NRECA Vision Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

and

EVIDENCE OF COVERAGE

VSP Enhanced Vision Plan

SEMO ELECTRIC COOPERATIVE

01-26031-003

EFFECTIVE DATE: January 1, 2019

NRECA

America's Electric Cooperatives

Introduction

Summary Plan Description

This is a summary plan description (SPD), also known as the *Benefits Booklet*. It describes the benefits provided to participants by the National Rural Electric Cooperative Association (NRECA) VSP Enhanced Vision Plan (the Plan).

Your Responsibilities

You are responsible for reading the SPD and related materials 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 have the ultimate responsibility for determining what services you will receive.

While reading this material be aware that:

- The Plan is provided as a benefit to persons who are eligible to participate, as defined in the chapter titled *Eligibility and Participation Information*. 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 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.

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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 Enhanced Vision Plan
Year End:	December 31
Plan Effective Date:	January 1, 2019

Plan Funding

Coverage under the Plan 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 validity of the Plan and any other provisions will be determined under the laws of the Commonwealth of Virginia. The type of administration of the Plan is sponsor administration. The records of the Plan 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. This I&FS Committee has 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, and 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 in order 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 the rules of the Plan 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

Telephone number: 703.907.5500

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

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

Benefits Administrator
SEMO ELECTRIC COOPERATIVE
P.O. BOX 520
SIKESTON, MO 63801

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 validity of the Plan 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 Medical Leave Act (FMLA)**	**Benefits Administrator** SEMO ELECTRIC COOPERATIVE P.O. BOX 520 SIKESTON, MO 63801
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 www.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 Enhanced 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	$250 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] *No-line and polycarbonate lenses are covered under the Enhanced plan. Additional options, such as anti-reflective coating, 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 only available 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 in a benefits-eligible classification;
- If your status is “active Employee,” you must also satisfy one of the hours of service requirements for active Employees; and
- Have satisfied the Eligibility Waiting Period, if applicable.

Benefits-eligible Classifications

The following participant classifications are eligible for benefits:

- Active Employees;
- Dependents of Employees;
- Disabled Employees receiving Employer-sponsored long-term disability (LTD) benefits;
- Dependents of disabled Employees receiving Employer-sponsored LTD benefit;
- 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 the chapter titled *Your Benefits During a Leave of Absence* 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 coverage under the Plan, 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

The following Employee job classifications are **not** eligible to participate in this Plan:

- Intern (including student intern, work-study student)
- Part-time employee
- Seasonal worker
- Temporary employee
- Other: Under age 21

See your benefits administrator if you have questions about eligibility.

Hours of Service Requirement for Active Employees

As a **full-time active Employee**, you must satisfy one of the following:

- 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 worked at another participating Employer within the past six months and met the eligibility requirements at the prior participating Employer; or
- At the time of annual enrollment, you have worked at least 1,000 hours for your Employer in the preceding calendar year.

Coverage for Your Dependents

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

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* (married or unmarried), up to age 26 who is:
  - Your biological child;
  - Your stepchild by marriage;
  - Adopted by you (or placed for adoption with you); or
  - A child for whom you have legal guardianship;
- Your child* 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*.

*****Your dependent child's coverage will end 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

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 other insurer since becoming an incapacitated adult child.

If all of the 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.

Note: When enrolling an incapacitated adult child, you must give documentation of prior coverage and tax dependency. You will be asked annually by your benefits administrator to attest to your dependent's continued eligibility under the Plan. You also may be asked to provide additional documentation to verify eligibility for one or more of your dependents at any time.

You and Your Spouse or Child Work for Participating Employers

One person cannot be simultaneously covered under the Plan as an Employee, Director or retiree and as a spouse or child. Also, an individual may not be covered under more than one NRECA-sponsored 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 Employer. 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 family coverage;
- Your spouse enroll in individual coverage while you and your dependent children enroll in 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 enroll 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-sponsored Vision Plan at the same time. Rather, you must choose to be covered as either 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.

