.
- When home care is not clinically appropriate and an alternative infusion site qualified to administer the drug is not available within a reasonable proximity (30 miles or less) to coordinate services. This may be due to the patient's clinical history or because the drug's characteristics require special handling. These situations will be evaluated by CVS Caremark clinical staff.

When the treating Physician provides written documentation 1) outlining the clinical rationale for requiring the patient to be treated at the designated facility and 2) confirming that the designated facility is unable to accept drugs dispensed by CVS Caremark. Such written documentation will be reviewed and approved by CVS Caremark clinical personnel **before** allowing coverage for the requested drugs under the medical benefit.

Prescription Digital Therapeutics

Prescription Digital Therapeutics (PDTs) are not covered under the Plan. PDTs include prescription-only software that is intended to prevent, manage or treat mental or physical conditions.

Sterilization Reversal

The Plan will not cover charges incurred in connection with a surgical procedure to reverse a vasectomy or a sterilization tubal ligation.

Surgical Expenses Not Covered by the Plan

Surgical expenses for 1) surgeries that are investigational or experimental or 2) Cosmetic Procedures (unless due to either a congenital defect that impairs the function of a body organ or an Accident) are not covered by the Plan.

Coordinating Benefits with Other Plans

This Plan contains a coordination of benefits provision that applies whenever an allowable expense is also covered under one or more other plans. The term “other plans” means:

- Other group plans, whether fully insured or self-insured;
- Governmental plans (except Medicaid); and
- Medical insurance as provided by a motor vehicle insurance contract.

Participants are required to notify the Plan if they are personally covered under any other medical Plan by calling NRECA’s Member Contact Center (MCC) at 866.673.2299 or by emailing MCC at ContactCenter@nreca.coop. Under the general coordination of benefits rule, the total benefits paid by all plans will not exceed 100% of allowable expenses. An allowable expense for coordination of benefits means any necessary expense covered at least in part by the NRECA Medical Plan.

Primary and Secondary Plans

When a claim is made, the primary plan pays benefits without regard to any other plans. The secondary plan adjusts benefits so that the total benefits payable do not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision, then to determine which plan is primary, the following rules apply, in the order listed:

- **Employee and dependent coverage:** The plan covering an individual, other than as a dependent, is primary to the plan covering an individual as a dependent;
- **Dependent child coverage when parents are not separated or divorced:** The plan of the parent whose birthday falls earlier in the calendar year will be primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary;
- **Dependent child coverage when parents are separated or divorced:** The parents’ plans pay in this order:
  1. The responsible parent’s plan, if a court decree has established financial responsibility for the child’s health care expenses;
  2. The custodial parent’s plan;
  3. The stepparent’s (i.e., the custodial parent’s spouse’s) plan; or
  4. The non-custodial parent’s plan;

- **Active and inactive employment:** The plan covering an individual through active employment is primary to the plan covering the individual through retirement or layoff status; or
- **Longer or shorter length of coverage:** If none of the above applies, then the plan covering the individual for the longest period is primary.

When it provides secondary coverage, this Plan's benefit is adjusted to account for the primary plan's payment and to exclude any charges that have been disallowed by the primary plan and for which the patient is not responsible. In this way, the total benefits available under both plans will not exceed the allowable expenses. This Plan never pays more than it would have paid without the coordination provision.

To receive payment on a claim when this Plan is secondary, you must attach an EOB from the primary plan to the itemized bill when you submit the claim. See the *Claims and Appeals* chapter for detailed instructions.

Coordination with Medicare

If you and any of your covered dependents are eligible for Medicare benefits, the benefits payable under this Plan will be coordinated with the benefits payable under Medicare. In some cases, this Plan will be the primary plan and will pay benefits without regard to your Medicare benefits. In other cases, this Plan will be the secondary plan and your benefits under the Plan will be reduced by your Medicare benefits. Here's how to determine if this Plan is primary or secondary:

- This Plan is the primary plan (and Medicare is secondary) if you are:
  - Actively at Work (e.g., if you have not yet retired);
  - Disabled and have not yet qualified for Medicare coverage; or
  - Within the first 30 months of your Medicare coverage for kidney dialysis treatment or a kidney transplant.
- **This Plan is the primary plan (and Medicare is secondary)** if you are an active Employee who has a Medicare-eligible dependent enrolled in the Plan, unless your dependent is qualified for Medicare coverage after the first 30 months of his or her Medicare coverage for kidney dialysis treatment or a kidney transplant; and
- **Medicare is the primary plan (and this Plan is secondary)** after the first 30 months of your Medicare coverage for kidney dialysis treatment or a kidney transplant.
- **Medicare is the primary plan (and this Plan is secondary)** if you are approved for long-term disability and are covered by Medicare (for a reason other than kidney dialysis or kidney transplant); and
- **Medicare is the primary plan for a covered dependent (and this Plan is secondary)** if you are approved for long-term disability and your dependent is covered by Medicare for a reason other than kidney dialysis or kidney transplant.

When this Plan is the primary plan, your benefits will be determined independently of any Medicare benefits you may receive. When Medicare is primary, the medical benefits under this Plan are reduced by the Medicare benefits available under Medicare Parts A and B, whether or not you have enrolled in both programs. The specific amount of the reduction will be determined by CBA and reflected on your EOB. If you anticipate that Medicare will be your primary plan, you should apply for full Medicare coverage under Medicare Parts A and B to ensure that you receive the maximum combined benefits available under Medicare and this Plan.

Occasionally, you or your dependents may have coverage under this Plan, Medicare, and a third plan, such as when you are covered as a dependent under a plan sponsored by your spouse's employer. In this case, the benefits payable under this Plan will be determined by first applying these Medicare coordination rules and then applying the rules listed in the *Primary and Secondary Plans* section.

Chapter 6: Prescription Drug Benefits

The prescription drug benefit is a key element of your health care benefits package under the Plan. This chapter describes how the prescription drug benefit works; explains its unique features; and outlines the prescription drugs that are covered, limited, and excluded.

How the Benefit Works

CVS Caremark is the Plan's pharmacy benefit manager (PBM). The role of the PBM is to:

- Provide a preferred pharmacy network of over 24,000 national retail, mail-order, and specialty pharmacies;
- Manage the Plan's Formulary, which is the list of drugs that the Plan covers; and
- Provide a dedicated customer service team for Plan Participants and their covered dependents.

The drugs included in the Plan's Formulary are subject to change from time to time by CVS Caremark, if accepted by the Plan. All drug lists are updated quarterly and are available at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you.

As a courtesy, the Plan may send a notice of change in the mail to you based upon your prior prescriptions filled providing you with additional notice of any changes and any impacts to your drug coverage.

Exclusive Choice Network

The Exclusive Choice Network is the Plan's preferred group of pharmacy providers. It includes CVS Pharmacy, Walmart, Sam's Club, Cardinal Health (Leader Drugs, Medicine Shoppe, Brookshire Drugs, and BI-LO Pharmacy), and the CVS Caremark Mail Order Pharmacy. You can fill prescriptions at any pharmacy, but you will receive a deeper discount by using a pharmacy in the Exclusive Choice Network. To find a participating retail network pharmacy, contact CVS Caremark. This network is not applicable to pharmacies in the state of Oklahoma.

Oklahoma Extended-Day Supply (EDS) Network

The Extended-Day Supply (EDS) Network is the Plan's preferred group of pharmacy providers in the state of Oklahoma. It includes any chain or independent retail pharmacy willing to participate in the network, including CVS Caremark mail-order. You can fill a prescription at any pharmacy, but you will receive a deeper discount by using a pharmacy in the EDS Network. To find a participating retail network pharmacy, contact CVS Caremark. This network is only applicable to pharmacies in the state of Oklahoma.

Performance Drug List

Because there are thousands of prescription drugs on the market with similar therapeutic effects at varying costs, CVS Caremark developed a Performance Drug List. The Performance Drug List contains brand-name prescription drugs for which no generic equivalent is available and generic prescription drugs. The list is updated each quarter, taking into account therapeutic factors and price.

Under the Plan's three-tier design, Participants pay a lower Copayment or Coinsurance amount when they use a preferred brand-name drug on the list compared with a non-preferred brand-name drug that is not on the list. This helps control costs by encouraging Participants to choose quality drugs that usually have the best price. In a three-tier prescription drug plan, Participants have a choice to:

- Pay the lowest Copayment or Coinsurance for a generic drug;
- Pay a higher Copayment or Coinsurance for a brand-name drug on the list; or
- Pay the highest Copayment or Coinsurance for a non-preferred brand-name drug not on the list.

You can find a current copy of this Plan's Formulary at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists. If you are unable to access the website, call NRECA's MCC to request a copy at no cost to you.

Performance Drug List Updates

A new-to-market product or a new variation of a product already on the market will not be added to the Formulary until that product has been evaluated, determined to be clinically appropriate and cost-effective, and approved by the CVS Caremark Pharmacy and Therapeutics Committee or other appropriate reviewing body. For example, as new specialty and hepatitis C products launch, all existing products in the class will be re-evaluated to determine appropriate Formulary placement and whether they will be excluded, added back, or not listed.

Coinsurance and Copayments (if Applicable)

You pay less when you use a participating (in-network) retail network pharmacy. If you use a non-participating retail network pharmacy (out-of-network), you must pay any difference between the in-network cost and the actual cost of the prescription.

For most prescription drugs, you must pay a specific-dollar amount (known as a Copayment) or a percentage (known as Coinsurance) toward the cost.

If you fill your prescriptions for covered generic drugs by mail order or at an Exclusive Choice pharmacy your Copayments are waived.

See the *Plan Highlights* chapter to check Coinsurance percentages and applicable Copayment amounts for the various types of prescription drugs provided under the Plan.

Maintenance Medications

Maintenance medications are prescription drugs taken for longer than 30 days for a chronic condition. By using mail-order service for long-term maintenance drugs, you can save money. You have two options for filling 90-day maintenance medication prescriptions: either the CVS Caremark Mail Order Pharmacy or a preferred network pharmacy. To find a participating retail network pharmacy, contact CVS Caremark. Note that the Plan has special rules for opioid maintenance medications. These are described in the *Coverage of Opioid Pain Management Medication* section below.

Coverage of Opioid Pain Management Medication

To help ensure the safe use of opioid pain management medications, the Plan has set coverage limits for opioid medications. These limits align with CVS Health's enterprise-wide opioid medication prescription fill policy and with the Centers for Disease Control and Prevention's latest guidelines, which are based on prescription prescribing limits up to 90 morphine milligram equivalents (MME) per day. The Plan limits coverage of opioid medications as follows:

- Limits the first fill of an opioid medication to **seven days' supply** for Participants who have not used opioid medication in the past 90 days. A Physician can submit a Prior Authorization request by calling CVS Caremark at 855.240.0536 if the Participant needs opioid medication for longer than seven days.
- Limits the quantity of opioid products prescribed to 90 MME per day. Opioid products containing acetaminophen or aspirin will be limited to four grams of acetaminophen or aspirin per day and products containing ibuprofen will be limited to 3.2 grams of ibuprofen per day.
- Requires the use of an immediate-release formulation of the opioid medication (e.g., generic Ultram or Lortab) before moving to an extended-release formulation of the opioid medication (e.g., Methadone or MS Contin).

Opioid medications that are prescribed to treat cancer-related pain are not subject to the Plan's coverage limits.

A list of common opioid medications subject to the seven-day initial fill limit is available at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists or by calling CVS Caremark Customer Care at 888.796.7322 if you have questions about opioid prescriptions. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you. Note that this list is subject to change on a quarterly basis.

CVS Caremark Mail Order Pharmacy

Your prescription drug Plan offers mail-order as an alternative to retail. Filling prescriptions by mail has three distinct cost-saving advantages over using a retail pharmacy:

- You can order up to a 90-day supply for a lower Copayment than three separate 30-day prescriptions at a retail pharmacy (at a non-Exclusive Choice or non-Extended-Day Supply pharmacy, the most you can order is a 30-day supply);
- Ingredient costs are lower and drug discounts are greater than at a retail pharmacy; and
- There is no dispensing fee, which lowers the prescription price (retail pharmacies charge a dispensing fee).

The CVS Caremark Mail Order Pharmacy provides a convenient and cost-effective way for you to order maintenance or long-term medication for direct delivery to your home. Mailing cost is included when drugs are obtained through the CVS Caremark Mail Order Pharmacy, unless you request a special shipping method (e.g., UPS, FedEx), in which case you must pay for the extra shipping charges.

If you take a maintenance medication, ask your Physician to write a prescription for 90 days with three refills (total of one year). Complete the mail service order form and send it to CVS Caremark with your original prescription. Credit card is the preferred payment method. You can expect to receive your prescription approximately 10 to 14 days after CVS Caremark receives your order. You will receive a new pre-printed order form and a return envelope with each shipment. When re-ordering, verify that your pre-printed name, identification number, and mailing address are all correct on the order form. Send the form to the pre-printed CVS Caremark mailing address on the order form.

You can choose to pay the cost-sharing amount when your mail-order is delivered. However, to avoid future order delays or canceled orders, Participants are encouraged to pre-pay the cost-sharing amount when they place the initial phone, mail, or online order. You can pre-pay by personal check, money order, debit card, or credit card. CVS Caremark permits a maximum outstanding mail order account balance of $200 per family. If your family balance exceeds that limit, CVS Caremark contacts the Plan Participant to request payment by bank card or credit card before releasing the order.

Once you have processed a prescription through CVS Caremark, you can obtain refills:

- **Online**: Visit caremark.com to order prescription refills or inquire about the status of your order. You will need to register on the site and log in.
- **Through the CVS Caremark mobile app**: Select "Refill Options."
- **By phone**: Call 888.796.7322 for CVS Caremark's fully automated refill phone service.
- **By mail**: Attach the refill label provided with your prescription order to a mail-service order form. Enclose your payment and mail the order form to the pre-printed mailing address on the form.

CVS Caremark Specialty Pharmacy

Specialty medications are specialized, often expensive medications that are used to treat and manage chronic or complex conditions. Specialty and biotech drugs are not eligible for coverage through retail pharmacies. All specialty or biotech drug prescriptions must be filled by mail using CVS Caremark Specialty Pharmacy mail service. The Plan limits specialty drugs to a 30-day supply at one time. This allows a dedicated CVS CareTeam to work closely with patients and Physicians to encourage patient treatment adherence, achieve better outcomes, and reduce medical costs.

You or your dependents must enroll before using CVS Caremark Specialty Pharmacy mail service to fill and refill both biotech and specialty drug prescriptions. Enroll by calling CVS Specialty Connect® at 800.237.2767 or online through caremark.com. After you enroll, a CareTeam specialist will work with you and your Physician to confirm coverage. They will discuss the availability of copay assistance and conduct a clinical review of the needed medicines. Thereafter, you can refill prescriptions online, by phone, or by mail.

Some specialty medications may qualify for a manufacturer Copayment assistance program, which could lower your out-of-pocket costs for those medications. When a Participant uses Copayment assistance for any such specialty medication, the Copayment assistance amount is not credited toward the Deductible or Coinsurance maximum. For this reason, if you participate in a high-deductible health plan and receive Copayment assistance for a specialty drug, you may not satisfy your Deductible as quickly compared with prior years**.**

You may see differences in your Deductible or Coinsurance totals when your specialty medication ships at a later date. Your Deductible and Coinsurance maximums may temporarily reflect the Copayment assistance amount but will be adjusted after your medication is shipped.

Also, when using Copayment assistance for specialty drugs, the Copayment assistance itself does not qualify for reimbursement from your tax-advantaged side account (e.g., health reimbursement arrangement (HRA) and health care flexible spending account (FSA)) because it is not a qualified out-of-pocket expense.

Prescription Drug Discount Programs

Caremark Cost Saver Program
The Caremark Cost Saver Program provides you with automatic access to industry-leading discount prescription pricing which allows you to pay the lowest available cost on select non-specialty generic medications covered by the Plan, when available. The Caremark Cost Saver program automatically compares the price under your pharmacy benefit to one of the major prescription drug discount programs and then applies the lowest price for select covered non-specialty generic medications at all in-network pharmacies. You do not need to register for this program or present any coupons to your in-network pharmacy to benefit from this program. You only need to present your medical ID card to the in-network pharmacy of your choice. The amount you pay will apply to your Deductible or Coinsurance maximum.

Other Prescription Drug Discount Programs
The Plan will not cover or reimburse any prescription drug that you purchase using prescription drug discount programs outside of your pharmacy benefit, including, but not limited to, GoodRx and WellRx. If you use a discount program to purchase a prescription drug, the Plan will not credit your Deductible or Coinsurance maximum either for the cost that is covered by the discount program or for any related out-of-pocket costs. Note that prescription drug discount programs are not valid with other insurance plans, including Medicare, Medicaid, and any state or federal prescription insurance.

