NRECA Vision Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

and

EVIDENCE OF COVERAGE

VSP Standard Vision Plan

ASSOCIATED ELECTRIC CO-OP

01-26073-002

EFFECTIVE DATE: January 1, 2021

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) VSP Standard Vision 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 VSP Vision Plan, which is a component Plan of the NRECA Group Benefits Program.

Plan Number:	501
Plan Type:	VSP Standard Vision Plan
Year End:	December 31
Plan Effective Date:	January 1, 2021

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
ASSOCIATED ELECTRIC CO-OP
2814 S Golden Ave
PO BOX 754
SPRINGFIELD, MO 65801

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

Mid-Atlantic Vision Service Plans, Inc.
VSP Claims
Vision Service Plan
Attention: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

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.

Chapter 1: Contact Information

For Information About	Contact
Claims	**VSP Claims** Vision Service Plan Attention: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018
General Benefit Questions • Eligibility • Enrollment • When Coverage Begins or Ends • Cost of Coverage • Family and Medical Leave Act (FMLA)	**Benefits Administrator** ASSOCIATED ELECTRIC CO-OP 2814 S Golden Ave PO BOX 754 SPRINGFIELD, MO 65801
COBRA Administrator	**UMR** **COBRA Administration** PO BOX 1246 Wausau, WI 54402
• **VSP benefits** • **VSP network providers** • **Customer service matters** • **Non-VSP provider benefits** • **Out-of-pocket expenses** • **View and retrieve benefit information**	**VSP Customer Service** 800.877.7195 Monday - Friday 8:00 am to 10:00 pm ET; Saturday 9:00 am to 5:30 pm ET vsp.com
Designating an Authorized Representative	**NRECA Privacy Officer** 4301 Wilson Boulevard Arlington, VA 22203-1860 Telephone: 703.907.6601 Fax: 703.907.6602 Email: privacyofficer@nreca.coop

Chapter 2: VSP Standard Vision Plan Highlights

Vision Service	VSP Provider	Non-VSP Provider
Eye exam	$10 Copayment	$10 Copayment Costs reimbursed up to $70
Prescription glasses (includes lenses & frames)	$20 Copayment	$20 Copayment
Frames	Up to $150 each calendar year Up to $80 each calendar year at Costco, Sam's Club, or Walmart	Up to $79 each calendar year
Lenses[1]		
• Single vision	Covered in full (2 lenses each calendar year)	Up to $45
• Bifocal		Up to $69
• Trifocal		Up to $91
• Lenticular		Up to $127
Contact lenses	$150 combined benefit (may be applied to evaluation, fitting, or lenses)	Up to $105 if elective; Up to $210 if Medically Necessary
Prescription safety glasses[2,3]	• $20 Copayment. • Lenses covered in full • Frames covered up to $60 once every calendar year	No coverage

[1]Lens options such as antireflective coating, no-line lenses, etc., may cost extra; however, VSP discounts are available for these add-on services.

[2]Only the Employee is eligible for this benefit.

[3]Prescription safety glasses benefit is available only if the safety glasses are obtained from a VSP Provider; it cannot be used at participating retail chains: Costco, Sam's Club, or Walmart.

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;
- 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);
- 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:

- A person who retires at or after age 55, regardless of years of service

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

- Intern (including student intern, work-study student)
- Other: Leased workers and student workers.

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.

As a **part-time Active Employee**, you must be classified as eligible for benefits and also satisfy one of these Hours of Service Requirements:

- You must work 1,000 hours in the first calendar year following your hire date; or
- At the time of annual enrollment, you had worked at least 1,000 hours for your Employer in the preceding calendar year.

Benefits as a part-time Active Employee begin on either the date you complete 1,000 hours or at the end of the Eligibility Waiting Period, whichever is later.

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 child[1] (married or unmarried), up to age 26 who is:
  - Your biological child;
  - Your stepchild by marriage;
  - 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 Vision Plan or another insurer since becoming an incapacitated adult child.

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 or child. Also, the same individual may not be covered under more than one NRECA group Vision Plan at one time.