Your Plan's Eligibility Waiting Period

An active employee is eligible to participate in the Plan after: 1 Month.

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 part-time service requirement.

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 effective date of the Plan or the date you meet the eligibility criteria, whichever is later. See the sections titled *Eligibility to Participate* and *Eligibility Waiting Period* in this chapter.

Cost of Coverage

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

- **Active Employees:** You and the employer share in the cost of the coverage.
- **Dependents of Employees:** You and the employer share in the cost of the coverage.
- **Disabled Employees:** You and the employer share in the cost of the coverage.
- **Dependents of disabled Employees:** You and the employer share in the cost of the 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 noted 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 have a qualifying event, you will have 31 days from the date of the event to make a request for enrollment or disenrollment. New dependents may be enrolled, as indicated, if they satisfy the requirements for eligibility under the Plan.

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 (i.e., 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.

Such coverage, if elected on a timely basis, will be 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 is not currently enrolled, you may enroll yourself and your spouse when you enroll a new dependent child.

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

Contact your benefits administrator if you have questions on qualified events.

Losing Other Coverage

If you decline vision coverage for yourself or your dependents because you or your dependents have other vision coverage and if either you or your dependents later lose the other vision coverage, you (or your dependents) may qualify for special enrollment in the Plan. Your new enrollment form must be completed within 31 days of the date vision coverage is 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 Marketplace) at the time you were eligible for vision coverage from your Employer, 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 would not have a special enrollment right if your coverage ended because you either failed to pay premiums on a timely basis or 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 (if dependents are covered under 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 non-custodial child, as required by any QMCSO, under the Employer 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

When you terminate employment with your Employer, your coverage ends at termination of employment;

Your coverage (and your dependents' coverage) for Plan benefits 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 intentionally misrepresent a material fact concerning eligibility for coverage or benefits under the Plan, or you or your dependents commit fraud to obtain coverage or benefits under the Plan. In either case, termination of coverage 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 the terms of the Plan;
- Your uncompensated leave of absence exceeds the thresholds outlined in the chapter titled *Your Benefits During a Leave of Absence*.
- **If you retire after age 65**, your coverage ends on the later of either your last day of employment or the last day of the month, if you elect retiree coverage.
- **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 these 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 coverage of a covered dependent; or
- When your covered dependent dies.

Rescission of Coverage

A Rescission of Coverage is a cancellation, termination or discontinuance of coverage that has retroactive effect, meaning that it will be effective as of a date in the past on which you were ineligible for coverage under the Plan. The Plan will rescind your (or your dependents') coverage with 30 days' advance written notice if the Plan determines in its sole discretion that your fraud against the Plan or your intentional misrepresentation of a material fact resulted in your (or your dependents') eligibility for coverage under the Plan when you (or your dependents) in fact were not eligible for coverage under the Plan. 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 the terms of the Plan. Your enrollment of an ineligible individual or your failure otherwise to comply with the Plan's requirements for eligibility will constitute 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 terminations if:

- The Plan terminates your (and your dependents') coverage retroactive to your employment termination date 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 in a timely manner, and (2) you paid no Plan premiums or contributions after your employment termination date;
- In the event you failed to pay timely, required Plan premiums or contributions for coverage under the Plan, and as a result the Plan terminates your (and your dependents') coverage retroactive to the last date of coverage for which you did pay required Plan premiums or contributions on a timely basis; or
- The Plan terminates your former spouse's or your covered stepchildren's coverage retroactive to the date of your divorce 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 for use only by you and your covered dependents. Possession of an 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, review the chapter titled *Continuing Coverage Under COBRA.*

Note: If you are an active Employee, Director or Retained Attorney covered under this Plan, and you voluntarily drop coverage under this Plan due to Medicare eligibility, you and your dependents will not have the option to elect COBRA coverage to continue coverage under this Plan.