Choosing a Brand When There's a Generic

Dispense as written (DAW) is another important, standard feature of the Plan’s prescription drug benefit. DAW applies to prescription drugs that have a generic equivalent. This feature encourages generic drug use while still giving you a choice.

When a generic equivalent is available and you choose a brand-name drug instead, you are responsible for the generic Copayment or Coinsurance plus the difference between the cost of the brand-name drug and the cost of the generic. This provision remains in effect even if the prescribing doctor notes or checks “dispense as written” or “do not substitute” on the prescription. For a generic drug, you pay only the generic Copayment or Coinsurance.

In the example below, DAW applies if you want Lipitor, but the generic version Atorvastatin is available. You would pay the generic Copayment plus the difference between the brand-name and the generic costs.

Drug Name	Cost
Lipitor	$183
Atorvastatin	$56
Cost difference	$127
Generic Copayment	$10
Patient Responsibility (cost difference plus generic Copayment)	**$137**

Prior Authorization

Certain prescription drugs or drug categories require Prior Authorization to ensure their safe, effective, and appropriate use. The Plan's Prior Authorization requirements are based on FDA-approved uses of the medication and FDA medication labeling. Prior Authorization means that your Physician must call CVS Caremark at 855.240.0536 to confirm, as applicable, that the prescribed medication is being appropriately used or is Medically Necessary. The Plan requires Prior Authorization for:

- All specialty and biotech prescription drugs;
- Certain ingredients (e.g., bulk powders or agents, compounding kits, and proprietary bases) present in compounded drugs;
- Certain non-preferred brands;
- Compounded drugs with a total cost of $300 or more;
- Drugs that are not on the Formulary;
- Drugs that are subject to Plan quantity limitations when a Physician determines that a larger quantity is needed;
- Drugs that have significant safety concerns or are subject to overuse or misuse;
- Drugs that require additional criteria requirements or documentation to approve coverage;
- Ivermectin;
- Medications to treat attention deficit and hyperactivity disorder in patients in patients 19 years and older;
- Obesity or weight loss drugs; appetite suppressants; and anorexiants;
- Prescription dietary supplements, prescription multivitamins, prescription probiotics;
- Sirturo, Sinuva and Gocovri;
- Solaraze 3% Topical Gel;
- Opzelura, Vuity, Gralise, Horizant, Lyrica, Lyrica CR, Xhance, Sucraid, Qbrexza, Sivextro, Nuzyra, and Osmolex ER;
- Testosterone replacement;
- Topical acne products;
- Transmucosal Immediate Release Fentanyl; and
- Voriconazole.

The criteria for Medical Necessity include not only the drug and diagnosis but also the clinical appropriateness of a medication in terms of the condition being treated, severity of condition, medication type, frequency of use, and duration of therapy. When the Plan denies coverage at a retail pharmacy because a drug has not been Preauthorized, the denial message from the pharmacy benefit manager to the pharmacist explains who the prescriber must call to obtain Prior Authorization.

Drugs Requiring Prior Authorization

Medications Requiring Prior Authorization for Medical Necessity lists medicines, by drug class, not covered without Prior Authorization for Medical Necessity. CVS Caremark maintains this list and updates it quarterly. You may access the list at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you.

If you continue to use one of these drugs without prior approval for Medical Necessity, you may be required to pay the full cost. If your doctor believes you have a specific clinical need for one of these drugs, your doctor should contact the CVS Caremark Prior Authorization Department toll-free at 855.240.0536. If you have any questions, you may call CVS Caremark Customer Care at 888.796.7322.

Multi-ingredient Compounded Prescriptions and Bulk-compounding Powders

A compounded drug is one that is made by combining, mixing, or altering ingredients, according to a prescription, to create a customized drug that is not otherwise commercially available.

The Plan covers compounded drugs when they are used for FDA-approved indications, for uses and routes of administration supported by or found in medical compendia, or for other currently accepted practice guidelines. All other Plan provisions apply. To be covered, all ingredients in the compounded medication and the compounded formulation itself must be covered. If the medication is reformulated, it must meet FDA-approved guidelines for the treated condition.

All compounded drugs with a total cost of $300 or greater require Prior Authorization. The main or most expensive ingredient determines your Copayment or Coinsurance (as applicable). All compounded drugs that contain one or more specialty pharmacy ingredient must be filled and dispensed by CVS Caremark Specialty Pharmacy. Applicable specialty drug Copayments apply.

If you continue to use one of these drugs without prior approval for Medical Necessity, you may be required to pay the full cost. If your doctor believes you have a specific clinical need for one of these drugs, your doctor should contact the CVS Caremark Prior Authorization Department toll-free at 855.240.0536. The Plan maintains a list of bulk powers, proprietary bases, and various topical products frequently marketed contrary to FDA approved indications and subject to Prior Authorization by CVS when such drugs or products are present in a compound drug. The list is subject to change and is not an all-inclusive list of all compound drugs subject to Prior Authorization. A listing of these drugs or products can be found at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists. If you have any questions, you may call CVS Caremark Customer Care at 888.796.7322. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you.

Step Therapy

Step therapy is an automated form of Prior Authorization that occurs at the point-of-sale to encourage the use of less costly, but similarly effective, medications before more costly medications are approved for coverage. Step therapy requires Participants to try a lower-cost medication (known as step 1) before progressing to a higher-cost alternative (known as step 2). Certain medications such as extended release opioids and agents to treat migraines require step therapy.

Quantity Limits

Quantity limits for covered prescription drugs are based on several factors, including, but not limited to, FDA-approved dosing, medical literature, and other supportive and analytic data.

Quantity duration limits define the maximum medication quantity that the Plan will cover in a specific time (e.g., 30 units or 1,000 mg per month).

Quantity level limits define the maximum medication quantity that the Plan will cover per prescription or Copayment (e.g., 30 units per prescription). For information about drugs requiring quantity limits or if a patient's condition warrants additional quantities of a medication beyond the Plan maximum, the prescriber can contact CVS Caremark at 855.240.0536.

The listing of Specialty and Non-specialty prescription drugs subject to quantity level limits may be updated quarterly by CVS Caremark and a current list can be found at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists or by calling CVS Caremark at 855.240.0536. If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list at no cost to you.

Medication Monitoring Program

To encourage the safe and appropriate use of prescription drugs, the Plan participates in a monitoring program through its prescription benefit manager, CVS Caremark. This program proactively identifies potential cases of fraud, waste, or abuse by flagging Participant behaviors of concern related to controlled substances and drugs with potential for misuse. Such behaviors include, but are not limited to, frequent claims, use of multiple prescribers, use of multiple pharmacies, and excessive medication use or claim costs. A pharmacist reviews the flagged situations and may contact prescribers to gather more information and determine the need for intervention, if any. To support safe and appropriate medication use, the Plan reserves the right to limit a Participant (or a covered spouse or dependent) indefinitely to one pharmacy for all of that individual's prescriptions. In this case, the Plan will send a letter notifying the Participant.

Prescription Drug Support Online

The CVS Caremark website allows you and your dependents to review your prescription drug benefits, cost-sharing, benefits coverage, general health, and drug information. You can order refills for mail order prescriptions and check your personal prescription history. You can also set up an email alert that will prompt you when it is time to refill a prescription. All personal and prescription drug information is password protected.

Chronic Condition Management

If you or your dependent(s) have a chronic condition, you will receive occasional mailings to help use medications appropriately and improve the quality of your life. For example, diabetes-related mailings offer free blood glucose monitors to Participants living with diabetes.

Pharmacy Clinical Support

Pharmacy clinical support, also known as cost containment, is part of the Plan. Pharmacy clinical support helps manage costs and adds another level of quality review by encouraging drug therapy compliance and proper use of the prescription drug benefit. Under this program, CVS Caremark reviews retail prescription claims and, in some cases, contacts the prescribing Physician to suggest drug therapy changes based on national clinical guidelines and standards of care. The Physician decides whether to follow the recommendations and approve the suggested changes for future prescriptions. For example, a medication will be reviewed when it is prescribed for longer than recommended for its particular drug class. Examples include muscle relaxants and gastrointestinal (GI) medications (e.g., Nexium, Aciphex, Omeprazole). Excessive refills of medications like these may be removed from a prescription if your Physician agrees. Every effort is made to ensure minimal disruption to you and your dependents. If you disagree with a Physician-approved change, you can request to have the refill reinstated by having your medical provider call CVS Caremark at 888.796.7322.

If cost containment changes are made to mail order prescriptions, you or your dependent will receive a letter with your filled order to notify you of the change. A short delay may occur while CVS Caremark attempts to contact your Physician to discuss potential changes.

What the Plan Covers

Diabetic Supplies

Diabetic supplies include, but may not be limited to, insulin, needles, clinitests, syringes, test strips, alcohol swabs, lancets, and select insulin pump supplies such as infusion sets, reservoir tips, and Polyskin.

Specialty and Biotech Drugs

Specialty and biotech drugs are used to treat a variety of serious and complex medical conditions, such as multiple sclerosis, certain cancers, growth hormone disorders, hemophilia, rheumatoid arthritis, Crohn's disease, cystic fibrosis, and hepatitis C. These drugs are derived from biological processes and are considered specialty drugs. Biotech drugs are generally single-source brand-name medications, meaning there is no generic equivalent available. Many are administered via injection rather than taken orally and require special shipping, storage, and administration.

Specialty and biotech drugs have a 30-day supply limit.

Because there are thousands of prescription drugs on the market with similar therapeutic effects at varying costs, CVS Caremark developed the Advance Control Specialty Formulary List. This list contains brand-name prescription drugs for which no generic equivalent is available and generic prescription drugs. The list is updated each quarter, taking into account therapeutic factors and price.

The CVS Caremark Specialty Pharmacy service helps Participants safely use specialty and biotech drugs and effectively adhere to the challenging treatment regimens associated with taking a specialty medication. You will have access to educational materials, phone consultations, and refill reminders to help with specific treatments.

CVS Caremark's Specialty Pharmacy Services also dispenses specialty drugs used to treat conditions related to:

- Asthma;
- Cancer;
- Crohn's disease;
- Enzyme replacement for lysosomal storage disorders;
- Growth hormone disorders;
- Hematopoiesis disorders;
- Hemophilia and Von Willebrand disease;
- Hepatitis C;
- Immune disorders;
- Multiple sclerosis;
- Psoriasis;
- Pulmonary arterial hypertension (PAH);
- Pulmonary disorders;
- Respiratory syncytial virus (RSV); and
- Rheumatoid arthritis.

The list of specialty drugs covered by the Plan is subject to change from time to time. A current list of specialty drugs can be found at cooperative.com > My Benefits > My Insurance > Prescription Drug > View Drug Coverage Lists. If you are unable to access the website, call NRECA's MCC at 866.673.2299 for a copy of the list at no cost to you.

Vaccines

Coverage for flu, COVID-19, zostavax, and pneumonia vaccines is available through the vaccine network, which consists of retail pharmacies that offer vaccines and are part of the national CVS Caremark retail pharmacy network. There is no cost and no Copayment because the Plan covers these vaccines at 100%. Call ahead for availability or to make an appointment, if required. Take your health ID card and a valid photo ID. Inform the provider that vaccines are covered at 100% under your prescription drug benefit. Visit caremark.com to find a network pharmacy in your area or call CVS Caremark Customer Care toll-free at 888.796.7322.

Specific Exclusions

These drugs are not covered under the Plan's prescription drug benefit:

- Allergy serums;
- Anabolic steroids;
- Biological sera (drugs that are obtained, purified, and standardized from human serum or plasma);
- Blood or plasma;
- Charges for the administration or injection of any drug, unless related to specialty pharmacy administration or injection;
- Compounded drugs marketed contrary to FDA-approved indications, for uses and routes of administration not supported by or found in medical compendia or for other currently accepted practice guidelines;
- Depigmenting agents;
- Dietary (nutritional) supplements such as Ensure, Limbrel, and Vanachol or specialized infant formula;
- Drugs administered in and billed by a Physician's office;
- Drugs administered to a patient by a Hospital, nursing home, extended-care facility, or similar institution that operates a pharmacy on its premises;
- Drugs prescribed, filled, or obtained by a Physician, pharmacist, or pharmacy that is not licensed in the United States;
- Drugs purchased outside of the United States (see the *Coverage While Traveling Outside the United States* section in the *Medical Plan Benefits* chapter);
- Drugs that do not require a prescription (over-the-counter drugs unless listed in the *Prescription Drugs and Supplies Covered Under the Plan* section);
- Infertility drugs;
- All insulin pumps and blood glucose monitors (unless covered under the medical Plan benefits). Disposable insulin pumps are covered under the pharmacy benefit;
- Investigational or experimental drugs;
- Non-prescription vitamins and minerals;
- Ostomy supplies (unless covered under the medical Plan benefits);
- Prescription Digital Therapeutics (PDT);
- Therapeutic devices or appliances, support garments, and other non-medical substances;
- Topical fluoride preparations;
- Topical Minoxidil (such as Rogaine);
- Vaccines other than Flu, Zostavax, Pneumonia, and COVID-19;
- Absorica, Absorica LD, Avage, Brand and generic versions of Duexis and Vimovo; Glumetza, Fortamet and their generics; Livalo, Xyosted, Jublia, Soaanz, Dextenza, Seglentis, Dartisla, Zetonna, Beconase AQ, Tivorbex, Yosprala, Durlaza, Ketoprofen ER, Zolpimist, Gimoti, Roszet, Trokendi XR, Qudexy XR, Aplenzin, Zipsor, Sprix, Arestin, Denavir, Treximet, Prudoxin, Rayos, Edluar, Cambia, Nalfon, Zorvolex, Ketoprofen, Sitavig, Qnasl, Zyflo (brand, generic & ext release), Forfivo XL, Fenortho, Xerese, Omnaris, *diclofenac powder 50 mg*, Ryaltris, Ziextenzo, and Entadfi;
- 510K artificial saliva products; and
- 510K medical device products.

Coverage Under Medicare

Retirees and their dependents age 65 and older are not eligible to participate in the Medical Plan, including prescription drug benefits, unless they enrolled in Medicare before retirement and elected COBRA Continuation of Coverage instead of the Plan's retiree benefits. For details, review the *Continuing Coverage Under COBRA* chapter. Note that if you are eligible for Medicare but your covered dependents are not Medicare eligible, then your dependents remain covered under the Plan's prescription drug benefit until Medicare becomes their primary insurer.

If you are under age 65 and become a Medicare-eligible Participant after January 1, 2023 due to disability or kidney dialysis treatment or a kidney transplant, you remain eligible to participate in the Plan with the Plan's medical benefits being secondary to Medicare and the Plan's prescription drug benefit being primary should you have no Medicare Part D Prescription Drug coverage and you:

- Have been totally disabled for at least six months;
- Are not currently working; and
- Are receiving disability payments from your Employer beyond the first six months of disability.

If you are under age 65 and become a Medicare-disabled Employee or are the dependent of such Medicare-disabled Employee that has Medicare after January 1, 2023, you may remain eligible to participate in the Plan with the Plan's medical benefit being secondary to Medicare and the Plan's prescription drug benefit being primary should you not enroll in any Medicare Part D Prescription Drug coverage.

If you are a Medicare-disabled Employee, or are the dependent of a Medicare-disabled Employee whose Medicare coverage began prior to January 1, 2023 (excluding those on Medicare due to kidney dialysis treatment or a kidney transplant), or are an under age 65 retiree or a dependent of an under age 65 retiree for whom Medicare is the primary payer, you will remain eligible to participate under the Plan's medical benefit with the medical Plan being secondary to Medicare, but you will not be eligible for the Plan's prescription drug benefit, unless you are not able to obtain comparable replacement Medicare Part D prescription drug coverage.

Participants covered under Medicare due to kidney dialysis treatment or a kidney transplant prior to January 1, 2023, shall remain covered under the Plan's prescription drug benefit for the first 30 months of his or her Medicare coverage for kidney dialysis treatment or a kidney transplant as long as they are under age 65 and not retired. After 30 months of coverage, when Medicare becomes the primary insurer, the Participant may enroll in a Medicare Part D prescription drug plan or another creditable plan. This Plan will become secondary to Medicare for medical benefits and the Plan's prescription drug benefit will become primary if you have no Medicare Part D Prescription Drug coverage.

If you are the Medicare-eligible dependent spouse or a Medicare-eligible dependent child of an Active Employee on Medicare due to kidney dialysis treatment or a kidney transplant, you remain eligible to participate in the Plan's prescription drug benefit as long as the Participant is still Actively at Work. The Participant will be eligible to enroll in a Medicare Part D prescription drug plan at the time that Medicare becomes the primary payer and the Medicare prescription drug coverage will be the primary payer for their prescription drugs. The NRECA medical plan will be the secondary payer.

For Medicare-disabled Participants, preventive drugs are covered under the Medical Plan at 100%. These individuals must submit paper claims to the address located on the back of their Health ID card.