Current Spouse

If both you and your current spouse 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 and dependent children enroll in Employee plus child(ren) or family coverage;
- Your spouse enroll 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 and eligible-dependent children), and your spouse has no coverage under his or her own employment record; or
- Your spouse enrolls in family coverage (including you and your eligible dependent children), and you have no coverage under your own employment record.

Former Spouse

If both you and your former spouse 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 enrollment election must **exclude** your jointly eligible dependent children; or
- Your **former spouse'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 Vision 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 former spouse) 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 enrollment election must **exclude** your jointly eligible dependent children; or
- Your **former spouse'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

No Waiting Period is required by this Plan.

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:

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

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 immediately preceding rehire of six months or longer.

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:** You pay the entire cost of your coverage.
- **Dependents of Employees:** You pay the entire cost of your coverage.
- **Disabled Employees:** You pay the entire cost of your coverage.
- **Dependents of disabled Employees:** You pay the entire cost of your coverage.
- **Under age 65 retired Employees:** You pay the entire 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); or
- 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.

If you use your Employer's IRC 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 themselves 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.

Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline for the special enrollment period for enrolling in a health plan after a loss of coverage or acquiring a new dependent due to birth, marriage, adoption, or placement of adoption shall be extended without regard to the Outbreak Period. The "Outbreak Period" runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

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

Losing Other Coverage

If you 1) declined vision coverage for yourself or your dependents because you have other vision coverage and 2) either you or your dependents later lose the other vision 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 vision coverage was lost.

A loss of other vision 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 vision plan or another group or individual vision insurance policy (through or outside of a Health Insurance Marketplace) at the time you were eligible for vision 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 vision coverage because you exhausted COBRA continuation coverage, and you were either 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 the covered dependent of a retiree who is currently enrolled in the Plan and you are under age 65, you are eligible for special enrollment upon marriage or acquisition of a new dependent by marriage, adoption, birth, placement for adoption, or legal guardianship.

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

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 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.
- **If 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.
- **If 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 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 you are the dependent child of a retiree**, your coverage ends when you no longer meet the Plan's dependent child eligibility requirements.

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. Dependent coverage also ends:

- For a spouse, upon divorce;
- For any dependent, when he or she no longer meets dependent eligibility requirements;
- 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

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

- If your Employer **excludes part-time Employees** from benefits eligibility, then your coverage will end at 11:59 pm on the last day you are considered full-time; or
- If your Employer **includes part-time Employees** in benefits eligibility, then coverage for you and your enrolled dependents continues through the end of the first calendar year in which you do not work 1,000 hours.

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 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);
- 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 become effective January 1 of the following year. However, if during the annual benefits enrollment period you elect a benefit option with an Actively at Work requirement and then, on the following January 1, you are on a leave of absence, your coverage effective date will be delayed until you return to work in a benefits-eligible position.

Paying for Benefits During Your Leave of Absence

You or your Employer must make the required premium payments for your benefits 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 in this chapter 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 your benefits coverage was terminated due to nonpayment of premiums while you were on an approved leave of absence and you return to work immediately following your approved leave, then you may re-enroll in this Plan within **31 calendar days** of the date you return work.

When you re-enroll within the 31-day period, most changes in coverage and corresponding costs will be effective on the date of your qualifying event. If you do not re-enroll within 31 calendar days of the date you return to work, you cannot re-enroll until either your next qualifying life (or employment) event or the next annual benefits enrollment period. For details, see the *When You Can Enroll (or Make Changes)* section in the *Eligibility and Participation* 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: VSP Standard Vision Plan Benefits

How the Plan Works

Through its VSP network doctors, VSP provides necessary and appropriate Plan benefits to you, subject to the limitations, exclusions, and Copayment(s) described in this SPD. When you need vision services, contact any VSP network doctor, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan benefits, VSP will provide benefit authorization directly to the VSP network doctor prior to your appointment.

You receive discounts on vision services and materials when you use a VSP provider. The VSP Plan has one of the largest nationwide networks of vision care providers. It is important to note that not all providers participate in the VSP network at Costco, Sam's Club, or Walmart. To find a VSP provider, you can use the *Find a Doctor* feature at vsp.com or call VSP customer service (see the *Contact Information* chapter).