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

The Plan's Right to Audit

The Plan reserves the right to audit your eligibility and the eligibility of your dependents by requesting substantiating documentation. In the event either you or your dependent(s) are later found to be ineligible for coverage, coverage will be cancelled 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 leave offered by your Employer, 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 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 Medical Leave Act** (FMLA) or the **Uniformed Services Employment and Reemployment Rights Act of 1994** (USERRA). Please refer to the specific sections describing each of these leave types for applicable information.

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

Compensated and Uncompensated Leave of Absence

Your approved leave of absence may be **compensated** or **uncompensated** and is 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 (for example: bereavement, community service time, 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 you either have a claim pending with that plan (whether 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 enrollment provisions of the Plan) 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 reenrollment options will vary when you return to work in a benefits-eligible position immediately following your leave. See the section in this chapter titled *Returning From a Leave of Absence* 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 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 days of the date you return to work, you cannot re-enroll until you experience a subsequent qualifying event or during the next annual benefits enrollment period. For details, see the section titled *When You Can Enroll (or Make Changes)* 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 benefit 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

Workers' compensation may be compensated or uncompensated leave. If your period of workers' compensation is compensated (see the section in this chapter titled *Compensated and Uncompensated Leave of Absence*), then you are eligible to continue your benefits. If you do not receive compensation during your period of workers' compensation, your coverage will end on the date your employment terminates.

Family Medical Leave Act (FMLA)

Certain leaves of absence may be protected under FMLA. If your leave is protected under FMLA, then when you return to work your Employer will continue to maintain your benefits coverage and provide for applicable reinstatement of 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.

Basic Leave Entitlement

FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

- Incapacity due to pregnancy, prenatal medical care or Child birth;
- 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.

Military Family Leave Entitlements

Eligible Employees whose Spouse, son, daughter or parent is on covered active duty or called to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Examples of qualifying exigencies include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to 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 more information on FMLA and paying for your benefits during a leave, contact your benefits administrator.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under USERRA, if you go on active duty in the U.S. Armed Forces or the National Guard of a state that is called to federal service, you will have certain employment and Employee benefit rights on completion of duty, provided you were on an authorized military leave of absence.

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 coverage can continue through the first 24 months of your approved military leave to the extent required by USERRA, provided that you continue to pay your contributions or premiums and have not voluntarily dropped your coverage.

You may elect to drop your coverage under this Plan when you begin military leave. Coverage stops if you stop paying your contributions or premiums or 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 must wait until the next annual benefits enrollment period to reenroll, unless you have an applicable special enrollment right, life event or employment event. For more information, see the sections titled *Special Enrollment Rights Under CHIP* and *Life and Employment Events* in the *Eligibility and Participation Information* chapter.

For more information on USERRA and paying for your benefits during a leave, contact your benefits administrator.

Chapter 5: VSP Enhanced 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 www.vsp.com or call VSP customer service (see the chapter titled *Contact Information*).

Benefit Authorization

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

When this benefit authorization is provided by VSP and services are performed before the benefit authorization expires (see below), this will constitute 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 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 plan highlights chapter titled *Vision Plan Highlights*.

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 their agreement with the doctor. You must pay the copayment (if any), amounts that exceed the Plan allowances, and any amounts for non-covered 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 (see the chapter titled *Vision Plan Highlights*), less any applicable copayments.

You must submit claims for services rendered or materials provided by non-VSP providers within 24 months following receipt of 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. Claim forms are not required in order for you to submit a claim to VSP. 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.

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

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

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

In the event of termination of a VSP Network doctor's membership, VSP will be liable to the VSP Network doctor for services rendered to you at the time of termination and permit the VSP Network doctor to continue to provide you with Plan benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another VSP Network doctor.

Copayments

The benefits described in this SPD are available to you subject to your payment of any 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)

No copayment applies to contacts 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;
  - Polycarbonate;
  - High index;
- 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 $250. The maximum benefit applies to the cost of contacts and contact lens exam combined. 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 obtain contact lenses, the Plan will not cover lenses or frames again for 12 months.