COBRA Participants age 65 or older are not eligible to participate in the Medical Plan, including the prescription drug benefit, unless they were enrolled in Medicare prior to their COBRA qualifying event. For details, review the *Continuing Coverage Under COBRA* chapter.

Creditable Coverage for Medicare

Creditable prescription drug coverage means coverage that is expected to pay at least as much as the standard Medicare Part D prescription drug plan pays. All of the NRECA medical plans with prescription drug plans are considered creditable prescription drug coverage.

It is important to note that an individual does not need to sign up for Medicare at age 65 (and will not incur a penalty) if he or she 1) has not yet signed up for Social Security or Railroad Retirement income benefits, and 2) has Employer-sponsored medical coverage based on his or her own (or a spouse's) Active Work status.

All Participants who are enrolled in Medicare should maintain creditable prescription drug coverage to avoid paying higher premium charges when they do enroll in a Medicare Part D prescription drug plan. This is important because if you have a break in creditable coverage of 63 continuous days or longer before enrolling in a Medicare Part D prescription drug plan, you may have to pay a higher premium when you do enroll. If you need one, call the MCC to request a Certificate of Creditable Drug Coverage from the Plan. Use the number listed in the *Contact Information* chapter.

Note: If you are an active Employee (or the dependent of an active Employee) covered under this Plan and you become eligible for Medicare, but this Plan does not provide creditable drug coverage, you may be eligible to switch to coverage under another NRECA Plan (if offered by your Employer). You must make this change within 31 days of Medicare eligibility. If you believe you qualify, contact NRECA Employee Benefit Services at 866.673.2299 for further information and eligibility requirements.

Coordination of Benefits

The Plan does not have a coordination of benefits provision for prescription drug benefits. This means that the Plan will pay only for drug charges that are first submitted to this Plan. If the Participant first submits drug charges to another plan and then later submits them to the NRECA Plan as a secondary payer, the Plan will not consider those drug charges for payment.

Chapter 7: Medical Claims and Appeals

General Information

This chapter describes the steps you must take to file a claim for Plan benefits and to seek an appeal if benefits are denied.

Certain benefits under the terms of this Plan are deemed “medical care” for purposes of ERISA and are eligible for the claims and appeals process described in this chapter. This means that you or your Authorized Representative may file a claim for those benefits and may appeal adverse claim decisions. An Authorized Representative is a person you authorize in writing to act on your behalf. You also may provide Cooperative Benefit Administrators (CBA) your written authorization to have a doctor or other health provider request appeals of benefit denials on your behalf.

The following is applicable only if the Plan benefit at issue is considered “medical care” for purposes of ERISA, as noted in the benefit descriptions in previous chapters. If the Plan benefit at issue is not considered “medical care” for purposes of ERISA, then there is no claims and appeals process for that benefit under the Plan.

When you receive services or supplies from a provider, you (or your provider) must file a **claim**. A claim means a request for plan benefits. This chapter describes each claim type available under this Plan, along with the applicable filing procedures, responsibilities, and time limits for each.

After you or your provider file a claim, the claims administrator reviews the documentation and notifies you of a decision in writing. If all or part of your claim is denied, it is known as an **Adverse Benefit Determination** (see the full definition in *Appendix A: Key Terms*).

If you receive an Adverse Benefit Determination, you have the right to ask the appeals administrator to review that decision through what is called an **internal appeal**. If your internal appeal is denied, you may request a second-level appeal review of your denied internal appeal.

The claims and appeals procedures in this chapter are intended to comply with applicable regulations by providing reasonable procedures for filing claims, notifying Participants of benefit decisions, and appealing Adverse Benefit Determinations. Follow these procedures for all claims for benefits under the Medical PPO Plan. An issue or dispute solely regarding your eligibility for coverage or participation in this Plan is not considered a claim for benefits and is not governed by the claims and appeals procedures described in this chapter. For more information, please contact your benefits administrator.

Claims & Appeals Contacts	
Type	**Name and Address**
Authorizing a representative	**NRECA Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard, Arlington, VA 22203-1860 703.907.6601 (phone) 703.907.6602 (fax) privacyofficer@nreca.coop
Filing a claim	**UMR** P.O. Box 30515 Salt Lake City, UT 84130-0515 877.233.1800

Claims & Appeals Contacts	
Type	**Name and Address**
Filing a pre-service appeal for services that require Prior Authorization through SHARE	**UHC Appeals—UMR** P.O. Box 400046 San Antonio, TX 78229 800.808.4424, ext 15227 (phone) 888.615.6584 (fax)
Filing an expedited pre-service appeal for services that require Prior Authorization through SHARE	**UHC Appeals—UMR** 800.808.4424, ext 15227 (phone) 888.615.6584 (fax)
Filing an internal appeal	**CBA—Appeals Administrator** P.O. Box 6249 Lincoln, NE 68506 866.673.2299 (phone) 402.483.9201 (fax)
Requesting an External Review or an expedited External Review	**CBA—Appeals Committee (External 9222)** P.O. Box 6249 Lincoln, NE 68506 866.673.2299 (phone) 402.483.9201 (fax)

Authorizing a Representative

An Authorized Representative is an individual you have designated in writing to represent you in the claims or appeals process. Once designated, an Authorized Representative (including your Physician) may then file a claim or appeal on your behalf or represent you in the appeal process. Within this chapter, references to “you” include your Authorized Representative or your provider if your provider is submitting a claim on your behalf.

To appoint an Authorized Representative, you must complete, sign, and submit a copy of the *Authorization to Use and Disclose Protected Health Information (PHI)* form to the NRECA Privacy Officer. The form is available on the Employee Benefits website at cooperative.com > My Benefits > Education & Resources > Insurance Plan Documents. After processing your form, the Privacy Officer will provide you with a copy for your records.

Contact the NRECA Privacy Officer if you have questions about authorizing a representative or about the use and disclosure of your protected health information. For Urgent Care Claims, a health care professional with knowledge of your medical condition will be permitted to act as your Authorized Representative.

Note: Neither CBA, NRECA, nor any participating Employers are responsible for how your Authorized Representative discloses your protected information or for his or her failure to protect such information.

Claims

Your provider must submit a claim for benefits under this Plan in writing or electronically to the claims administrator. If your provider does not submit the claim on your behalf, you are responsible for submitting it to the claims administrator. Claim forms are available on the NRECA Employee Benefits website at cooperative.com > My Benefits. Ask your benefits administrator if you need help obtaining a claim form.

There are four types of claims under this Plan:

- Pre-service Claim;
- Post-service Claim;
- Concurrent Care Claim; and
- Urgent Care Claim.

These claim types are defined in *Appendix A: Key Terms*.

A claim is considered filed when it is received by the claims administrator in accordance with these procedures. The time frame to provide you with a determination notice starts when the claim is filed. However, if your Pre- or Post-service Claim (other than Urgent Care) is incomplete, the Plan may suspend its decision by providing you written notice and an opportunity to complete your claim. In such event, the period for making a determination will be suspended from the date written notice is sent by the Plan until the date your response is received. The notice will specifically describe the information required to complete your claim. Upon receipt of your response, the calculated time period begins, even if your response is insufficient. In any event, the Plan must make a claim determination within the statutory time frame (see the *Claims Review Timeline* table later in this chapter). Your claim may be denied in whole or in part.

Filing a Claim

You are responsible for ensuring that your claim is filed correctly and that the services have been authorized by the claims administrator beforehand, even if the provider offers to file the claim on your behalf. You can get a claim form directly from the claims administrator (see the *Contacts* table at the start of this chapter). **You have 12 months from the date you received a service or purchased a supply to file a claim for benefits for that service or supply.**

Depending on the claim type, some or all of the following information may be required:

- Patient's name, date of birth, and relationship to the Participant;
- Group number and individual member number;
- Condition (diagnosis) and the treatment or service for which approval is being requested;
- Service provider's name, address, and tax identification number;
- Records or other documentation to support the request for approval;
- Date(s) service was rendered or purchase was made;
- Diagnosis code, procedure codes, and descriptions of each service or supply; and
- Original copies of the itemized charge(s) for each service or supply. Photocopies are acceptable only if you are covered by two plans and you sent the original bill to the primary payer. Note that monthly statements, balance due bills, and credit card receipts are not acceptable documentation for itemized charges.

If you have other coverage that pays benefits before this Plan (e.g., another Employer's plan), you must first submit your claim to the primary payer before submitting a claim to this Plan. Once the primary payer has adjudicated the claim, you should submit a paper claim to the claims administrator within the applicable time frame described in the *Claims Review Timeline* table. When you file your claim under this Plan, you must attach your *Explanation of Benefits* notice from your primary payer.

Submit claims for each family member separately. It is important to keep copies of every claim because the documentation you submit will not be returned to you.

Once received by the claims administrator, your claim will be processed according to the Plan provisions, the guidelines used by the claims administrator, and the claim coding submitted by the provider.

Claim Review Timeline

Claim Type[1]	When you will be notified of a determination	Determination extension period	Deadline to supply more information
Pre-service	Within **15 calendar days** of claim receipt (unless the claims administrator requests an extension or further information)	**One** period of up to **15 calendar days**	**45 calendar days** from the date you receive the request notice
Pre-service (Urgent Care)	1. Within **72 hours** of claim receipt; or 2. If more information is needed, within **48 hours** of the earlier of: (a) the date the claims administrator receives the requested information, or (b) your original deadline to provide more information	**None** permitted	**48 hours** from the time of request (**Note**: The claims administrator has **24 hours** after receiving your claim to request more information.)
Concurrent Care (extension of treatment)	Within **15 calendar days** of claim receipt (unless the administrator requests an extension or more information)	**One** period of up to **15 calendar days**	**45 calendar days** from the date you receive the request notice
Concurrent Care (Urgent Care)	Within **24 hours** (if your claim is received 24 hours before the prescribed treatment period or number of treatments expires)	**None** permitted	**48 hours** from the time of request (**Note**: The claims administrator has **24 hours** after receiving your claim to request more information.)
Post-service	Within **30 calendar days** of claim receipt (unless the claims administrator needs an extension or more information)	One period of up to **15 calendar days**	**45 calendar days** from the request notice receipt date

[1]You have 12 months from the date you received a service or purchased a supply to file a claim for benefits for that service or supply.

Claim Determinations, Extensions, and Requests for Additional Information

If you have properly followed the claims procedure, the claims administrator will issue a written determination within the time frames listed in the *Claims Review Timeline* table.

If your claim cannot be processed because you did not provide sufficient information, the claims administrator will notify you about what additional information is missing and when you must submit it. If you do not provide the necessary information within the required time frame, your claim may be denied in whole or in part.

If the claims administrator needs an extension of time to evaluate your claim, you will be notified why the extension is needed and when a decision will be rendered.

Content of the Determination Notice

Regardless of the claim type, you will be notified of an Adverse Benefit Determination in writing. The notice will include:

- The specific reason(s) for the adverse determination;
- The specific Plan provisions on which the determination is based;
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- If applicable, a statement citing the internal rule, guideline, or protocol that was used to make the adverse determination, plus a statement that a copy of such rule will be provided free of charge to you upon request;
- If the adverse determination is based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request;
- If the claim is for Urgent Care, a description of the expedited review process;
- For medical claims, information that identifies the related claim; and
- Any additional information required under applicable law.

Further, the notice will contain the procedures you must follow to appeal the denial, the time limits applicable to such procedures and a statement indicating your right to file suit under Section 502(a) of ERISA following a denial of your claim on final appeal.

Appealing an Adverse Benefit Determination

If you disagree with an Adverse Benefit Determination on a claim, you have the right to have your Adverse Benefit Determination reviewed on appeal. This Plan has both an Internal Appeal Process and an External Review process that applies to certain Adverse Benefit Determinations. Generally, you must exhaust the Internal Appeal Process before seeking an External Review or bringing a civil action under Section 502(a) of ERISA.

Regardless of any verbal discussions that you have had about your claim, you have **180 calendar days** from the date you receive an Adverse Benefit Determination to file a written internal appeal with the claims administrator.

Documenting Your Appeal

The information in this section applies to both internal and external appeals. For purposes of this explanation, “reviewer” means the CBA Appeals Administrator (for internal appeals) and the Independent Review Organization (IRO) (for External Reviews).

All appeals must be submitted in writing (unless noted otherwise) and must include **at least** the following information:

- Your name;
- Name of the Plan (i.e., the Medical PPO Plan);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

Your appeal may also include any additional written comments, documents (including additional medical information), records, or other information that supports your request for benefits.

The reviewer will look at the claim without considering the prior denial. The review on appeal will consider all comments, documents, records, and other information that you submit relating to your claim regardless of whether that information was part of the initial claim determination and (if applicable) your internal appeal.

In addition, the person who reviews your appeal will not be a subordinate of the person who made the initial decision to deny your claim or, if applicable, your appeal. If the denial is based, in whole

or in part, on a Medical Judgment, the reviewer will consult a health care professional who has appropriate training and experience in the appropriate medical field. This health care professional will not be someone who consulted on the previous determination(s) and will not be a subordinate of any person who was consulted on the previous determination or determinations.

Note: Include all information that you want the reviewer to consider at the time you file your appeal. Remember that the date the appeal is filed is the date it is received by either the CBA Appeals Administrator, the CBA Appeals Committee or the Independent Review Organization. The reviewers must render a determination within the time frames described in this chapter regardless of whether you indicate more information to be forthcoming.

Filing an Internal Appeal

If the claims administrator denies your claim (an Adverse Benefit Determination), you have the right to file a written appeal within **180 calendar days** of the date you receive the Adverse Benefit Determination notice. The CBA Appeals Administrator (the reviewer) has full and discretionary authority to administer and interpret the Plan for all internal appeals.

Appeals for Urgent Care Claims may be filed verbally. All others must be filed in writing with the appeals administrator (by either U.S. mail or overnight delivery) to the address listed in the *Contacts* table.

Internal Appeal Timeline		
Filing deadline		Within **180 calendar days** of the date you receive the written Adverse Benefit Determination from the claims administrator
When you will be notified of a determination	**Urgent Care**	Within **72 hours** from receipt of the appeal
	Pre-service	Within **30 calendar days** from receipt of the appeal
	Concurrent Care	In the appeal time frame for pre-service, Urgent Care, or Post-service Claims as appropriate to the request
	Post-service	Within **60 calendar days** from receipt of the appeal

The review period begins when your appeal is received, regardless of whether the reviewer has all the information necessary to decide the appeal. If you want to grant the reviewer more than the stated time to make a determination, you may voluntarily agree to an extension by notifying the reviewer in writing.

To help prepare your appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim, as noted below. However, a request for documentation does not extend the time period allowed for you to file an appeal.

To obtain a copy of the claim file and other documents or records the reviewer may have related to your claim, send your written request to the reviewer. Your request must include your name, the patient's name (if different), the group policy number, the individual member ID number, date of service, service provider, and what documents you are requesting. Send your request to the internal appeals administrator at the address noted in the *Contacts* table in this chapter.

You may also ask your state's consumer assistance program or ombudsman for help filing your appeal. To determine if your state has such resources, refer to the U.S. Department of Labor (DOL) website at dol.gov/ebsa/ or call the DOL Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272).

Internal Appeal Review and Determination

The reviewer will notify you of the decision in writing. If your Urgent Care Claim is denied in whole or in part, you may also receive a verbal notice followed by a written notice within three days.

Regardless of the claim type, if your appeal is denied you will be notified in writing. The notice will include the following information:

- The specific reason(s) for the denial;
- The specific Plan provisions on which the determination is based;
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- If applicable, a statement citing the internal rule, guideline, or protocol that was used to make the determination, plus a statement that a copy of such rule will be provided free of charge to you upon request;
- If the denial is based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request;
- If the claim is for Urgent Care, a description of the expedited review process;
- For medical claims, information that identifies the related claim; and
- Any additional information required under applicable law.

Further, the notice will contain the procedures you must follow to appeal the denial, the time limits applicable to such procedures, and a statement describing your right to file suit under Section 502(a) of ERISA following a denial of your claim on final appeal.

External Review

If the CBA Appeals Administrator denied your internal appeal based on Medical Judgment, or if you have otherwise exhausted the internal appeals process for a claim involving Medical Judgment, you have the right to request an External Review. Additionally, if your internal appeal of a Rescission of Coverage (whether or not the rescission has any effect on any particular benefit at the time) is denied, you have the right to request an External Review. All other Adverse Benefit Determinations (including a denial, reduction, or nonpayment of benefits because you do not meet the Plan's eligibility requirements (excluding a Rescission of Coverage)) are not eligible for this Plan's External Review process.

The denial notice you receive from the internal appeals administrator will describe the Plan's External Review procedures.

External Review Types

The difference between a **standard** and an **expedited** External Review is the time frame for making a determination.