Benefit Authorization

VSP authorizes Plan benefits according to both your Plan's level of coverage and the latest eligibility information furnished to VSP by the Plan Administrator. When you request Plan services, VSP reviews your prior benefit utilization to determine if you are eligible for new services.

When VSP authorizes benefits and the authorized services are performed before the benefit authorization expires (see below), this constitutes a claim against the Plan even if your coverage has ended or the Plan was terminated. If you receive services from a VSP network doctor without a benefit authorization or if you obtain services from a non-VSP provider, you are responsible for payment in full to the provider at the non-VSP provider benefit level described in the *Vision Plan Highlights* chapter.

If you are eligible for and obtain covered services or materials from a **VSP network doctor**, VSP will pay the VSP network doctor directly according to its agreement with the doctor. You must pay the Copayment (if any) amounts that exceed the Plan allowances and any amounts for noncovered services or materials.

If you are eligible for and obtain covered services or materials from a **non-VSP provider**, you must pay the provider's full fee. You will be reimbursed by VSP according to the non-VSP provider reimbursement schedule shown in the *Vision Plan Highlights* chapter, less any applicable Copayments. Claim forms are not required in order for you to submit a claim to VSP; however, as a convenience, non-VSP provider reimbursement forms are available for download from VSP's website at vsp.com. A request for reimbursement under the Plan should consist, at a minimum, of a copy of the provider's itemized bill and the name, address, telephone number, and Member ID number.

You must submit claims for services rendered or materials provided by non-VSP providers within 24 months after you receive the services or materials. Your failure to file a claim within that time will not invalidate or reduce your claim if it can be shown that the claim was submitted as soon as reasonably possible following receipt of the services or materials.

VSP does not mail you an explanation of benefits (EOB). Rather, your VSP provider explains VSP coverage and payment information at the time of service. For information about your VSP benefits and claims, you can visit vsp.com to set up a personal account to view your claims history.

VSP will, upon request, provide you with a complete record of your claims experience for the past two years.

For emergency conditions of a nonmedical nature, such as lost, broken, or stolen glasses, contact VSP's customer service department for assistance.

If a VSP network doctor's membership terminates, VSP will be liable to the VSP network doctor for services rendered to you at the time of termination. The VSP network doctor may continue to provide you with Plan benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for another VSP network doctor to provide such services.

Copayments

The benefits described in this SPD are available to you subject to your payment of applicable Copayments. Amounts that exceed plan allowances, annual maximum benefits, options reimbursements, or any other stated Plan limitations are not considered Copayments and are your responsibility. Any additional care, service, or materials not covered by this Plan may be arranged between you and the doctor.

The Plan has the following Copayments:

- Eye exam Copayment: $10
- Prescription glasses Copayment: $20 (includes glasses and frames)

Copayments do not apply to contact lenses.

What the Plan Covers

Through VSP Network providers, the Plan provides benefits equal to 100% of the R&C Rate, after Copayment, for these vision expenses:

- Eye exams by an optometrist or ophthalmologist once every calendar year;
- Lenses (prescription glasses) including:
  - Single vision;
  - Lined bifocal;
  - Lined trifocal;
  - Lenticular;
  - Progressive;
- Frames (prescription glasses), up to a maximum of $150 ($80 at Costco, Sam's Club, or Walmart). VSP providers give a 20% discount on any out-of-pocket expenses above the Plan's covered expense limitations; and
- Contacts, including two contact lenses or a 12-month supply of disposable contact lenses every calendar year up to a maximum benefit of $150. The maximum benefit applies to the combined cost of contact lenses and the contact lens exam. VSP providers also provide a 15% discount on contact lens exams. Your maximum benefit amount may go much further by using a VSP provider for your contact lens exam.

  Note: Visually necessary or elective contact lenses are provided in lieu of all other lenses and frame benefits available. When you choose contact lenses, the Plan will not cover lenses or frames again for 12 months.

During one calendar year, the Plan covers a maximum of:

- Two lenses (one set of glasses);
- Two contact lenses (subject to maximum allowance); or
- A 12-month supply of disposable contact lenses (subject to maximum allowance).