During the calendar year, the Plan will pay for 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 and 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 and side shields are covered in full. Side shields are covered in full. Savings on other lens options apply.

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, as 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.

These benefits are subject to pre-approval 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, you should call VSP first to verify whether in-network rates are available. Send claims for non-VSP services to VSP for processing.

Additional Plan Discounts

The following discounts are available when you use a VSP network vision provider:

- Average 20% savings on lens options such as scratch resistant and anti-reflective coatings;
- Additional discounts on prescription glasses and sunglasses, including lens options. Note that discounts on these items are available from any VSP Network vision provider within 12 months of a covered patient's eye exam.
- Average 15% savings on laser vision correction. Discounts include pre- and post-operative services in conjunction with the surgery. The minimum discount available for laser eye surgery is 5%. There are some cases where a VSP participating provider 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. **Note:** Discounts do not apply to items such as contact lens solution, cases, cleaning products or repairs of spectacles, lenses, or frames. Discounts will not apply if prohibited by a manufacturer.

In addition to discounts on vision services and materials when you use a VSP provider, the VSP program offers discounts on the following:

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

For more information, visit www.vsp.com.

[1] The NRECA VSP plan does NOT cover hearing aids; this is only a discount program.

[2] Lens enhancements and/or extra savings and discounts do NOT apply to Costco, Sam's Club or Walmart pricing.

Pre-Certification

Certain Plan benefits (low vision lenses, lenticular lenses and medically necessary contact lenses) require VSP's pre-certification before such Plan benefits are 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 chapter entitled *Claims and Appeals Procedures* for details on how to request an appeal.

A second level appeal and other remedies are also available (see the chapter entitled *Claims and Appeals Procedures*). VSP shall resolve any second level appeal within 30 calendar days. You may designate any person as your authorized representative. Where you do not designate an authorized representative, the doctor will be deemed to be the authorized representative.

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

Coverage While Traveling Outside the United States

In order for a service obtained outside the United States to be covered under the Plan, 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 needs to be provided with the bill showing the daily 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 United States currency at the prevailing rate.

Benefits for covered services received outside of the United States will always be paid to the Plan participant. The participant is required to pay for all foreign services up front before submitting a claim for charges to the Plan.

General Exclusions

The Plan will 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;
- Not necessary for yourself or a dependent;
- 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 for the treatment of injury or illness incurred by victims of domestic violence;
- For treatment while you are confined to jail, prison or other house of correction as a result of conviction for a criminal or other public offense;
- For those which the covered person otherwise would not 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 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 and anti-reflective 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, antireflective 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 of the 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;
- Cosmetic lenses;
- Laminated lenses;
- Photochromic lenses, tinted lenses (except Pink #1 and Pink #2);
- 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 them 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 only share information with persons or organizations that have a legitimate interest in that information, and they will only share information 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 will 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.

Note that to receive payment on a claim when this Plan is secondary, you must submit an EOB from the primary plan and attach it to the itemized bill. 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 (for example, 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 section titled *Primary and Secondary Plans*.

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 may be obtained upon request from the Customer Service Department. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review.

VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (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 regarding an appeal or grievance concerning vision care services provided 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* at the end of this SPD).

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. Be sure to 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 more information, please contact your benefits administrator.

Claims and 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 and 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 form titled *Authorization to Use and Disclose Protected Health Information (PHI)* 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 www.vsp.com.

Some or all of the following information may be required:

- Patient's name, date of birth, and relationship to the participant;
- Group number and individual member number;
- 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 for approval;
- Date(s) service was rendered or purchase was made;
- Diagnosis code, procedure codes, and descriptions of each service or supply; and
- Original copies of the itemized charge(s) for each service or supply. Photocopies are only acceptable if you're 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.

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 time frame listed in the table entitled *Claim Review Timeline*.