You may request an **expedited** External Review if:

- Your denied claim involves a medical condition for which the time frame to complete an Urgent Care internal appeal would seriously jeopardize your life or health (or would jeopardize your ability to regain maximum function) and you have filed a request for an Urgent Care internal appeal;
- Your denied internal appeal involves a medical condition for which the time frame to complete a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
- Your denied internal appeal concerns an admission, availability of care, continued stay, or health care service for which you received Emergency services but have not been discharged from the facility.

External Review Timeline	
Filing deadline	Within **four months** of the date you receive the written Adverse Benefit Determination for your internal appeal

External Review Timeline	
Preliminary review by CBA	• Within **five calendar days** after receipt of your External Review request (standard review) • **Immediately** (expedited review)
Preliminary review notification	• In writing, within **one calendar day** after completion of the preliminary review (standard review) • Immediately (expedited review)
If **incomplete**	Re-file with complete information within the original **four-month filing period** or **48 hours** after receiving the request for additional information
If **eligible** for review	CBA–Appeals Administrator will assign your appeal to an Independent Review Organization (IRO) and provide a full External Review file to the IRO within **five calendar days**
If **ineligible** for review	No further reviews are available
Deadline to supply additional information	Within **10 calendar days** after you receive notice that the IRO has accepted your claim
IRO notifies you of a determination	• In writing, within **45 calendar days** after the IRO receives the request (standard reviews) • Within **72 hours** (expedited reviews)

Preliminary Review of Your External Review Request based upon Medical Judgement

The Plan has **five calendar days** to complete a preliminary review of your External Review request for all claims based upon Medical Judgment. This review confirms that:

- You are (or were) covered under the Plan at the time the service or supply was requested or provided;
- The Adverse Benefit Determination did not occur because you failed to meet the Plan's eligibility requirements;
- The Adverse Benefit Determination was based on Medical Judgment;
- You have exhausted the Plan's Internal Appeal Process (unless you were not otherwise required to exhaust the process before requesting External Review); and
- You have provided all the information and forms required to process the External Review.

Preliminary Review Results Notification

The Plan will send an acknowledgment notice to you within **one calendar day** after completing the preliminary review.

- If your request is incomplete, the notice will describe the information or materials needed to make the request complete. You must re-file your External Review request with complete information within either the original **four-month** filing period or **48 hours** after receiving the request for additional information;
- If your request is not eligible for External Review, the notice will describe the reasons why it was not eligible and will explain your right to contact the Department of Labor's Employee Benefits Security Administration regarding such matters; or
- If your request is eligible for External Review, the Plan must assign it to an IRO accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or other similar

nationally recognized accrediting organization. The Affordable Care Act and other applicable regulations require this referral.

Appeal Assignment to an Independent Review Organization (IRO)

The Plan will provide the full External Review file to the IRO within **five calendar days** of assigning the case to it.

- The IRO will notify you that it has been assigned to review your external appeal and may offer you the opportunity to present additional information; and
- The IRO will review the following items (if they are received by the applicable deadline) without regard to any previous decisions or conclusions:
  - Your medical records;
  - Your attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or provider;
  - The terms of the Plan under which you have coverage;
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;
  - The IRO's clinical reviewer's opinion; and
  - The Plan's applicable clinical review criteria, unless the criteria are inconsistent with the Plan terms or with applicable law.

External Review Determination Notification

The IRO will notify both you and the Plan of the External Review decision within the required time frame described in this section. The determination will contain:

- A general description of the reason for the request;
- Information sufficient to identify the claim at issue;
- The date the IRO received the assignment to conduct the review;
- The date of the IRO's decision;
- The principal reason(s) for the decision, including references to the evidence, documentation, specific Plan provisions, and evidence-based standards used to reach the decision;
- A statement that the determination is binding on all parties except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to the Claimant; and
- Current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service (PHS) Act section 2793.

If the Determination Is Favorable

- For pre-service appeals, the claims administrator will immediately authorize the service;
- For post-service appeals, the claims administrator will promptly process the claim for benefits;
- For services rendered by a network provider, any benefit payment due will be made to the network provider directly; and
- You remain responsible for any applicable Copayment, Deductible, and Coinsurance under the Plan.

If the Determination Is Unfavorable

- No additional benefits are due from the Plan. You are responsible for any charges you incurred for the services received;

- The determination notice is binding on all parties; and
- No further review is available under the appeal process. However, you may have other remedies available under state or federal law, such as filing a lawsuit under Section 502(a) of ERISA.

Legal Action

You must complete the procedures described in both the *Claims* and the *Appealing an Adverse Benefit Determination* sections of this chapter before you can take legal action regarding benefits under this Plan. Any suit for benefits must be brought within one (1) year after receipt of the notice of denial on internal review or external review, whichever is later.

Appealing an Adverse Benefit Determination: Rescission of Coverage

Your (or your dependents') medical Plan benefits coverage will be terminated retroactively if you:

- Perform an act, practice, or omission that constitutes fraud against the Plan or
- Make an intentional misrepresentation of material fact

that resulted in your (or your dependents') eligibility for Plan coverage when you (or your dependents) in fact were not eligible for Plan coverage.

Retroactive termination of coverage due to these circumstances is considered a **Rescission of Coverage** as outlined in the *Rescission of Coverage* section of Chapter 3.

If your (or your dependents') coverage is terminated retroactively, you may appeal the decision in accordance with the rescission appeal procedures described in the advance written notice of coverage termination sent to you by the Plan. For purposes of these rescission appeal procedures, NRECA will be the named fiduciary and will have discretionary authority to resolve factual issues and make final determinations with regard to appeals related to rescissions.

Chapter 8: Prescription Drug Claims and Appeals

General Information

This chapter describes the steps you must take to file a claim for Plan benefits and to seek an appeal if you receive an Adverse Benefit Determination. An Adverse Benefit Determination occurs when your claim for reimbursement, request for benefit exception, or Preauthorization for Medical Necessity is denied. You have the right to ask for a review of that decision through what is called an internal appeal (first level and second level). If both your first- and second-level internal appeals are denied, in whole or in part, then you may request an External Review.

An issue or dispute related solely to your eligibility for coverage or participation in this Plan is not considered a claim for benefits and is not governed by the claims and appeals procedures described in this chapter. For more information, please contact your benefits administrator.

The steps in this chapter are intended to comply with applicable regulations by providing reasonable procedures for filing claims, notifying Participants of benefit decisions, and appealing Adverse Benefit Determinations. Be sure to follow these procedures for all claim and benefit appeals under this Plan.

When you receive prescription drugs or supplies from a participating network pharmacy, the pharmacy verifies your eligibility and coverage and, if required, may contact your provider to request Preauthorization from CVS Caremark. As the Participant, you are responsible for ensuring Preauthorization is obtained from CVS Caremark. CVS Caremark will directly reimburse the network provider for covered prescription drugs or supplies if your Preauthorization is approved.

If you obtain prescription drugs or supplies from a non-network retail pharmacy or from a non-CVS Caremark Mail Order Pharmacy, you must pay the provider in full and then submit a claim for reimbursement. A **claim for reimbursement** means a request for Plan benefits that is made in accordance with the procedures outlined in this chapter. After you submit a claim for reimbursement, CVS Caremark processes the claim against your Plan provisions to determine coverage. If your claim is approved, you will receive a reimbursement check in the mail from CVS Caremark. If your claim is denied, you have the right to request either a benefit exception or Preauthorization for Medical Necessity from CVS Caremark. See the *Prior Authorization* section later in this chapter.

Prescription Drug Claims & Appeals Contacts	
Type	**CVS Caremark**
Authorizing a representative	**CVS Caremark** **Research Department** P.O. Box 832407 Richardson, TX 75083 888.796.7322
Prior Authorization (when required)	**CVS Caremark** P.O. Box 686005 San Antonio, TX 78268-6005 888.796.7322
Filing a claim for reimbursement	**CVS Caremark** P.O. Box 52136 Phoenix, AZ 85072 888.796.7322

Prescription Drug Claims & Appeals Contacts	
Type	**CVS Caremark**
Filing a first-level Internal Appeal	**CVS Caremark Prescription Claim Appeals (MC 109**) P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866.689.3092
Filing a second-level Internal Appeal	**CVS Caremark Prescription Claim Appeals (MC 109)** P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866.689.3092
Filing a request for External Review	**CVS Caremark** External Review Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866.443.1172

Authorizing a Representative

An Authorized Representative is someone (including your Physician) who you designate in writing to file a claim or an appeal on your behalf or to represent you in the claims or appeals process. For purposes of this chapter, references to “you” may include your Authorized Representative or provider if your provider is submitting a claim or appeal on your behalf. For Urgent Care Claims, a health care professional with knowledge of your medical condition will be permitted to act as your Authorized Representative.

To appoint an Authorized Representative, you must complete, sign, and submit a copy of the *Authorization to Use and Disclose Protected Health Information (PHI)* form to the NRECA Privacy Officer. The form is available on the Employee Benefits website at cooperative.com > My Benefits > Education & Resources > Insurance Plan Documents. After processing your form, the Privacy Officer will provide you with a copy for your records. Contact the NRECA Privacy Officer if you have questions about authorizing a representative or about the use and disclosure of your protected health information. Note that neither the insurer, NRECA, nor any participating Employers are responsible for how your Authorized Representative discloses your protected information or for his or her failure to protect such information.

Prior Authorization

The Plan contains specific criteria that must be met for certain prescriptions to be covered. The Plan requires Prior Authorization review to ensure these drugs meet the Plan' coverage criteria. You must file all appeals with CVS Caremark.

If no Prior Authorization was required or if CVS Caremark provided Preauthorization, file your appeal with CVS Caremark.

For additional information about Prior Authorization, refer to the *Drugs Requiring Prior Authorization* section in the *Prescription Drug Benefits* chapter.

Claims

Your provider must submit a claim for reimbursement for benefits under this Plan to CVS Caremark. If your provider does not submit the claim on your behalf, you must send a claim for reimbursement in writing to CVS Caremark. Reimbursement claim forms are available in the *My Benefits* section of cooperative.com. Ask your benefits administrator if you need help obtaining a reimbursement claim form.

This Plan has four types of claims, which are defined in *Appendix A: Key Terms*:

- Pre-service;
- Post-service;
- Concurrent Care; and
- Urgent Care.

A claim for reimbursement is considered filed when it is received by CVS Caremark in accordance with these claims procedures. CVS Caremark's time period to provide you with a determination notice starts when the claim for reimbursement is filed, even if the information necessary to decide the claim is incomplete when it was first filed.

If your claim for reimbursement does not include sufficient information for CVS Caremark to make an initial benefit determination, you may need to provide additional information. If you do not provide the requested information within the time period described in the *Claims Review Timeline* table, your claim for reimbursement may be denied in whole or in part.

Note: This Plan does not provide for coordination of pharmacy benefits. This means the Plan will cover prescription drug claims (medicines, drugs, or supplies) only as a primary (not as a secondary) payer.

Filing a Claim for Reimbursement

When you receive prescriptions, you are responsible for filing the claim for reimbursement correctly. You are also responsible for obtaining Prior Authorization, if required, **before** you receive services or purchase supplies. Contact CVS Caremark if you have questions about filing your claim (see the *Contacts* table at the beginning of this chapter). **You have 24 months from the prescription fill date to file a claim for reimbursement for benefits for that drug or supply.** You will receive a benefit determination within 30 calendar days of the date your claim was received.

Depending on the claim type, some or all of the following information is required:

- Participant (Health ID cardholder) name and complete address;
- Group and individual member number;
- Patient's name, date of birth, gender, relationship to the Participant, and phone number; and
- Original copies of the itemized charge for each service or supply. Pharmacy receipts must include the patient name, prescription number, medicine National Drug Code (NDC) number from your prescription label or receipt, fill date, metric quantity, total charge, days' supply for your prescription, pharmacy name, and address or pharmacy National Association of Boards of Pharmacy (NABP) number. If available, you must also provide the prescribing Physician's National Provider Identification number. Monthly statements, balance due bills, and credit card receipts are not acceptable documentation for itemized charges. Cash register receipts are accepted only for diabetic supplies, if itemized.

Submit claims for reimbursement for each family member separately. It is important to keep copies of every claim because the documentation you submit will not be returned to you.

Once received by the claims administrator, your claim for reimbursement will be processed according to the Plan provisions, the guidelines used by the claims administrator, and reimbursed at the contracted rate less any applicable copay or coinsurance.

Claim Determinations, Extensions, and Requests for Additional Information

If your claim cannot be processed because you did not provide sufficient information, the claims administrator will tell you what additional information is required. If you do not provide the necessary information by the deadline, your claim may be denied.

If the claims administrator needs an extension of time to evaluate your claim for reimbursement, you will be notified of why the extension is needed and when a decision will be rendered.

Claim Determination Notice Content

Regardless of the claim type, you will be notified of an Adverse Benefit Determination in writing. The notice will include:

- The specific reason(s) for the adverse determination;
- For Prior Authorization claims only, the specific Plan provisions on which the determination is based;
- If applicable to Prior Authorization claims only, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- If applicable, a statement citing the internal rule, guideline, or protocol used to make the Adverse Determination, plus a statement that a copy of such rule will be provided free of charge to you upon request;
- If the Adverse Determination is based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request; and
- Any additional information required under applicable law.

The notice will also contain the procedures you must follow to appeal your claim denial decision, the time limits applicable to such procedures, and a statement indicating your right to file suit under Section 502(a) of ERISA following a denial of your claim on final appeal.

Appealing an Adverse Benefit Determination

If you disagree with an Adverse Benefit Determination on a claim, you have the right to have the decision reviewed on appeal. This Plan has both Internal Appeal and External Review processes for certain Adverse Benefit Determinations. Generally, you must exhaust the Internal Appeal Process before seeking an External Review or bringing a civil action under Section 502(a) of ERISA.

Regardless of any verbal discussions you have had about your claim, you have **180 calendar days** from the date you receive an Adverse Benefit Determination to file a written internal appeal with CVS Caremark.

The information in this section applies to both internal and external appeals. As mentioned at the beginning of this chapter, references within this section to “you” include your provider (if your provider is authorized to appeal on your behalf) or another Authorized Representative.

Within this explanation, “reviewer” means:

- For first-level Internal Appeals, the CVS Caremark Prescription Claim Appeals Administrator;
- For second-level Internal Appeals, the CVS Caremark Prescription Claim Appeals Administrator; and
- For External Reviews, the CVS Caremark External Review Appeals Department.

Documentation to Include with Your Appeal

All appeals must be submitted in writing (unless otherwise noted) and must include:

- Your name;
- Plan name (i.e., the Medical PPO Plan);

- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

Your appeal may also include any additional written comments, documents (including additional medical information), records, or other information that supports your request for benefits.

Appeal Review Information

The reviewer will conduct a full and fair review of your appeal if you have submitted it by the proper deadline. The reviewer will look at the claim anew, without considering the prior denial. The review on appeal will consider all comments, documents, records, and other information you submit relating to your claim, regardless of whether that information was part of the initial claim determination or, if applicable, your internal appeal.

In addition, the person who reviews your appeal will not be a subordinate of the person who made the initial decision to deny your claim or, if applicable, your appeal. If the denial is based, in whole or in part, on a Medical Judgment, the reviewer will consult a health care professional who has appropriate training and experience in the appropriate medical field. This health care professional will not be someone who consulted on the previous determination (or determinations) and will not be a subordinate of any person who was consulted on the previous determination (or determinations).

Note: At the time you file your appeal, it is very important to include all information you want the reviewer to consider. The date the reviewer receives your appeal is considered to be the date the appeal is filed. The reviewer must then render a determination within the time frame described in this chapter regardless of whether you indicate that more information is forthcoming.

First-level Internal Appeal

If CVS Caremark denied your claim (an Adverse Benefit Determination) based on administrative or clinical terms as defined in *Appendix A: Key Terms*, then you have the right to request a first-level internal appeal within **180 calendar days** of the date you receive the Adverse Benefit Determination notice. The reviewer has full and discretionary authority to administer and interpret the Plan for all first-level internal appeals.

Where to Send Your Internal Appeal

First-level internal appeals for Urgent Care Claims may be filed verbally. All others must be filed in writing with the reviewer (by either U.S. mail or overnight delivery) to the address listed in the *Prescription Drug Claims & Appeals Contacts* table.

Submit your first-level and subsequent appeals to CVS Caremark if your claim is denied and the drug or supply either required Prior Authorization by CVS Caremark or did not require Prior Authorization.

First-level Internal Appeal Timeline		
Filing deadline		Within **180 calendar days** of the date you receive the written Adverse Benefit Determination
When you will be notified of a determination	Urgent Care	Within **72 hours** after the reviewer receives the appeal
	Pre-service	Within **30 calendar days** from the reviewer's receipt of the appeal
	Concurrent care	Within the appeal time frames listed in this table for pre-service, Urgent Care, or Post-service Claims as appropriate to the request
	Post-service	Within **60 calendar days** after the reviewer receives the appeal
Determination extension period		None permitted

The review period begins when your internal appeal is received, regardless of whether the reviewer has all the information necessary to decide the appeal.