Authorized Providers

Eye examinations must be performed by an **optometrist** or **ophthalmologist**. An **optometrist** or **optician** must furnish any lenses and frames. All providers must be legally qualified to perform these services in the jurisdiction in which the services are rendered. Providers cannot be related to the covered patient by blood or marriage.

An **optician** is a person whose services include:

- Preparing and ordering ophthalmic lenses based on a prescription, and
- Furnishing eyeglass frames.

An **optometrist** is a doctor who is licensed to practice optometry.

An **ophthalmologist** is a medical doctor specializing in eye care who is generally, but not necessarily, an eye surgeon.

Prescription Safety Glasses

For a $20 Copayment, the lenses and frames for prescription safety glasses are covered once every calendar year. The cost of frames is covered, up to a $60 retail allowance. Single, lined, bifocal, and trifocal lenses are covered in full. Side shields are covered in full. Other lens options are available for a discounted price.

The prescription safety glasses benefit is available to Employee Participants only and must be acquired through a VSP provider. The prescription safety glass benefit is not available if the safety glasses are obtained from Costco, Sam's Club, or Walmart.

Low-vision Care

The Plan provides benefits for professional services that are necessary to treat severe visual problems that are not correctable with regular lenses. This includes supplemental testing and supplemental aids (i.e., evaluation, diagnosis, and prescription of vision aids where indicated). The maximum benefit for all low-vision services and materials is $1,000 every two years. All low-vision services are subject to prior approval by VSP's optometric consultants.

Low-vision benefits are subject to preapproval by VSP's optometric consultants whether you use a VSP network provider or a non-VSP network provider. If you visit a VSP network provider, supplemental testing is covered up to 100% and supplemental aids are covered up to 75%. For non-VSP network providers, you must pay the full fee at the time of service, and if VSP approves the low-vision services, you will be reimbursed up to the amount that VSP would pay a network provider for the same services or material.

Out-of-Network Reimbursements

The Plan covers vision services and materials provided by non-VSP providers. Out-of-network maximums for each calendar year are:

- Eye exam up to $70;
- Single vision up to $45;
- Lined bifocal up to $69;
- Lined trifocal up to $91;
- Lined lenticular up to $127;
- Progressive up to $91;
- Frames up to $79;
- Contacts up to $105 (if elective); and
- Contacts up to $210 (if Medically Necessary).

Copayments apply when you obtain services from a non-VSP vision provider. You must pay the provider in full at the time of your appointment and then send a claim to VSP for partial reimbursement. If you decide to see a non-VSP provider, call VSP first to verify whether in-network rates are available. Send claims for non-VSP services to VSP for processing.

Additional Plan Discounts

When you use a VSP network vision provider, these discounts are available:

- An average of 20% savings on lens options such as scratch resistant and anti-reflective coatings;
- Additional discounts on prescription glasses and sunglasses, including lens options[1]. Discounts on these items are available from any VSP network vision provider within 12 months of a covered patient's eye exam.
- An average of 15% savings on laser vision correction. Discounts include pre- and post-operative services in conjunction with the surgery but do not apply to items such as contact lens solution; cases; cleaning products; or repairs to prescription glasses, lenses, or frames. The minimum discount available for laser eye surgery is 5%. Some VSP-participating providers may offer a special price on the surgery for a limited time; the minimum 5% discount ensures that utilizing a VSP provider will result in an even deeper discount. To obtain discounts on laser eye surgery, you must be referred by a VSP provider. Discounts will not apply if prohibited by a manufacturer.

In addition to the discounts for using a VSP provider, the VSP program also offers:

- Savings[2] for VSP members and their extended families on digital hearing aids (up to $2,400 per pair) and replacement batteries through TruHearing;
- Up to 50% savings[1] on UNITY® digital lenses;
- Up to 40% savings[1] on sunsync® light-reactive lenses; and
- Up to $500 savings on LASIK at NVision and TLC eye centers.

For more information, visit vsp.com.

Pre-certification

Certain Plan benefits (low-vision lenses, lenticular lenses, and Medically Necessary contact lenses) require VSP's pre-certification before being covered. VSP's pre-certification determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

Initial Determination: VSP will approve or deny requests for pre-certification of services within 15 calendar days after receiving the request from your doctor. If a pre-certification cannot be resolved within 15 days, VSP may extend the time for its decision by no more than 15 additional calendar days.