If a claim cannot be processed because you did not provide sufficient information, VSP will notify you 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 their control, they 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 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 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, 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 www.dol.gov/ebsa/consumer_ info_health.html or call the Department of Labor Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272).

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 (that is, the VSP Enhanced 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 the 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.

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 twelve months from the date the second-level appeal determination was issued.

Appealing an Adverse Benefit Determination: Rescission of Coverage

Your (or your dependents') coverage under a vision plan benefit option shall be retroactively terminated 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 coverage under the Plan when you (or your dependents) in fact were (or are not) eligible for coverage under the Plan.

Retroactive termination of coverage due to these circumstances is considered a **rescission of coverage** as outlined in the *Rescission of Coverage* and *When Coverage Ends* sections of Chapter 3.

If your (or your dependents') coverage is retroactively terminated, then the 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.

Chapter 8: 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 in accordance with the Plan's procedures is not a prohibited 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 a prohibited 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 third party liability provision of the Plan 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 with its recovery of any amounts for which the Plan is entitled to be reimbursed, including the completion of any forms, and to repay the Plan any amounts you receive for benefits paid by the Plan. The right to reimbursement of the Plan 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: any judgment, settlement, or other payment made or to be made by or on behalf of a third party; any liability or other insurance coverage, worker's 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 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 shall be subrogated (that is, substituted for) all rights or recovery that you have against any third party for benefits paid under the Plan. This means that in the event you receive a settlement, judgment, or compensation from a third party as a result of an injury or sickness, the Plan has the independent 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. The right to reimbursement of the Plan 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. 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 subrogation rights of the Plan. Any costs incurred by the Plan in matters related to subrogation will be paid for by the Plan. The costs of legal representation you incur will be your responsibility.

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 your benefits are paid by the Plan and then you 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 of reimbursement, 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 these benefits, the Plan may take legal action to pursue repayment plus interest at the rate equal to the prime rate plus 3% (compounded annually from the date that is 30 days after your receipt of the other benefits) on the principal amount of the advance that is not repaid within 30 days of your receipt of the other benefits. The Plan may also recover from you reimbursement of the Plan's costs and attorney's fees incurred 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 the Plan made an overpayment or a payment was made in error, either to you or on your behalf, the Plan has a right at any time to recover that overpayment 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 shall 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 operation of the Plan, 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 "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries. No one, including your Employer 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 $149 a day, not to exceed $1,496 (2018 limit, 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 which 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, D.C. 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 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 on the NRECA Employee Benefits website at cooperative.com > My Benefits > Education & Resources > Insurance Plan Documents.

Chapter 9: Continuing Coverage Under COBRA

General Information

Federal law requires the VSP Enhanced Vision Plan (the Plan) to give eligible individuals and their families the opportunity to continue their coverage when they have a qualifying event that results in a loss of coverage under the Plan.

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 who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other participants, including annual enrollment and special enrollment rights.

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

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,);
- The spouse of an eligible individual;
- Dependent children of eligible individuals; and
- Children of eligible individuals who are receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO).
- In certain cases involving the 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 an active Employee, Director or Retained Attorney covered under this Plan, and you voluntarily drop coverage under this Plan due to Medicare eligibility, you and your dependents will not have the option to elect COBRA coverage to continue coverage under this Plan.

Initial Qualifying Events

The following events may allow a qualified beneficiary to continue coverage when it would otherwise end. **Eligible individuals who have terminated coverage under the 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 the following 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 Chapter 3 in the *Coverage for your Dependents* section. The COBRA administrator will know when a dependent child reaches age 26 and becomes ineligible for coverage for this reason; however, you must notify them 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 initial qualifying event is:

Initial Qualifying Event	Coverage Period
Your reduction in hours, resulting in loss of benefits eligibility[1]	18 months

Initial Qualifying Event	Coverage Period
Your employment termination[1]	18 months
Your dependent child no longer meets the dependent eligibility requirements (e.g., he or she reaches age 26 or is over age 26 and ceases to be disabled)	18 months
Your divorce (coverage extends to former spouse and to dependent children)	36 months
Your death (coverage extends to eligible spouse, and to 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. Such surviving spouse and dependent coverage 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).