To help prepare your internal appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim. However, a request for documentation does not extend the time period allowed for you to file an appeal. Send a written request to the reviewer to obtain a copy of your claim file and other documents or records the reviewer may have related to your claim. Your request must include your name, the patient's name (if different), group policy number, individual member ID number, date of service, service provider, and a description of which items you are requesting. Send your request to the reviewer, at the address noted in the *Contacts* table.

You may also ask your state's consumer assistance program or ombudsman for help filing your appeal. To determine if your state has such resources, refer to the U.S. Department of Labor (DOL) website at dol.gov/ebsa/consumer_info_health.html or call the DOL Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272).

First-level Internal Appeal Review and Determination

The reviewer will notify you of the decision in writing. If your Urgent Care Claim is approved or denied in whole or in part you will receive a verbal notice followed by a written notice within three days. Regardless of the claim type, if your first-level internal appeal receives an Adverse Benefit Determination you will be notified in writing or electronically. The notice will include:

- The specific reason(s) for the adverse determination;
- The specific Plan provisions on which the determination is based;
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- If applicable, a statement citing the internal rule, guideline, or protocol used to make the Adverse Determination, plus a statement that a copy of such rule will be provided free of charge to you upon request;
- If the adverse determination is based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request; and
- Any additional information required under applicable law.

Further, the notice will contain the procedures you must follow to appeal the Adverse Benefit Determination, the time limits applicable to such procedures, and a statement describing your right to file suit under Section 502(a) of ERISA following a denial of your claim on final appeal.

Second-level Internal Appeal

If the CVS Caremark Prescription Claim Appeals Administrator issued an Adverse Benefit Determination for your first-level internal appeal based on Medical Judgment as defined in *Appendix A: Key Terms*, then you have the right to request a second-level internal appeal within **180 calendar days** of the date you receive the Adverse Benefit Determination notice. The reviewer has full and discretionary authority to administer and interpret the Plan for all second-level internal appeals.

Second-level internal appeals for Urgent Care Claims may be filed verbally. All others must be filed in writing with the reviewer (by either U.S. mail or overnight delivery) to the address listed in the *Prescription Drug Claims & Appeals Contacts* table.

Second-level Internal Appeal Timeline		
Filing deadline		Within **180 calendar days** of the date you receive the written Adverse Benefit Determination
When you will	**Urgent care**	Within **72 hours** after the reviewer receives the appeal

Second-level Internal Appeal Timeline		
be notified of a determination	**Pre-service**	Within **30 calendar days** from the reviewer's receipt of the appeal
	Concurrent Care	Within the appeal time frames for pre-service, urgent care, or Post-service Claims as appropriate to the request
	Post-service	Within **60 calendar days** after the reviewer receives the appeal
Determination extension period		None permitted

The review period begins when your internal appeal is received, regardless of whether the reviewer has all the information necessary to decide the appeal.

To help prepare your internal appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim. However, a request for documentation does not extend the time period allowed for you to file an appeal. To obtain a copy of the claim file and other documents or records the reviewer may have related to your claim, send your written request to the reviewer. Your request must include your name, the patient's name (if different), group policy number, individual member ID number, date of service, service provider, and what documents you are requesting. Send your request to the reviewer at the address noted in the *Contacts* table.

You may also ask your state's consumer assistance program or ombudsman for help filing your appeal. To determine if your state has such resources, refer to the U.S. Department of Labor website at dol.gov/ebsa/consumer_info_health.html or call the DOL Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272).

Second-level Internal Appeal Review and Determination

The reviewer will notify you of the decision in writing. If your Urgent Care Claim is approved or denied in whole or in part you will receive a verbal notice, followed by a written notice within three days. Regardless of the claim type, if your second-level internal appeal receives an Adverse Benefit Determination, you will be notified in writing or electronically. The notice will include:

- The specific reason(s) for the adverse determination;
- The specific Plan provisions on which the determination is based;
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- If applicable, a statement citing the internal rule, guideline, or protocol used to make the adverse determination, plus a statement that a copy of such rule will be provided free of charge to you upon request;
- If the adverse determination is based on Medical Necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment will be provided to you free of charge upon request; and
- Any additional information required under applicable law.

Further, the notice will contain the procedures you must follow to appeal the Adverse Benefit Determination, the time limits applicable to such procedures, and a statement describing your right to file suit under Section 502(a) of ERISA following a denial of your claim on final appeal.

External Review (Standard and Expedited)

The Adverse Benefit Determination notice you receive from the previous reviewer will describe the Plan's External Review procedure. You have the right to request an External Review of your Adverse Benefit Determination if the CVS Caremark Prescription Claim Appeals Administrator

issued an Adverse Benefit Determination for your second-level internal appeal and you have otherwise exhausted the internal appeals process for a claim involving Medical Judgment.

For information about Adverse Benefit Determinations that involve Rescission of Coverage (whether or not the rescission has any effect on benefits at that time), see the *Appealing an Adverse Benefit Determination: Rescission of Coverage* section of this chapter.

External Review Types

The difference between a standard External Review and an expedited External Review is the time frame allowed for making a determination. You may request an expedited External Review if:

- Your Adverse Benefit Determination involves a medical condition for which 1) the time frame to complete an urgent care internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and 2) you have filed a request for an urgent care internal appeal;
- Your final internal Adverse Benefit Determination involves a medical condition where the time frame to complete a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
- Your final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which you received Emergency services but have not been discharged from the facility.

The table below summarizes the External Review timeline. Details about each step appear in the following sections.

External Review Timeline	
Filing deadline	Within **four months** of the date you receive the written Adverse Benefit Determination of your internal appeal
Preliminary review by CVS Caremark	• Within **five calendar days** after receipt of your External Review request (standard review) • **Immediately** (expedited review)
Preliminary review notification	• In writing, within **one calendar day** after the preliminary review is complete (standard review) • **Immediately** (expedited review)
If **incomplete**	Re-file with your appeal with complete information within either the original **four-month** filing period **or 48 hours** after receiving the request for additional information
If **eligible** for review	Within **five calendar days**, CVS Caremark assigns your appeal to an Independent Review Organization (IRO) and provides the full External Review file to the IRO
If **ineligible** for review	No further reviews are available.
Deadline to supply additional information	Within **10 calendar days** after you receive notice that the IRO has accepted your claim for review
IRO notifies you of a determination	In writing, within **45 calendar days** after the IRO receives the request (standard reviews) Within **72 hours** (expedited review)

Preliminary Review

The CVS Caremark External Review Appeal team has **five calendar days** to complete a preliminary review of your External Review request. This review confirms that:

- You are (or were) covered under the Plan when the prescription drug benefit was requested or provided;
- The Adverse Benefit Determination did not occur because you failed to meet the Plan's eligibility requirements;
- The Adverse Benefit Determination was based on Medical Judgment;
- You have exhausted the Plan's Internal Appeal Process (unless you were not otherwise required to do so before requesting External Review); and
- You have provided all the information and forms required to process the External Review.

Preliminary Review Results Notification

The CVS Caremark External Review Appeal team will send an acknowledgment notice to you within **one calendar day** of the preliminary review.

- **If your External Review request is incomplete**, the notice will describe the information or materials needed to make the request complete. You must re-file your External Review request with complete information either within the original **four month** filing period or within **48 hours** after receiving the request for additional information, whichever occurs first;
- **If your request is not eligible for External Review**, the notice will describe why it was not eligible and explain your right to contact the Department of Labor's Employee Benefits Security Administration regarding such matters; or
- **If your appeal is eligible for External Review**, the CVS Caremark External Review Appeal team must assign it to an Independent Review Organization accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or other similar nationally recognized accrediting organization. The Affordable Care Act and other applicable regulations require this referral.

Assignment to an Independent Review Organization (IRO)

- The CVS Caremark External Review Appeal team will provide the full External Review file to the IRO within **five calendar days** of assigning the case to it;
- The IRO will notify you that it has been assigned to review your external appeal and may offer you the opportunity to present additional information; and
- The IRO will review the following items (if they are received by the applicable deadline) without regard to any previous decisions or conclusions:
    - Your medical records;
    - Your attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the plan, Claimant, or provider;
    - The terms of the plan under which you have coverage;
    - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;
    - The IRO's clinical reviewer's opinion; and
    - The Plan's applicable clinical review criteria, unless the criteria are inconsistent with the Plan terms or with applicable law.

External Review Determination Notification

The IRO will notify both you and the CVS Caremark External Review Appeal team of the External Review decision within the time frame described in the *External Review Timeline* table. The determination will contain:

- A general description of the reason for the request;
- Information sufficient to identify the claim at issue;
- The date the IRO received the assignment to conduct the review;
- The date of the IRO's decision;
- The principal reason(s) for the decision, including references to the evidence, documentation, specific Plan provisions, and evidence-based standards used to reach the decision;
- A statement that the determination is binding on all parties except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to the Claimant; and
- Contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service (PHS) Act section 2793.

If the Determination Is Favorable

- For **pre-service** appeals, the claims administrator will immediately issue the necessary authorization for the service upon receipt of the approval letter;
- For **post-service** appeals, the claims administrator will process the claim for benefits upon request from the member;
- For services rendered by a network provider, any benefit payment due will be made to the network provider directly; and
- You remain responsible for any applicable Copayment, Deductible, and Coinsurance under the Plan.

If the Determination Is Unfavorable

- No additional benefits are due from the Plan and you are responsible for any charges you incurred;
- No further review is available under the appeal process. However, you may have other remedies available under state or federal law, such as filing a lawsuit under section 502(a) of ERISA; and
- The determination notice is binding on all parties.

Legal Action

You must complete the procedures described in the *Claims* and the *Appealing an Adverse Benefit Determination* sections of this chapter before you can take legal action regarding benefits under this Plan. Any suit for benefits must be brought within 12 months of the date of the final denial, whether from the internal appeal or the External Review. Refer to the *Agent for Service* section under *Plan Information* and to the *Legal Action* section of the *Medical Claims and Appeals* chapter for more information about legal action.

Appealing an Adverse Benefit Determination: Rescission of Coverage

Your (or your dependents') medical Plan benefits coverage will be terminated retroactively if you:

- Perform an act, practice, or omission that constitutes fraud against the Plan or
- Make an intentional misrepresentation of material fact

that resulted in your (or your dependents') eligibility for Plan coverage when you (or your dependents) in fact were not eligible for Plan coverage.

Retroactive termination of coverage due to these circumstances is considered a **Rescission of Coverage** as outlined in the *Rescission of Coverage* section of Chapter 3.

If your (or your dependents') coverage is terminated retroactively, you may appeal the decision in accordance with the rescission appeal procedures described in the advance written notice of coverage termination sent to you by the Plan. For purposes of these rescission appeal procedures, NRECA will be the named fiduciary and will have discretionary authority to resolve factual issues and make final determinations with regard to appeals related to rescissions.

Chapter 9: FutureMe Benefits and Resources

FutureMe Powered by NRECA

The NRECA Medical Plan gives you access to FutureMe, a well-being program powered by NRECA. The program's resources, described in this chapter, are designed to encourage improving your holistic health and well-being. The Plan's approach to well-being is about more than just physical fitness or losing weight. It's about taking a comprehensive approach toward physical, mental, and financial well-being to achieve a long, fulfilled, and prosperous life. NRECA has contracted with WebMD to provide components of the FutureMe program.

Participation in any FutureMe offering is completely voluntary and there are no benefit limitations within the NRECA Medical Plan imposed on plan participants that choose not to engage in this program.

Information about FutureMe's services, resources, educational materials, tools, and more, can be found by visiting cooperative.com > My Benefits > My Insurance.

FutureMe portal, offered through NRECA's vendor partner WebMD, is an interactive website that provides you with access to the information you need to make better choices about your health. The site includes a variety of resources and easy-to-use tools developed by one of the most trusted sources of health and medical information: WebMD. However, medical decisions are ultimately made by you and your Physician and do not involve the Plan. Key features of FutureMe portal are:

FutureMe survey: a brief, confidential questionnaire that helps you understand your health risks based on your screening results and lifestyle habits; and

FutureMe habits: online health coaching modules where you can select activities to meet your short- and long-term health and well-being goals.

To access the FutureMe portal, visit cooperative.com > My Benefits > My Insurance.

In addition to the benefits offered as part of FutureMe, your Employer may also offer a separate well-being program. Check with your benefits administrator to learn about your Employer's additional well-being offerings.

FutureMe rewards

Your Employer has elected to participate in FutureMe rewards during this Plan year.

FutureMe rewards is an online tracking program through WebMD where your Employer may recognize you and your family for taking a more active role in your health and well-being. When you complete specific activities included in FutureMe rewards, you can earn points and (if applicable) receive certain incentives. Your benefits administrator will provide information about FutureMe rewards and any incentives that may be available to you.

The following individuals are eligible to participate in FutureMe rewards:

- Employees;

Life Strategy Counseling Program

The NRECA Life Strategy Counseling Program (LSC) offers confidential, professional support for personal life issues or concerns. It is available to all eligible Employees, along with their dependent spouses and children over age 18, whose co-op participates in the Plan.

Life Strategy Counseling Services

The program offers counseling by phone, or in-person up to five (5) visits for issues such as:

- Family or relationship problems;

- Parenting difficulties;
- Anxiety and depression;
- Stress management;
- Work-related problems;
- Substance use and abuse;
- Grief and loss;
- Emotional and physical abuse; and
- Suicidal thoughts.

Additional services are available to assist Participants with work-life balance issues, such as:

- Childcare: parenting and childcare resources, local children's programs, tutoring resources, and selecting a college.
- Adult care: locating an elder care facility; aging issues; Medicare and Medicaid information; and long-term care evaluation.
- Convenience: real estate and relocation services, home or appliance repairs, and pet services.
- Financial: basic personal financial resources, access to information and educational materials, educational materials in electronic format.
- Legal: access to qualified consultants for information and consultation, up to thirty (30) minutes of consultation by phone or in person per legal issue, discount of up to 25% off standard legal fees as offered by network of attorneys after initial consultation, resources and personalized researched referrals, identity theft recovery services – telephonic consultation up to sixty (60) minutes in length with a financial counselor.

Life Strategy Counseling (LSC) will put you in touch with a dedicated master's-level counselor who will work with you. You will have access to telephonic counseling and support 24 hours a day, 7 days a week, 365 days a year. These calls are confidential. You can also obtain information through online chat.

At your request, the LSC can refer you to further professional assistance in your area as appropriate.

Access to online resources like webinars, articles, and skill builders is also available through cooperative.com > My Benefits > My Insurance.

Note: Fees charged by agencies outside LSC are not included in this coverage. You are responsible for paying any fees incurred outside of the program.

FutureMe coaching

Through FutureMe, you have access to coaching to provide you with medical information and well-being support either by phone or, in some cases, online. Coaches are health professionals with training and certifications in specific fields such as behavior change, nutrition, diabetes management and tobacco cessation, and they are matched with Participants based on their individual needs. Participants and their dependents who are 18 and older can message a coach through the FutureMe portal or call a coach directly with times available seven days a week.

Coaches work with Participants managing chronic conditions, including asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease, and congestive heart failure. They also provide tobacco cessation services, a dedicated weight management program, and lifestyle coaching to address the whole person and all dimensions of well-being. All conversations with FutureMe coaches are confidential. You can connect with a health coach, find information about health topics and conditions, check FutureMe coaches hours of availability, and access well-being tools and resources through the FutureMe portal via the NRECA Employee Benefits website at cooperative.com > My Benefits, or by calling 888.321.1521.

Tobacco Cessation Program

Studies show that tobacco users have a better chance of quitting when they participate in a counseling program. You and your covered dependents who are 18 or older may access a tobacco cessation program through FutureMe coaching. The program is designed to help individuals stop using tobacco products, including cigarettes and smokeless tobacco.

Program Participants who may need nicotine replacement therapy (NRT) (e.g., patch, gum, lozenge) can purchase those items without a prescription. Program Participants may also be referred to their provider to receive coverage for tobacco cessation prescription medications (e.g., Chantix, Zyban). Program Participants who chew tobacco are not eligible for prescription medications because tobacco cessation prescription drugs are not approved by the FDA for use with chewing tobacco. FutureMe coaches can be reached via phone at 866.321.1521.

Weight Management Program

Participants with a weight management goal are encouraged to explore the Positively Me program. This enhanced coaching program supports Participants who are ready to take action and commit to targeted weight loss outcomes. The Positively Me program is a 12-month weight management program of one-on-one mentoring that emphasizes consistency and accountability. With a curriculum inspired by National Diabetes Prevention Program guidelines, the Positively Me program focuses on cognitive restructuring and sustainable lifestyle habits. Participants are encouraged to work with a coach once every two weeks for the first six months, followed by unlimited sessions for the remainder of the year. Participants can call 866.321.1521 to speak with a coach about weight management and to learn more about the Positively Me program.