Appeals: If VSP denies the doctor's request for pre-certification, the doctor, you, or your Authorized Representative may appeal the denial. VSP will provide the requestor with a final review determination within 30 calendar days from the date the request is received. Please refer to the *Claims and Appeals* chapter for details on how to request an appeal.

A second-level appeal and other remedies are also available (see the *Claims and Appeals* chapter). VSP will resolve any second-level appeal within 30 calendar days. You may

---

[1]*Lens enhancements, extra savings, and discounts do not apply to Costco, Sam's Club, or Walmart pricing.*

[2]*The NRECA VSP Plan does not cover hearing aids; this Plan offers only discounts*.

designate any person as your Authorized Representative. Where you do not designate an Authorized Representative, the doctor will be deemed to be your Authorized Representative.

For more information about VSP's criteria for authorizing or denying Plan benefits, contact VSP's customer service department.

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, provider's name, date of service, 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.

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. For example, 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;
- For services rendered by yourself or by anyone related to you or your dependents by blood or marriage.

Specific Exclusions

The Plan does not cover emergency vision care. For emergency conditions of a medical nature, contact a Physician under your medical plan.

The Plan does not cover:

- Corrective vision treatment of an experimental nature;
- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (when the patient's refractive error is less than a ± .50 diopter power);
- Replacement of lenses, including contact lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available;
- Scratch coatings, anti-reflective, and no-line lenses;
- Services and supplies in connection with medical or surgical treatment of the eye;
- Services and supplies that are in connection with special procedures such as orthoptics, vision training, subnormal vision aids, and tonography;
- The cost of photosensitive, anti-reflective, or aniseikonic lenses beyond the cost that would be paid for clear, white lenses;
- The cost of sunglasses or other tinted glasses beyond the cost that would be paid for clear, white lenses; or
- Two pairs of glasses in lieu of bifocals.

Patient Options: Exclusions Benefit Limits

This Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects **any of the following extras**, the Plan will pay the basic cost of the allowed lenses, and the covered person will pay the additional costs for the options. VSP may, at its discretion, waive any Plan limitations, if, in the opinion of VSP's optometric consultants, the benefit is necessary for your visual welfare:

- Optional Cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses (no-line);
- Cosmetic lenses;
- High-index lenses;
- Laminated lenses;
- Oversized lenses;
- Photochromic lenses, tinted lenses (except Pink #1 and Pink #2);
- Polycarbonate lenses (except for children);
- UV (ultraviolet) protected lenses; and
- Certain limitations on low-vision care.

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 vision 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 Vision Plan.

VSP does not coordinate benefits with individual (non-group) plans. However, if you are covered by **more than one group VSP plan**, the plans may coordinate benefits to cover 100% of your out-of-pocket costs.

When processing a claim that involves coordination of benefits, VSP may need to share personal information about you—for example, with another insurance company. When this is necessary, VSP will share information only with persons or organizations that have a legitimate interest in that information, and it will share information only when not prohibited by law.

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.

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: Complaints and Grievances

If you have a question or problem, your first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer your question and resolve the matter informally. Complaints and grievances include disagreements about access to care or the quality of care, treatment, or service.

If a matter is not initially resolved to your satisfaction, you may then communicate a complaint or grievance to VSP orally or in writing by using the complaint form, which you can obtain from the Customer Service Department. You also have the right to submit written comments or supporting documentation about a complaint or grievance to assist in VSP's review.

VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution will occur as soon as possible, but no later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

Mid-Atlantic Vision Service Plan, Inc., is subject to regulation in the Commonwealth of Virginia by the State Corporation Commission Bureau of Insurance (pursuant to Title 38.2 of the Code of Virginia) and the Virginia Department of Health (pursuant to Title 32.1 of the Code of Virginia). If you have questions about an appeal or grievance concerning vision care services that have not been satisfactorily addressed by VSP, you may contact the Office of Managed Care Ombudsman for assistance:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
877.310.6560 (Toll free)
ombudsman@scc.state.va.us

Chapter 7: Claims and Appeals

General Information

When you receive services from a VSP network provider, the provider verifies your eligibility and coverage and obtains any required authorizations from VSP. VSP will directly reimburse the network provider for covered services. If you obtain services from a non-VSP provider, you must pay the provider in full at the time of your appointment and submit a claim for reimbursement. A claim means a request for Plan benefits that is made in accordance with the claim procedures outlined in this chapter.