Important: Release of Liability for the FutureMe Program

By participating in the FutureMe Plan (Plan), you (and your dependents, if applicable) acknowledge that you are not aware of any physical, mental, or emotional disability or any medical condition that would preclude you from safely participating in the events, programs, or activities of the Plan. You and your health care provider are ultimately responsible for determining appropriate treatment and care and for deciding whether you are able to participate in these events, programs, or activities. You recognize that your participation in these events, programs, or activities may have certain benefits, but that the possibility also exists that you could sustain a serious permanent Injury or an Injury resulting in death, including, but not limited to, those caused by your own negligence or the negligence of others. By participating in the events, programs, or activities of the Plan, you (and your dependents, if applicable) hereby elect to assume those risks and acknowledge that your participation is voluntary.

In consideration for being allowed to participate in the Plan events, programs, and activities, you (and your dependents, if applicable) do hereby release, waive, indemnify/hold harmless, forever discharge, and covenant not to sue NRECA, the NRECA Group Benefits Program, and your Employer, together with their Directors, officers, agents, employees, successors, and assigns from any and all liability for any and all claims, demands, actions, or causes of action relating to loss, damage, or destruction of personal property or to personal, bodily, emotional, or mental injuries, including death, sustained as a result of your participation in the events, programs, and activities of the Plan. This release of liability will be binding on your personal representatives, heirs, estate, next-of-kin, executors, and assigns. This release of liability will remain in effect so long as you (and your dependents, if applicable) participate in any events, programs or activities of the Plan. The foregoing does not impact your coverage (and your dependent's coverage, if applicable) under this Plan or the NRECA dental, vision, disability and life, and accidental death and disability insurance Plans.

Chapter 10: Continuing Coverage Under COBRA

General Information

Federal law requires the Medical PPO Plan (the Plan) to offer eligible individuals and their families the opportunity to continue their coverage when they have a qualifying event that results in a loss of Plan coverage.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage is the same coverage that the Plan offers to other similarly situated Participants and beneficiaries. Each qualified beneficiary who elects COBRA continuation coverage has the same rights under the Plan as other Participants, including annual enrollment and special enrollment rights.

You and your family may also have coverage options through the Health Insurance Marketplace, Medicaid, or other group health plans (such as a spouse's plan), some of which may cost less than COBRA continuation coverage. You can learn more about the Marketplace and Medicaid options at healthcare.gov.

For questions or information not covered in this chapter, contact your COBRA administrator using one of the methods in the *Contact Information* chapter.

Qualified Beneficiary

Generally, a qualified beneficiary (also referred to in this chapter as "you" or "Participant") is an individual who will lose coverage under a group health plan because of a qualifying event. Depending on the type of qualifying event, qualified beneficiaries can include:

- Eligible individuals (Employees, retirees, Directors,);
- An eligible individual's spouse or domestic or civil union partner;
- Dependent children of eligible individuals;
- Children of eligible individuals who are covered by the Plan pursuant to a Qualified Medical Child Support Order (QMCSO); and
- In certain cases involving bankruptcy of the cooperative, a pre-65 retired Employee, the pre-65 retired Employee's spouse (or former spouse), and his or her dependent children.

Qualifying Events

A qualifying event is an event that causes an eligible individual to lose group health coverage. Qualifying events are either initial or secondary. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that the Plan must offer continuation coverage.

Depending on the qualifying event, your COBRA administrator may require additional information or documentation.

Note: If you are covered by this Plan as an active Employee, Director or Retained Attorney and you voluntarily drop coverage because you become eligible for Medicare, you and your dependents cannot elect COBRA coverage to continue coverage under this Plan. Additionally, if you experience a change in job position or union membership that causes you to lose coverage, this is not a COBRA qualifying event, and COBRA continuation coverage will not be available.

Initial Qualifying Events

The following events may allow a qualified beneficiary to continue coverage that would otherwise end. **Eligible individuals who have terminated coverage under this Plan because they have other coverage are not considered qualified beneficiaries for purposes of COBRA continuation coverage.**

You (Eligible Individual)	Your Spouse or Domestic or Civil Union Partner	Your Dependent Children
• Reduction in hours that results in ineligibility • Employment ends for any reason other than gross misconduct	• Eligible individual's reduction in hours that results in ineligibility • Eligible individual's employment ends for any reason other than gross misconduct • Divorce or termination of a domestic or civil union partnership • Eligible individual's death	• Eligible individual's reduction in hours that results in ineligibility • Eligible individual's employment ends for any reason other than gross misconduct • Divorce or termination of a domestic or civil union partnership • Eligible individual's death • Loss of dependent status

Your Notification Responsibilities for Initial Qualifying Events

The COBRA administrator will offer COBRA continuation coverage to all qualified beneficiaries once they receive notice that a qualifying event has occurred. Your Employer will notify the COBRA administrator of your termination of employment, reduction of hours, retirement, or death. However, you or your covered dependents **must** notify the COBRA administrator by the specified deadline when one of these qualifying events occurs:

- A divorce or termination of domestic or civil union partnership. Notify the COBRA administrator within **60 days** of the divorce or termination of domestic or civil union partnership. Notify the COBRA administrator of a divorce separately from any qualified domestic relations order that you may submit for retirement plans; and
- A dependent child loses dependent status. Notify the COBRA administrator within **60 days** of the date the dependent child no longer meets the Plan's dependent child eligibility requirements as described in the *Coverage for Your Dependents* section of the *Eligibility and Participation Information* chapter. The COBRA administrator knows when a dependent child reaches age 26 and becomes ineligible for coverage; however, you must notify the administrator of all other dependent status changes. Coverage ends at the end of the month in which the child reaches age 26 regardless of any separate notification requirements for which you are responsible.

If you or your covered dependents do not notify the COBRA administrator **within 60 days** of the qualifying events listed above, the covered dependent's COBRA rights will expire.

Once the COBRA administrator is notified that one of these events has occurred and you have confirmed the mailing address of the qualified beneficiary, the COBRA administrator will notify the appropriate parties of their COBRA continuation coverage rights.

Note that notice to your spouse or domestic or civil union partner is treated as notice to any dependent children who reside with your spouse or domestic or civil union partner.

Length of COBRA Continuation Coverage

The period of COBRA continuation coverage for qualified beneficiaries for each qualifying event is:

Initial Qualifying Event	Coverage Period

Initial Qualifying Event	Coverage Period
Your reduction in hours, resulting in loss of benefits eligibility[1]	18 months
Your employment termination[1]	18 months
Your dependent child no longer meets eligibility requirements (e.g., he or she reaches age 26 or is over age 26 and ceases to be disabled)	36 months
Your divorce or your domestic or civil union partnership terminates (coverage extends to former spouse or domestic or civil union partner and to dependent children)	36 months
Your death (coverage extends to eligible spouse, domestic or civil union partner, and dependent children or children of domestic or civil union partner)	36 months *See Special Rule for Surviving Spouse and Dependents*

[1]*When the qualifying event is your termination or reduction in hours and you became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for your spouse and dependents can last until 36 months after the date you became entitled to Medicare.*

Special Rule for Surviving Spouse and Dependents

If you die, your surviving spouse and dependent children are eligible to continue coverage beyond the required 36-month COBRA period. Your benefits administrator, not the COBRA administrator, coordinates coverage continuation in the event of your death. Such coverage for each surviving spouse and dependent will end independently on the earliest of:

- The date required contributions are not made;
- The date the surviving spouse reaches age 65;
- The date each covered dependent no longer qualifies as a dependent child; or
- The date the surviving spouse remarries, dies, or registers as a partner in a new domestic or civil union partnership in any state, except as provided by federal law for any longer period (applicable to both the surviving spouse and dependent children).

Second Qualifying Events

An 18-month extension of COBRA coverage may be available to your spouse or domestic or civil union partner and dependent children who elected COBRA continuation coverage if a second qualifying event occurs during their first 18 months of COBRA continuation coverage. When a second qualifying event occurs, coverage may be extended for an additional 18 months for a maximum duration of 36 months. These second qualifying events include:

Second Qualifying Event[2]	Maximum Duration for Covered Spouse, Domestic or Civil Union Partner, or Dependents
Your divorce or termination of your domestic or civil union partnership after the initial qualifying event	Additional 18 months (for a total of 36 months)
Your Medicare entitlement	Additional 18 months (for a total of 36 months)
Your death	Additional 18 months (for a total of 36 months)

Second Qualifying Event[2]	Maximum Duration for Covered Spouse, Domestic or Civil Union Partner, or Dependents
Your dependent child no longer meets the dependent eligibility requirements (e.g., reaches age 26, or, if over 26, ceases to be disabled)	Additional 18 months (for a total of 36 months)

[2]The second event is a second qualifying event only if it would have caused you to lose coverage under the Plan in the absence of the first qualifying event. Notify your COBRA administrator if you experience a second qualifying event.

To receive this extension of coverage, qualified beneficiaries must notify the COBRA administrator about the second qualifying event within **60 days** after it occurs. Failure to notify the COBRA administrator within **60 days** of the second qualifying event means that the qualified beneficiary is ineligible for extension rights under COBRA. If your COBRA continuation coverage period is extended, your COBRA administrator will notify you of the coverage extension period.

Note: The COBRA administrator will know when a dependent child reaches age 26 and becomes ineligible for coverage. Coverage ends at the end of the month during which the child reaches age 26. As a result of this second qualifying event, the COBRA administrator will send the applicable COBRA information to the child at his or her address of record so that he or she may independently elect the COBRA extension.

Social Security Disability Extension

An 11-month extension of COBRA coverage may be available if a qualified beneficiary meets the following criteria:

- The qualified beneficiary is determined to be disabled by the Social Security Administration at some time before the 60th day of COBRA continuation coverage; and
- The qualified beneficiary notifies the COBRA administrator of the Social Security Administration's Disability determination and provides a copy of the determination to the COBRA administrator before the end of the initial 18-month COBRA continuation period and within **60 days** of the latest of:
  - The date on which the qualifying event (i.e., termination of employment or reduction of hours) occurs;
  - The date coverage is lost (or would be lost) as a result of the qualifying event;
  - The date of the Disability determination by the Social Security Administration; or
  - The date that the qualified beneficiary receives (or is deemed to have received) the initial COBRA notice or SPD that describes the notice procedures.

If one qualified beneficiary is disabled and meets the above criteria, all qualified beneficiaries in that family are entitled to the 11-month Disability extension. If the COBRA continuation coverage period is extended, the COBRA administrator will notify each family member of the coverage extension period. Conversely, if the qualified beneficiary is determined to no longer be disabled, coverage will end for all family members.

Electing COBRA Continuation Coverage

To elect COBRA continuation coverage, contact your COBRA administrator within the COBRA election period outlined in the COBRA enrollment notice. If you do not elect COBRA continuation coverage during the election period, all rights to elect COBRA continuation coverage will end.

If you elect COBRA, your COBRA coverage will be the same coverage you had immediately before the qualifying event, unless at the time of COBRA enrollment you choose another available coverage option offered by your Employer.

Each qualified beneficiary who elects COBRA continuation coverage has the same benefits, choices, and services that a similarly situated participant or beneficiary currently receives under the Plan, such as the right during an open enrollment season to choose among available coverage options. COBRA participants are also subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The Plan's rules for filing benefit claims and appealing any claims denials also apply.

Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, your spouse may elect COBRA continuation coverage even if you do not. A designated representative acting on behalf of you, your spouse, or your dependent children may also make the election(s). You or your spouse can elect COBRA continuation coverage for one, several, or all dependent children who are qualified beneficiaries.

COBRA Election Period

You and your covered dependents have **60 days** from the date of the COBRA enrollment notice or from the date coverage terminates (whichever is later) to elect COBRA continuation coverage. Your specific COBRA enrollment deadline will appear in your COBRA enrollment notice. If mailed, election forms must be postmarked no later than the deadline listed on the COBRA enrollment notice. If hand delivered, the COBRA administrator must receive the election forms no later than the deadline as shown on the COBRA enrollment notice.

A qualified beneficiary who waives COBRA continuation coverage may change his or her mind and enroll in coverage by returning the completed enrollment forms to the COBRA administrator before the original deadline. In this case, COBRA continuation coverage will begin on the date the completed election form is signed. Qualified beneficiaries who do not elect COBRA continuation coverage by the enrollment deadline lose all rights to elect COBRA continuation coverage.

Cost of COBRA Continuation Coverage

Qualified beneficiaries must pay the entire cost of their COBRA continuation coverage. Costs and payment procedures for each coverage option are explained in the COBRA enrollment notice sent to each qualified beneficiary.

The cost cannot exceed 102% of the group health plan's cost (Employer plus eligible individual contributions) for coverage of a similarly situated Plan Participant or beneficiary who is not receiving COBRA continuation coverage. The additional 2% is an administration fee permitted by law.

During an 11-month Disability extension described in the *Social Security Disability Extension* section of this chapter, the qualified beneficiary's cost may not exceed 150% of the cost to the group health plan (Employer plus eligible individual contributions) for coverage of a similarly situated Plan Participant or beneficiary who is not receiving COBRA continuation coverage.

Making Payments for COBRA Continuation Coverage

You do not have to send your first payment with your COBRA continuation coverage election form. However, benefits will not be available and claims will not be paid until the first premium payment is received. The due date and mailing address for your payments will be listed on your first billing notice. You must make your first payment no later than **45 days** after the date you elect coverage. All subsequent payments have a 30-day grace period. Your first payment will be for the time period between your coverage termination date and the end of the current month. COBRA continuation coverage is effective (retroactive to the date active coverage ended) only when you enroll by the COBRA enrollment deadline and make your first payment within **45 days** of your COBRA election date.

If you do not make a COBRA payment on time, you will lose COBRA continuation coverage rights under the NRECA group health Plans.

Changing COBRA Continuation Coverage

Whenever your status or that of a dependent changes, you must notify the COBRA administrator **within 60 days**. COBRA continuation coverage may be modified based on Plan rules if you experience a qualifying event (e.g., birth, marriage, divorce, termination of a domestic or civil union partnership, change in dependent eligibility). Refer to the *Eligibility and Participation Information* chapter for a list of life and employment events. Premiums may be adjusted if your coverage changes.

Adding a New Dependent

You may add coverage for a newly eligible dependent after the initial COBRA qualifying event if the dependent meets eligibility requirements and is enrolled **within 60 days** of becoming eligible. Except for newborn or newly adopted children, only a qualified beneficiary may cover dependents added after the initial qualifying event and added dependents may not extend coverage individually. In contrast, newly born or adopted children who become dependents after the initial qualifying event have individual continuation rights.

To enroll newly eligible dependents in COBRA, you must contact your COBRA administrator **within 60 days** of the dependent becoming eligible. Most coverage changes are effective on the date of the event or the date you call your COBRA administrator, whichever is later. **Note**: The timely medical Plan enrollment of your dependent gained through birth, adoption, or placement for adoption will be made retroactively to the date of birth, adoption, or placement for adoption.

Discontinuing Your Coverage or Removing a Dependent from Coverage

To discontinue your COBRA continuation coverage, you must notify the COBRA administrator. Coverage will be terminated as of either the event date or the date you call your COBRA administrator, whichever is later. Premiums will continue to be billed and claims will be processed until you notify the COBRA administrator and provide any required documentation. Claims that you or your dependents incur after your coverage ends will be denied. If you do not supply the required documentation, you will receive a notice from the COBRA administrator, after which coverage will terminate as of the date of loss of eligibility.

Coordination of COBRA Continuation Coverage

If you already have other group insurance (or Medicare) and elect COBRA continuation coverage under an NRECA Plan, your coverage must be **coordinated**. This means that one plan will be considered primary and the other plan will be secondary. To determine which plan is primary, refer to the provisions described in the *Coordinating Benefits with Other Plans* section of the *Medical Plan Benefits* chapter. If you have other coverage, you must notify the COBRA administrator for each plan in which you are enrolled.

End of COBRA Continuation Coverage

If you or your dependents elect COBRA continuation coverage, that coverage can continue for the time period indicated in the *Length of COBRA Continuation Coverage* section of this chapter. Whenever your status (or a dependent's status) changes, you must notify the COBRA administrator within **60 days**. For details, see the *Changing COBRA Continuation Coverage* and *Second Qualifying Events* sections in this chapter.

Coverage will end when a qualified beneficiary exhausts the maximum period of COBRA continuation coverage. Coverage may also end **before** the maximum extension date if:

- Any required premium or contribution is not paid in full. Coverage will be terminated retroactively as of the end of the month for which the last full payment was made;
- Your Employer no longer provides coverage to any eligible individuals. Coverage terminates on the date the coverage is no longer offered;

- A qualified beneficiary obtains coverage after his or her COBRA qualifying event under another group plan that does not impose any exclusions for pre-existing conditions that you or your dependents may have. Coverage terminates on the date the qualified beneficiary obtains coverage under the other group plan or the date you contact the COBRA administrator, whichever is later;
- A qualified beneficiary engages in conduct (such as fraud) that would justify the Plan's termination of coverage for a similarly situated Participant or beneficiary not receiving continuation coverage. Coverage will terminate on the date of the event;
- A qualified beneficiary is determined by the Social Security Administration to no longer be disabled. A qualified beneficiary (or Authorized Representative) must notify the COBRA administrator within **60 days** of the Social Security Administration's determination. For details, see the *Social Security Disability Extension* section earlier in this chapter; or
- A qualified beneficiary becomes entitled to Medicare Part A, Part B, or both. The qualified beneficiary must notify the COBRA administrator in writing within 60 days of Medicare entitlement. Coverage will terminate on the effective date of the entitlement. All other family members who are qualified beneficiaries remain eligible to participate in COBRA.

The COBRA administrator will continue to bill you for coverage and process claims until you notify him or her to terminate coverage and provide any required documentation. Claims for expenses that you or your dependents incur after coverage ends will be denied. If you do not provide documentation when required, the COBRA administrator will notify you, after which coverage will terminate as of the date of loss of eligibility.

For More Information

For questions or information not covered in this chapter, contact your COBRA administrator using one of the methods in the *Contact Information* chapter.

Changing Your Address

To protect your (and your family's) rights, keep the COBRA administrator informed of any address changes for you and your family members. Keep copies of all correspondence with the COBRA administrator for your records.

Transitioning to Medicare Using COBRA

COBRA continuation coverage may be used to bridge the gap in health coverage as you transition to Medicare. This is important because if you experience a gap in health coverage that exceeds 63 days, you will lose the guaranteed right to purchase an individual Medicare supplemental insurance policy that does not impose pre-existing condition exclusions. For details, visit medicare.gov.

Chapter 11: Important Notifications and Disclosures

Not a Contract of Employment

This Plan must not be construed as a contract of employment and does not give any Employee a right of continued employment, nor may the Plan be construed as a guarantee of other benefits from your Employer.

Non-assignment of Benefits

You and your covered dependents, if any, cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan to a third party before you receive it. A benefit payment made by the Plan to a provider of health care services or supplies does not make such provider an assignee of benefits or otherwise confer on such provider any rights under the Plan or ERISA. An Authorized Representative designation made by you or a covered dependent is not an assignment of benefits with respect to the Plan. An attorney-in-fact designation made by you or a covered dependent pursuant to a power of attorney document is not an assignment of benefits with respect to the Plan.

Third-party Liability

The Plan does not cover expenses that you incur as a result of an Injury or Sickness caused by a third party (such as in an automobile Accident). The Plan's third-party liability provision allows you to receive benefits and, at the same time, places the expense of coverage with the person or entity that may be liable for the Injury or Sickness. If a covered individual receives any settlement or otherwise is compensated by a third party as a result of an Injury or Sickness, the Plan has the right to recover from, and be reimbursed by, the covered individual for all amounts this Plan has paid and will pay as a result of that Injury or Sickness, up to and including the full amount the covered person receives from third parties.

As a condition of receiving benefits under this Plan, you are expected to cooperate with CBA in its recovery of any amounts for which the Plan is entitled to be reimbursed. Your cooperation may include completing any forms or repaying to the Plan any amounts you receive for benefits paid by the Plan. The Plan's right to reimbursement comes first, even if the covered individual is not paid for all the claims for damages **or if the payment received is for damages other than medical expenses**. The Plan will seek recovery for payment of benefits through subrogation or reimbursement, and the Plan's right of full recovery may be from any source of payment, including, but not limited to: 1) any judgment, settlement, or other payment made or to be made by or on behalf of a third party; 2) any liability or other insurance coverage, workers' compensation, you or your covered dependent's own uninsured or underinsured motorist coverage, any medical payments, any "no-fault," or school insurance coverage paid or payable; and 3) automobile medical payments or recovery from any identifiable fund. For purposes of this provision, "you" includes Participants, their covered dependents, COBRA beneficiaries, and any other person who may recover under this Plan on your behalf (e.g., your estate).

Subrogation

Immediately upon paying any benefits to you, the Plan will be subrogated (i.e., substituted for) all rights or recovery that you have against any third party for benefits paid under the Plan. This means that if you receive a settlement, judgment, or compensation from a third party as a result of an Injury or Sickness, this Plan has the independent right to recover from, and be reimbursed by you for all amounts the Plan has paid and will pay as a result of that Injury or Sickness, up to and including the full amount you receive from third parties. The Plan's right to reimbursement comes first, even if you are not paid for all the claims for damages **or if the payment received is for damages other than medical expenses**. You must notify the Plan within 45 days of the date when notice is given to any third party of your intention to recover damages due to your Injury or Sickness. If you enter into litigation for payment of your Injury or Sickness, you must not prejudice, in any way, the Plan's

subrogation rights. The Plan will pay for any costs it incurs in matters related to subrogation. Any costs you incur for legal representation will be your responsibility.

Your Duty of Reimbursement

In most cases, the Plan will not be reimbursed directly by the third party. Normally, your claim against the third party will be settled with the third party. Therefore, if the Plan pays your benefits and you then receive settlement from the third party (or the third party's insurer) to compensate you for benefits paid under this Plan, you must reimburse the Plan for the benefits it paid to you—up to the amount of such compensation. This Plan's right of reimbursement is a first-priority right, to be satisfied before payment of any other claims, including attorney's fees and costs, and regardless of any state's make-whole doctrine.

If you fail to repay the Plan any amounts you receive for benefits paid under this Plan, the Plan reserves the right to bring legal action against you for amounts owed to the Plan and/or to suspend payment(s) for any future Plan benefits until it has recovered such amounts.

If you do not repay the Plan within 30 days of your receipt of third-party benefits, the Plan may take legal action to pursue repayment plus interest. Such interest is calculated on the principal amount of the advance that is not repaid within 30 days of your receipt of the other benefits, using a rate equal to the prime rate plus 3% (compounded annually from the date that is 30 days after your receipt of the other benefits). The Plan may also recover from your reimbursement the Plan's costs and attorney's fees it incurs to enforce this repayment provision.

Mistakes in Payment

Although every effort is made to pay your benefits from the Plan accurately, mistakes can occur. If a mistake is discovered, the Plan Administrator will make corrections that are deemed appropriate. You will be notified if a mistake is found.

Healthcare Audit Reward Program

The Healthcare Audit Reward Program (HARP) encourages Participants to check their family's health care bills. If you find a billing error of at least $100 and the error is verified by Cooperative Benefit Administrators, Inc. (CBA), you may receive 10% of the error amount, subject to a $5,000 maximum HARP reimbursement. Contact CBA at 866.673.2299, Option 1, and ask the HARP specialist for more information.

Right of Recovery of Overpayment

If it is later determined that either the Plan made an overpayment or the Plan made a payment in error, either to you or on your behalf, then the Plan has a right, at any time, to recover that payment from the person to whom or on whose behalf the overpayment or erroneous payment was made. The Plan has the right to recover overpayments as a result of, but not limited to:

- Fraud;
- Any error the Plan makes in processing a claim; or
- Benefits paid after the death of the Employee.

If the overpayment is not refunded to the Plan, the Plan reserves the right to bring a legal action to recover the overpayment, to offset future benefit payments until the overpayment is recovered, or both. You will be notified if a mistake is found.

Changing or Terminating the Plan

This Plan may be amended or terminated at any time, for any reason, by action of the Plan Sponsor or your Employer. This includes the right to change the cost of coverage. These changes may be made with or without advance notice to Plan Participants. However, your rights to claim benefits for

the period prior to the termination or amendment will not be affected if such benefit is payable under the Plan as in effect before the Plan is terminated or amended.

Severability

If any provision of this Plan is held invalid, the invalid provision does not affect the remaining parts of this Plan. The Plan is construed and enforced as if the invalid provision had never been included.

Statement of ERISA Rights

Your Rights

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 will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, 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 request to the Plan Administrator, copies of documents governing the Plan's operation, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 Plan "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may

file suit in federal court. In such case, the court may require NRECA, as Plan Administrator, to provide the materials and pay you up to $184 a day, not to exceed $1,846 per request (2023 limit, as may be indexed annually) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or 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.

Assistance with Your Questions

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

Women's Health and Cancer Rights Act (WHCRA)

Covered individuals who had or are going to have a mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). If you receive mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of a mastectomy, including swelling associated with the removal of lymph nodes (lymphedemas).

These benefits will be provided subject to the same Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the *Plan Highlights* chapter for specific Coinsurance applicable to these benefits.

Contact your benefits administrator for more information about WHCRA.

HIPAA Privacy Rights

Availability of HIPAA Notice of Privacy Practices

The privacy rules under Health Insurance Portability and Accountability Act (HIPAA) govern how health information about you may be used and disclosed by the Plan and provide you with certain rights with respect to your health information. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan and describes the Plan's legal duties and privacy practices relative to such information.

If you would like a copy of the Plan's Notice of Privacy Practices, please contact NRECA's Privacy Officer as indicated in the *Contact Information* chapter. The Plan's Notice of Privacy Practices is also available electronically on the NRECA Employee Benefits website. Log in to cooperative.com >

My Benefits. A link to the Notice of Privacy Practices is located at the bottom of the page (“HIPAA Notice”).

Appendix A: Key Terms

Accident

A non-occupational injury caused by a sudden and unforeseen event that occurred at an exact time and place.

Actively at Work, Actively Working or Active Work

Means that an Employee must be present at work at the business establishment of the Employer or at other locations to which the Employer's business requires the Employee to travel on a day that is one of the Employer's scheduled work days and must be performing, in the usual way, all regular duties of the Employee's job on that day.

An Employee will be deemed to be Actively at Work on a day that is not one of the Employer's regularly scheduled workdays only if the Employee was Actively at Work on the preceding scheduled workday. An Employee will be deemed to satisfy the Active Work Requirement if he or she is on an Employer-approved leave of absence (e.g., FMLA absence, disability, jury duty, bereavement leave, vacation), but does not include time off as a result of disciplinary suspension.

In no event will an Employee be deemed to be on an Employer-approved leave of absence for any absence that continues longer than 12 weeks, except for an FMLA leave of absence to care for family members who are injured while on active duty in the armed forces, including the National Guard or Reserves, which provides the Employee with a leave up to 26 weeks.

Adverse Benefit Determination

An Adverse Benefit Determination means any of the following:

A denial, reduction, termination of, or failure to make full or partial payment for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of your eligibility to participate in a benefit option under the Medical PPO Plan.

An Adverse Benefit Determination also occurs when the Plan does not cover an item or service for which benefits are otherwise provided because the item or service is determined to be experimental, unproven, investigational, or not Medically Necessary or appropriate.

Note: A Rescission of Coverage, as defined under applicable law, is any Adverse Benefit Determination, regardless of whether the rescission has an adverse effect on any particular benefit at that time a determination is made. For additional details, see the *Appealing an Adverse Benefit Determination: Rescission of Coverage* section in the *Medical Claims and Appeals* chapter.

Ambulatory Surgical Center

Any public or private institution that:

- Is licensed as an Ambulatory Surgical Center by the state in which the center is located; or
- Is established, equipped, and operated primarily as a facility for performing surgical procedures and meets all the following requirements:
    - Is operated under the supervision of a staff of Physicians, maintains adequate medical records for each patient, and provides for periodic review of the facility and its operation by a utilization or tissue committee composed of Physicians other than those who own or supervise the facility
    - Permits a surgical procedure to be performed only by a Physician privileged to perform such procedure in a Hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used
    - Provides no overnight accommodations for patients and has at least two operating rooms, one post-anesthesia recovery room, and full-time service from registered nurses for patient care in all operating and post-anesthesia recovery rooms

- Is equipped to perform diagnostic x-ray and laboratory examinations required in connection with the surgery to be performed and has the necessary equipment and trained personnel to handle foreseeable emergencies including, but not limited to, a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction, and a blood bank or other supply for hemorrhaging.
- Maintains written agreements with one or more Hospitals in its area for immediate acceptance of patients who develop complications or require postoperative confinement.

The surgical suite or facility must be accredited by either the Accreditation for Ambulatory Health Care or the American Association of Accreditation Plastic Surgery Facilities.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is 1) conducted in connection with the prevention, detection, or treatment of cancer (or other Life-threatening Disease or Condition) and is federally funded through a variety of entities or departments of the federal government; 2) is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or 3) is exempt from investigational new drug application requirements.

Authorized Representative

A person who you have authorized in writing to represent you in the claims process, the appeals process, or both.

Birthing Center

A facility that can be used instead of a Hospital setting for the birth of a child. A Birthing Center must:

- Be certified or approved by a state department of health or other legally constituted regulatory state authority;
- Be equipped and operated primarily for the purpose of providing an alternative method of childbirth (this does not include an abortion center or clinic);
- Operate under the direction of a Physician;
- Permit a surgical procedure to be performed only by a Physician;
- Require an examination by an obstetrician at least once prior to delivery (to identify high-risk pregnancies);
- Offer prenatal and postpartum care;
- Provide at least two birthing rooms;
- Have available the necessary equipment—including a fetal monitor, incubator and resuscitator—and trained personnel to handle foreseeable emergencies;
- Provide the services of registered graduate nurses for patient care;
- Not provide beds or other accommodations for patients to stay more than 48 hours;
- Maintain written agreements with one or more Hospitals in the area for immediate acceptance of patients who develop complications or who require post-delivery confinement;
- Provide for periodic review by an outside agency; and
- Maintain adequate medical records for each patient.

Chemotherapy

Outpatient treatment of disease using chemical agents.

Children's Health Insurance Program (CHIP)

Provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program.

Claimant

A Participant who is making a claim for Plan benefits.

Coinsurance

Your share of the costs for a covered health care service, calculated as a percentage of the allowed amount. For example, if the plan's allowed amount for an office visit is $100 and you have met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or Plan pays the rest of the allowed amount.

Concurrent Care Claim

A claim for which the claims administrator has approved an ongoing course of treatment to be provided over a period of time or for a certain number of treatments where one of the following is also true:

- The claims administrator determines that the approved course of treatment should be reduced or terminated before the end of such period of time or number of treatments has been completed. **Note**: This does not apply where the reduction or termination is due to Plan amendment or termination; or
- You must request an extension of the course of treatment or number of treatments beyond what the claims administrator has approved (when pre-service approval is required and the continuing services have not yet been provided).

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

Convalescent Nursing Home

A legally operated institution that:

- For a fee, provides room, board, and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care;
- Is under full-time supervision of a Physician or registered nurse;
- Keeps adequate medical records;
- If not operated by a Physician, has the services of one available under an established agreement;
- Is not an institution, or part of one, used mainly as a rest facility or a facility for the aged; and
- Is licensed for skilled nursing care.

Copayment

A fixed amount (e.g., $15) that you pay for a covered health care service, usually at the time when you receive the service. Copayments may vary based on the type of covered health care service.

Cosmetic Procedure

A treatment or surgery that is intended to improve the patient's physical appearance, that is not Medically Necessary and from which no significant improvement in physiologic function can be expected (regardless of emotional or psychological factors).

Custodial Care

Care that helps you with your daily living activities. Custodial Care is not covered under this Plan. Examples include assistance with walking, getting in and out of bed, bathing, dressing, eating, and

performing normal bodily functions. Other examples include preparation of special diets and help taking medication that can usually be self-administered. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel.

Deductible

The amount that you must pay toward covered expenses for covered health services or supplies before the medical Plan begins to pay any portion of the cost of covered expenses for those covered services or supplies. In-network and out-of-network annual Deductibles and annual out-of-pocket maximums accumulate jointly. For example, if you use an in-network provider, the amount applied to your in-network annual Deductible also counts toward your out-of-network annual Deductible, and vice versa.

Director

Means you are a Director in a participating cooperative and includes:

- Advisory Directors;
- Alternate Directors; and
- Director Emeritus, up to a maximum of three.

Your Employer may or may not elect to provide coverage for the above-listed classes (see the *Eligibility and Participation Information* chapter for details).

Durable Medical Equipment

Equipment and supplies ordered by a Physician for everyday or extended use. Examples include wheelchairs, Hospital beds, and respirators. Air conditioners, humidifiers, air purifiers, and other similar convenience items are **not** considered Durable Medical Equipment.

Durable Medical Equipment is equipment that is recognized as such by Medicare Part B and meets all the following criteria:

- It can stand repeated use;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to a person in the absence of Sickness or Injury;
- It is appropriate for home use;
- It is related to the patient's physical disorder;
- It is for temporary use only;
- It is certified, in writing by a Physician, as being Medically Necessary;
- It is the standard, basic model rather than a deluxe, luxury model;
- It is not more costly than alternative services that would be effective for diagnosis and treatment of the condition; and

It enables a patient to make reasonable progress in treatment.