After you file a claim, VSP reviews all documentation and notifies you of the 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 Plan 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.

This chapter describes the steps you must take to file claims and request appeals. These steps 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 and appeals for benefits under this 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 questions about eligibility for coverage or participation that do not involve claims for benefits, contact your benefits administrator.

Claims & Appeals Contacts	
Type	**Name & Address**
Authorizing a representative	**NRECA Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard Arlington, VA 22203-1860 703.907.6601 703.907.6602 privacyofficer@nreca.coop
Filing a claim	**VSP Claims Administrator** Vision Service Plan Attention: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018 800.877.7195
Filing an internal appeal	**VSP Member Appeals** 3333 Quality Drive Rancho Cordova, CA 95670 800.877.7195

Claims & Appeals Contacts	
Type	**Name & Address**
Filing a second-level appeal	**VSP Member Appeals** 3333 Quality Drive Rancho Cordova, CA 95670 800.877.7195

Authorizing a Representative

An Authorized Representative is an individual who you designate 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 an appeal on your behalf or represent you in the 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.

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: The insurer, NRECA, and participating Employers are not responsible for how your Authorized Representative discloses your protected information or for his or her failure to protect such information.

Claims

If your provider does not submit a claim on your behalf, you must send the claim in writing to VSP. Claim forms are available on the VSP website. If you need help obtaining a claim form, ask your benefits administrator.

A claim is considered filed when it is received by VSP in accordance with these claims procedures. VSP’s time period to provide you with notice of a determination starts when the claim is filed, regardless of whether VSP has all of the information necessary to decide the claim when it is first filed.

If a claim does not include sufficient information for VSP to make an initial benefit determination, you may be asked to provide additional information. If you do not provide the additional information within the time period identified in the *Claim Review Timeline* table, your claim may be denied, in whole or in part.

Note: If you are covered by more than one group-sponsored VSP plan, you may be able to take advantage of VSP-facilitated coordination of benefits. To do so, you must advise both VSP and your provider that you have dual coverage before receiving services or supplies.

Filing a Claim

When you receive services from a VSP network provider, you do not complete any paperwork or claim forms. If you decide to see a non-VSP provider, you must pay the provider in full at the time of your appointment and submit a claim form for reimbursement. Claim forms are not required in order to submit a claim to VSP; however, as a convenience, non-VSP provider reimbursement forms are available for download from VSP’s website at vsp.com.

Some or all of the following information may be required for your claim:

- Patient's name, date of birth, and relationship to the Participant;
- Group number and individual member number;
- Medical condition (diagnosis) and the treatment or service for which approval is being requested;
- Service provider's name, address, and tax identification number;
- Medical records or other documentation to support the request;
- 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 or balance due bills and credit card receipts **are not acceptable** documentation for itemized charges.

Once received by VSP, your claim will be processed for payment according to the Plan provisions, the guidelines used by VSP, and the claim coding submitted by the provider. It is important to keep copies of every claim because the documentation you submit will not be returned to you.

Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline for when a participant may file or perfect a benefit claim shall be extended without regard to the Outbreak Period. The "Outbreak Period" runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

Claim Review Timeline	
Event	**Description**
Claim filing deadline	After the charges are incurred and within **12 months** from the date services were rendered or material provided
You are notified of a determination	Within **30 calendar days** after claim receipt, unless administrator requests extension or additional information
Claims determination extension	One period of up to **15 calendar days**
Your deadline to supply additional information	**45 calendar days** from your receipt of request for additional information

Claim Determinations, Determination Extensions, and Requests for Additional Information

If you have properly followed the claims procedure, VSP will issue a written determination within a reasonable period of time but not later than the timeframe listed in the table titled *Claim Review Timeline*.

If a claim cannot be processed because you did not provide sufficient information, VSP will notify you about what additional information they need and when you must submit it. If you do not provide the necessary information within the required timeframe, your claim may be denied, in whole or in part. If VSP needs an extension of time due to circumstances beyond its control, it will notify you of the reason and the date when a decision will be made.