Eligibility Waiting Period

The period, if any, chosen by the Employer, that is required before participation in the Plan is available to an Employee.

Emergency Medical Condition

A medical condition, including a Mental Health Condition or Substance Abuse, that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- A serious threat to the individual's health;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services

Emergency services include both the following:

- Initial services. A medical screening examination within the capability of a Hospital emergency department or freestanding independent emergency department, including ancillary services routinely available in the emergency department, to determine whether an "Emergency Medical Condition" exists.
- Post-stabilization services. Additional services covered under the Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after a participant or dependent is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the initial services were provided.

Employee

A person who is employed by the Employer; provided such person is Actively Working or deemed to be Actively at Work pursuant to the terms of the Plan and Employer elections.

Employer

The organization, cooperative, association, system, or entity from which you receive a salary for performing your job responsibilities and through which you receive benefits under the Plan.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

External Review

An appeal option available for certain medical claims after the internal claims and appeals review process has been exhausted and the Adverse Benefit Determination has been upheld. The External Review is conducted by an Independent Review Organization (IRO).

Family and Medical Leave Act (FMLA)

Provides certain employees with up to 12 weeks of unpaid, job-protected leave per year.

Formulary

A list of prescription drugs, both generic and brand-name, used by practitioners to identify drugs that offer the greatest overall value. A committee of Physicians, nurse practitioners, and pharmacists maintain the Formulary.

Habilitation Services

Health care services delivered by a licensed or certified provider to help a person learn, improve, or maintain skills that were never previously learned or acquired and are necessary for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language therapy, and other services for people with disabilities in a variety of inpatient and outpatient settings.

Habilitation Services and *Rehabilitation Services* can be similar but are performed for different purposes. While Rehabilitation Services help a patient regain function that they have lost, Habilitation Services help someone maintain, learn, or improve skills they need for daily living functions but did not learn or acquire (often in childhood) due to a developmental, cognitive, or other condition.

Healthcare Audit Reward Program

The Healthcare Audit Reward Program (HARP) encourages Participants to check their family's health care bills and rewards them if they find a billing error of at least $100. The error must be verified by Cooperative Benefit Administrators, Inc. (CBA).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Is a federal law which created national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The law also provides security provisions and data privacy to keep a patients' medical information protected.

Home Health Care Agency

Considered to be one of the following:

- A Hospital that provides a program of home health care;
- A home health agency as defined by Medicare; or
- An organization that is certified by the patient's Physician as an appropriate provider of home health services, is licensed or certified as a Home Health Care Agency if the state or local jurisdiction in which it is located requires such licensing or certification, has a full-time administrator, keeps written records of services provided to the patient, and has at least one registered nurse (RN) or the care of an RN available.

Benefits for services provided by home health care agencies are subject to the following conditions:

- The services and supplies must be ordered by a Physician as a part of the home health care plan;
- The patient must be under the care of a Physician who submits the home health care plan. This Plan is a written program for the care and treatment of a Sickness or Injury in the patient's home. It must certify that inpatient confinement in a Hospital, Convalescent Nursing Home, or skilled nursing facility would be required if the home care weren't provided; and
- The home health care benefit will not exceed the amount that would have been paid had the services and supplies been furnished by a Hospital during an inpatient confinement. For this purpose, a Hospital Confinement is considered a continuous period during which inpatient care in a Hospital, Convalescent Nursing Home, or skilled nursing facility would be required were it not for the home care.

Hospice Care Program

A program directed by a Physician to help care for a terminally ill person through either:

- A centrally administered, medically directed, and nurse-coordinated program that provides a coherent system of primarily home care, uses a hospice team, and is available 24 hours a day, seven days a week; or
- Confinement in a hospice. A hospice is a facility that provides short periods of stay for a terminally ill person in a homelike setting for either direct care or respite. This facility may be either freestanding or affiliated with a Hospital. It must operate as an integral part of the Hospice Care Program. If such a facility is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a hospice.

A Hospice Care Program must meet standards set by the National Hospice Organization and be approved by the Plan. If such a program is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice Care Program.

Hospital

An institution that is:

- Accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals; or

- Operated in accordance with the law under the supervision of a staff of Physicians and with 24-hour-a-day nursing service, and that is primarily engaged in providing:
    - General inpatient medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or
    - Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a Hospital or with a specialized provider of those facilities.

An institution that does not meet the tests of the above items but is state licensed and accredited by the Joint Commission for Accreditation of Hospitals as a community mental health center and residential treatment facility for alcoholism and drug abuse or as an Ambulatory Surgical Center.

In no case will the term Hospital include a Convalescent Nursing Home or an institution that:

- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged;
- Furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living; or
- Is operated primarily as a school.

For institutions that care for alcoholism, mental illness, and Substance Abuse, the term “Hospital” also means (respectively) an alcohol dependency treatment center, a psychiatric day treatment facility, and a drug dependency treatment center.

Hospital Confinement

A covered person is considered confined when he or she is a registered patient in a Hospital and a room and board charge is made. A Hospital Confinement for more than 24 hours is considered an inpatient expense regardless of whether a room and board charge is incurred: for example, observation charges for a period of more than 24 hours.

Hours of Service

An hour of service is an hour for which employees receive direct or indirect compensation from your co-op. This includes:

- Hours worked, including overtime
- Paid vacation
- Holidays
- Sick leave
- Leave under the Family Medical Leave Act (FMLA)
- Jury duty
- Military training or service
- Disability

Injury

Bodily harm that is the direct result of an Accident and not related to any other cause. This Accident must not be employment-related.

Immunization

An injection with a specific antigen to promote antibody formation. It is used to make a person immune to a disease or less susceptible to a contagious disease.

Internal Appeal Process

A review of an Adverse Benefit Determination conducted by the applicable claims administrator upon request by the Plan Participant.

Life-threatening Disease or Condition

A disease or condition that is likely to result in death unless the disease or condition is interrupted.

Medical Emergency

A sudden and unexpected physical condition for which immediate services, diagnoses, or treatment are required to avoid threat to life or limb. Emergency medical treatments or services must be determined to be Medically Necessary to be covered under the Plan.

Medical Judgment

A coverage decision that is based on the medical plan's (or claims administrator's) requirements for the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. A determination that a treatment is experimental or investigational, or as otherwise defined by applicable law.

In connection with the External Review process, the External Reviewer is generally responsible for determining whether an Adverse Benefit Determination involves Medical Judgment.

Medically Necessary, Medical Necessity, or Medically Necessary Services and Supplies

To be considered Medically Necessary, medical services or supplies must meet all the following criteria:

- Ordered by a Physician;
- Consistent with the symptom or diagnosis and treatment of the Sickness or Injury;
- Appropriate within the standards of good medical practice;
- The most appropriate supply or level of service that can be safely provided to the patient in the appropriate setting;
- Not solely for the convenience of the patient, a Physician, a Hospital, or another medical care facility;
- Not for educational, investigational, or experimental services;
- Not for services that are mainly for the purpose of medical or other research; and
- Not for Cosmetic Procedures provided solely to improve appearance unless due to either a congenital defect that impairs function or an Accident.

For Hospital inpatient care to be considered Medically Necessary, the patient's symptoms or medical condition must be such that the services cannot be safely provided on an outpatient basis. The length of a Hospital Confinement and Hospital services and supplies will be considered Medically Necessary only to the extent that they are determined to be both related to the treatment of the Sickness or Injury and not provided for the scholastic education or vocational training of the patient.

In addition to the criteria listed above, the Medical Necessity criteria for prescription drugs include not only the drug and diagnosis but also an evaluation of the clinical appropriateness of a medication in terms of the condition being treated, severity of condition, medication type, frequency of use, and duration of therapy.

Mental Health Condition

A condition which manifests signs or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Conditions may include Psychosis, Affective disorder, Anxiety disorders, Personality disorders, Obsessive-compulsive disorders, Attention disorders with or without hyperactivity, and Other psychological, emotional, nervous, behavioral or stress-related

abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

Mental Health

Services that are required to diagnose and treat a Mental Health Condition that impairs the behavior, emotional reaction or thought processes.

Out-of-Pocket (OOP) Coinsurance Maximum

The limit on the amount you pay for covered health services after you have paid your Deductible and excluding any Copayments. Plans generally pay all covered costs (except Copayments) for the rest of the year after you reach this limit. This limit includes only amounts paid for covered services. For example, out-of-network reductions or claims for cosmetic treatment do not count toward the OOP Coinsurance Maximum. Amounts in excess of the non-network reimbursement amount also do not apply to the OOP Coinsurance Maximum.

Partial Hospitalization Program (PHP)

Either a full or partial day in a psychiatric Hospital or in the behavioral health department of a Hospital. The Plan treats both a full and a partial day of treatment as one inpatient day that is subject to the Plan's inpatient benefit provisions.

Participant

A person who is defined as eligible to receive health benefits and enrolled in this benefit plan.

Performance Drug List

A Performance Drug List is a guide within select therapeutic categories for Plan members and health care providers. Generics should be considered the first line of prescribing. If there is no generic available, there may be more than one brand-name medicine to treat a condition. These preferred brand-name medicines are listed to help identify products that are clinically appropriate and cost effective.

Physician

A legally qualified medical doctor or practitioner who is licensed in the governing jurisdiction and practicing within the scope of the license. The Physician (or doctor) must not be related to the covered Participant or patient by blood, marriage, or adoption.

Plan Administrator

The person or entity responsible for keeping an employee benefit plan in compliance and managing the plan for the exclusive benefit of Plan participants as stated in the Plan Information section of this Summary Plan Description.

Plan Sponsor

An employer or organization that offers a group health plan to its employees or other eligible members as stated in the Plan Information section of this Summary Plan Description.

Post-service Claim

All claims that are not Pre-service Claims; for example, a claim for benefits that you make after receiving health care services.

Prescription Digital Therapeutics

A prescription-only software that is intended to prevent, manage or treat mental or physical conditions.

Pre-service Claim

Any claim for a benefit for which, in order to pay benefits, the Plan specifically requires the Participant or provider to receive approval (called Preauthorization) from the claims administrator before obtaining medical services, such as in the case of Preauthorization or Prior Authorization of health care items or services.

If a Participant or provider calls the Plan for the sole purpose of learning whether a charge will be covered, that call is not considered a Pre-service Claim, unless the Plan specifically requires the Participant to call for Prior Authorization. The fact that the Plan may grant Prior Authorization does not guarantee that the Plan will ultimately pay the claim.

If you receive services that require Preauthorization or Prior Authorization without receiving Prior Authorization or approval from the claims administrator, the claim will be reviewed as a Post-service Claim.

Preauthorization (Preauthorize, Prior Authorization, or Predetermination of Medical Services)

A decision by the Plan about whether a health care service, treatment plan, prescription drug, or Durable Medical Equipment is Medically Necessary. Sometimes Preauthorization is also called Prior Authorization, prior approval, or precertification. The Plan may require Preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise that your Plan will cover the cost.

Qualified Medical Child Support Order (QMCSO)

Generally, a state court or agency may issue a medical child support order requiring an ERISA-covered health plan to provide health benefits coverage to a child or children. The group health plan must determine whether such medical child support order is qualified. An order that is determined to be qualified is called a Qualified Medical Child Support Order (QMCSO). A state child support enforcement agency may also obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. For further information about QMCSOs, call the Member Contact Center at 866.673.2299.

Qualifying Payment Amount (QPA)

The median contracted amount calculated in accordance with the methodology established in the No Surprises Act and its implementing regulations and other regulatory guidance, as may be amended and updated from time to time.

Radiation Therapy

Outpatient treatment of disease through high-energy x-rays or radioactive substances.

Reasonable and Customary (R&C) Rates

R&C means “Reasonable and Customary,” which is the current, most common fee charged in a geographic area for a particular treatment or service. The R&C Rate for any service or supply is the usual charge for the service or supply in the absence of insurance, but not more than the prevailing charge for a like service or supply in the geographic area.

A **like service** is a service of the same nature and duration that requires the same skill and is performed by a provider of similar training and experience.

A **like supply** is a supply that is identical or substantially equivalent.

Area means the municipality (or, in the case of a large city, the subdivision of it) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service or supply.

When determining applicable R&C Rates, CBA in its sole discretion consults industry-wide databases, which may include, without limitation, Fair Health and a factor of Medicare rates, and relies on the methodologies of third parties, whether or not such databases and third parties are listed in the Plan. CBA may also consider factors such as:

- The nature and duration of the service;
- The skills required to perform that service;
- The training and experience of the provider who performs the service; and
- The medical supplies necessary for the treatment or service.

Rehabilitation Services

Health care services that help a person maintain, restore, or improve skills and functioning for daily living that have been lost or impaired because that person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric Rehabilitation Services in a variety of inpatient or outpatient settings.

Rescission of Coverage

A cancellation, termination, or discontinuance of coverage that has retroactive effect, meaning that it will be effective as of the date on which you were ineligible for Plan coverage.

Restorative Speech Therapy

Therapy by a qualified Speech Therapist to restore speech loss or correct impairment due to:

- A congenital defect for which corrective surgery has been performed; or
- An Injury or Sickness.

Retained Attorney

One attorney retained as outside counsel by the participating cooperative on an ongoing basis. Your Employer may or may not elect to provide coverage for the above-listed classes (see the *Eligibility and Participation Information* chapter for details).

Routine Patient Costs

Items and services typically provided under the Plan for a Participant not enrolled in a clinical trial. Routine Patient Costs exclude:

- Investigational items, devices, or related services;
- Items and services that are not included in the patient's direct clinical management but instead are provided in conjunction with data collection and analysis; or
- A service clearly not consistent with widely accepted and established standards of care for a particular diagnosis.

SHARE Program

NRECA Medical Plan participants use the SHARE program to preauthorize health care services and benefits. The program also provides services to help participants manage their health care better and get the most from their benefits.

Services provided by SHARE include:

- Inpatient hospital stay evaluations and treatment
- Medical case management

- Discharge planning
- Outpatient nursing care and medical equipment coordination
- Medical facility transfers and evaluations

Sickness

Any disease or illness that is not employment-related. Sickness must begin while the Employee is covered under the Plan. The term also includes:

- Pregnancy; or
- Any medical complications of pregnancy.

Speech Therapist

A provider who meets all these conditions:

- Has a master's degree in speech pathology;
- Has completed an internship;
- Is licensed by the state where the Speech Therapist performs services (if that state requires licensing); and
- Is not related to you or your dependent by blood or marriage.

Substance Abuse

The pattern of pathological use of alcohol or other mind-altering drugs, which is characterized by impairments in social and occupational functioning; debilitating physical condition, or which produces physiological dependency evidenced by physical tolerance or withdrawal. For purposes of this definition, substance includes alcohol and drugs, excluding caffeine, included on the National Institute of Drug Abuse list of addictive drugs.

Substance-related Disorder

Services for the diagnosis and treatment of Substance Abuse.

Teladoc General Medical and Mental Health Consultation

A visit arranged through Teladoc, a company that provides telehealth general medical and mental health consultations.

Charges for General Medical and Mental Health consultations are subject to all the Plan's limitations and provisions, including requirements such as Medical Necessity, Deductible(s), and cost-sharing requirements.

Terminal Illness

A condition that limits a person's life expectancy to six months or less.

Transition of Care

A period of time permitted under the Plan to continue your care if there is a change in the Plan provisions while you are in the middle of care, such as a provider no longer is participating in the Plan's provider network or a prescription drug is no longer covered. Transition of Care also means the movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities.

Urgent Care Claim

Any Pre-service Claim for medical care or treatment for which the typical non-urgent care determination time periods could:

- Seriously jeopardize a patient's life, health, or ability to regain maximum function; or
- In the opinion of a Physician with knowledge of the patient's medical condition, would subject that patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The attending provider who files the claim decides whether a Pre-service Claim is an Urgent Care Claim. The claims administrator defers to the attending provider's judgment. When the attending provider does not define the claim as an Urgent Care Claim, an individual acting on behalf of the claims administrator will apply the judgment of a prudent layperson with average knowledge of health and medicine to decide whether the claim is an Urgent Care Claim.

Note: If you need care for a condition that could seriously jeopardize your life, you should obtain such care without delay. Benefits will be determined when the claim is processed.

Urgent Care Clinic

Also known as urgent care, walk-in care, immediate care, or convenient care, a clinic focused on delivering ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent Care Clinics primarily treat injuries or illnesses that require immediate care but are not serious enough to require an emergency room visit.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994. Signed into law on October 13, 1994, USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. USERRA is intended to minimize the disadvantages to an individual that can occur when that person needs to be absent from his or her civilian employment in order to serve in the uniformed services.

Waiting Period

The period, if any, chosen by the Employer, that is required before participation in the Plan is available to an Employee.