Content of the Claim Determination Notice

You will be notified of an Adverse Benefit Determination in writing (paper or electronic). The notice will include (as applicable):

- The specific reason(s) for the Adverse Benefit 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 indicating the internal rule, guideline, or protocol that was relied upon to make the Adverse Benefit Determination, plus a statement that a copy of such rule will be provided free of charge to you upon request; and
- Any additional information required under applicable law.

Further, the notification will 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 appeal (internal or second-level).

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 and a second-level appeal review process for Adverse Benefit Determinations. Generally, you must exhaust the Internal Appeal Process before seeking a second-level appeal review. 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 claim, as noted below. However, a request for documentation does not extend the time period allowed for you to file an appeal.

A copy of your claim file is available online at vsp.com or by sending a written request to the VSP Claims Administrator**.** Your request must include your name, the patient's name (if different), the group policy number, the individual member ID number, the date of service, service provider, and what documents you are requesting**.**

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, check the U.S. Department of Labor website at dol.gov/ebsa/consumer_info_health.html or call the Department of Labor Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272).

Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline for when a participant may file an appeal of an adverse benefit determination under the Plan's claims procedure shall be extended without regard to the Outbreak Period. The "Outbreak Period" runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

Documentation to Include with Your Appeal

You must request an appeal in writing (unless noted otherwise). Your request must include **at least** the following information:

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

As part of your appeal (internal or second-level), you may submit any additional written comments, documents (including additional medical information), records, or other information that supports your request.

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

In addition, the person who reviews the appeal will not be a subordinate of the person who made the initial decision to deny your claim or appeal (in whole or in part). If the denial is based in whole or in part on Medical Judgment, VSP Member Appeals will consult with a health care professional who has appropriate training and experience in the applicable 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: It is very important that you submit all of the information that you want VSP Member Appeals to consider at the same time you file your appeal. Remember that the date the appeal is filed is the date it is received by VSP Member Appeals. VSP Member Appeals must render a determination based on the date that you file your appeal regardless of whether you indicate that more information is forthcoming.

Internal Appeal Process

If your claim for benefits is denied (referred to as an “Adverse Benefit Determination”), you or your duly Authorized Representative have the right to file a written appeal with VSP Member Appeals within 180 days of the date you receive the Adverse Benefit Determination notice, regardless of any discussions regarding the claim. VSP Member Appeals has full authority to administer and interpret the terms of this Plan in relation to an internal appeal.

Your internal appeal request must be submitted by the applicable deadline listed in the *Internal Appeal Timeline* table. Refer to the *Claims and Appeals Contacts* table for the filing address.

Internal Appeal Timeline	
Event	**Description**
Appeal filing deadline	Within **180 days** of the date you receive a written Adverse Benefit Determination
You are notified of a determination	Within **30 days** from receipt of the appeal
Appeals determination extension	None permitted

The determination review period begins when the appeal is received, regardless of whether VSP Member Appeals has all of the information necessary to decide the appeal. If you want to allow more than the stated time for VSP Member Appeals to make a determination, you may voluntarily agree to an extension by contacting VSP Member Appeals.

Internal Appeal Review and Determination

VSP Member Appeals will send you a written notice of the internal appeal decision. If your Urgent Care Claim is denied in whole or in part, you may receive a verbal notice. If so, written notice will be furnished no more than three days later.

You will be notified of an Adverse Benefit Determination on appeal in writing (paper or electronic). The notice will include (as applicable):

- The specific reason(s) why your appeal was denied;
- The specific Plan provision(s) on which the determination was based;
- 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, and a statement that a copy of the documents relied upon will be provided to you free of charge upon request;
- If the adverse determination was 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 request a second-level appeal, (including the time limits to file such an appeal). It will also include a statement indicating your right to file suit under Section 502(a) of ERISA if your second-level appeal is denied.

Second-level Appeal Process

You may file a second-level appeal if your internal appeal is denied. Using this second-level appeals process has no effect on your rights to any other benefits under this Plan. Before you submit your written request, you may request additional information about second-level appeals by contacting VSP Member Appeals.

Second-level Appeal Timeline	
Event	**Description**
Filing deadline	Within **60 days** of the date you receive a written Adverse Benefit Determination for your internal appeal
You are notified of a determination	Within **60 days** from receipt of internal appeal, unless VSP Member Appeals requests an extension
Appeals determination extension	None permitted

If your second-level appeal is denied in whole or in part, you will receive a written notice that includes (as applicable):

- The specific reason(s) why your appeal was denied;
- The specific Plan provision(s) on which the denial was based;
- A statement citing the internal rule, guideline, or other criterion that was used to make the denial and a statement that a copy of such rule will be provided free of charge to you upon request;

- If the Adverse determination was 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;
- A statement that you have the right to request, free of charge, copies of documents, records, and other information relevant to your appeal;
- Any additional information required under applicable law; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA.

Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline for when a participant may file a request for an external review after receipt of a final internal adverse benefit determination shall be extended without regard to the Outbreak Period. The “Outbreak Period” runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

Legal Action

You must complete the claim process, the Internal Appeal Process, and the second-level appeal process before you are allowed to file suit. If you do not exhaust all administrative remedies before filing suit, it will result in dismissal of the claim. Any suit for benefits must be brought within 12 months from the date the second-level appeal determination was issued.

Appealing an Adverse Benefit Determination: Rescission of Coverage

Your (or your dependents’) vision 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: Continuing Coverage Under COBRA

General Information

Federal law requires the VSP Standard Vision 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,);
- An eligible individual's spouse;
- 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.

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	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 • 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 • 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. Notify the COBRA administrator within **60 days** of the divorce. 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 is treated as notice to any dependent children who reside with your spouse.

Length of COBRA Continuation Coverage

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

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 (coverage extends to former spouse and to dependent children)	36 months
Your death (coverage extends to eligible spouse, and dependent children)	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 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, or Dependents
Your divorce 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)

Second Qualifying Event[2]	Maximum Duration for Covered Spouse, or Dependents
Your death	Additional 18 months (for a total of 36 months)
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.

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.

Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline for the period to elect COBRA coverage shall be extended without regard to the Outbreak Period. The “Outbreak Period” runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

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.

Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline to pay COBRA premiums shall be extended without regard to the Outbreak Period. The “Outbreak Period” runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

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, 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 vision 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 *Vision 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.

Chapter 9: 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 vision 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 vision 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.

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 Administrator 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.

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 $159 a day, not to exceed $1,594 per request (2020 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.

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

Actively at Work 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 a full-time basis 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, jury duty, bereavement leave, vacation), but does not include time off as a result of Injury or Sickness.

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.

If an Employee is confined for medical care or treatment in a Hospital, at any institution, or at home on the date coverage would otherwise become effective, then the effective date of his or her eligibility to participate in the Plan will be postponed until he or she receives final medical release from the medical confinement and satisfies the Active Work Requirement.

Adverse Benefit Determination

An Adverse Benefit Determination means any of the following:

- A denial, reduction, termination of, or failure to provide or make payment for, a benefit, including any such denial, reduction, or failure to provide or make payment based on a determination of your eligibility to participate in a benefit option under this 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, or 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.

Authorized Representative

An Authorized Representative is an individual you have authorized to represent you in the claims process, the appeals process, or both.

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 Claimant is a Plan Participant who is making a claim for benefits under the Plan.

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.

COVID-19 Outbreak Period

The period from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

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).

Eligibility Waiting Period

The period, if any, chosen by the Employer, that is required before participation in the Plan is available to an Employee.

Employee

A person who is Actively Working for the Employer.

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.

Family and Medical Leave Act (FMLA)

Provides certain employees with up to 12 weeks of unpaid, job-protected leave per year.

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.

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.

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.

Medical Judgment

Medical Judgment includes decisions that are based on the applicable medical plan's (or claims administrator's) requirements for 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.

Participant

A person who is defined as eligible to receive health benefits and enrolled in this benefit plan.

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.

Rescission of Coverage

A cancellation, termination, or discontinuance of coverage that has retroactive effect, meaning it will be effective as of the date you were ineligible for Plan coverage.

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).

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.

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.