Note: Your benefits administrator, and not the COBRA administrator, will coordinate coverage continuation in the event of your death.

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. The maximum length of COBRA continuation coverage when a second qualifying event occurs is 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)
Your death	Additional 18 months (for a total of 36 months)

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

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

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

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

Social Security Disability Extension

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

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

If one qualified beneficiary is disabled and meets the above criteria, all of the 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.

You or your spouse can elect COBRA continuation coverage on behalf of all the qualified beneficiaries. A designated representative acting on behalf of you, your spouse or your dependent children may also make the election(s). You 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 until the later of the following time periods to elect COBRA continuation coverage:

- 60 days from the date of the COBRA enrollment notice, or
- 60 days from the date coverage terminates.

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 indicated on the COBRA enrollment notice.

A qualified beneficiary who waives COBRA continuation coverage may change his or her mind and enroll in coverage as long as the COBRA administrator receives the completed election forms before the COBRA enrollment notice deadline. In this case, COBRA continuation coverage will begin on the date the completed election form is signed.

Qualified beneficiaries who do not elect COBRA continuation coverage by the enrollment deadline lose all rights to elect COBRA continuation coverage.

Cost of COBRA Continuation Coverage

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

The cost cannot exceed 102% 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. The additional 2% is the 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 along 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 for your payments will be listed on your first COBRA billing notice. You must make your first payment for COBRA continuation coverage no later than **45 days** after the date you elect COBRA continuation coverage. All subsequent payments will have a 30-day grace period. **Note**: 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.

Mail payments to the address indicated in the first COBRA billing notice that you receive after your election or subsequent coverage change.

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

Changing COBRA Continuation Coverage

Whenever your status or that of a dependent changes, you must notify the COBRA administrator **within 60 days**. COBRA continuation coverage may be modified based on Plan rules if you experience a qualifying event (e.g., birth, marriage, divorce, or change in dependent eligibility). Refer to the *Eligibility and Participation Information* chapter for a list of life and employment events. Premiums may be adjusted for 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 the eligibility requirements and is enrolled **within 60 days** of becoming eligible. However, except for newborn or newly adopted children, dependents added after the initial qualifying event may be covered only by a qualified beneficiary and 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 election, 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 section of this chapter titled *Length of COBRA Continuation Coverage*. Whenever your status or that of a dependent changes, you must

notify the COBRA administrator within **60 days**. For details, see the sections in this chapter titled *Changing COBRA Continuation Coverage* and *Second Qualifying Events*.

Coverage will end when a qualified beneficiary exhausts the maximum period of COBRA continuation coverage; however, coverage may 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 their 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 section titled *Social Security Disability Extension* 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 them that you want to terminate coverage and provide any required documentation. Claims that you or your dependents incur after the 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 changes in your and your family members' addresses. Keep copies of all correspondence with the COBRA administrator for your records.

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 of the 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 work days only if the Employee was Actively at Work on the preceding scheduled work day. 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, any institution or at home on the date coverage would otherwise become effective, 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

Adverse Benefit Determination means any of the following:

- A denial, reduction or termination of a benefit, or a 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 it 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 an Adverse Benefit Determination, whether or not there is, in connection with the rescission, an adverse effect on any particular benefit at that time. For additional details, see the section titled *Appealing an Adverse Benefit Determination: Rescission of Cove*rage in the *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.

Claimant

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

Director

Means you are a Director in a participating cooperative, and includes:

- Advisory Directors;

- Alternate Directors;
- Director Emeritus, up to a maximum of three; and

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, of continuous employment with the Employer 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.

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 or not an Adverse Benefit Determination involves Medical Judgment.

Rescission of Coverage

A Rescission of Coverage is a cancellation, termination or discontinuance of coverage that has retroactive effect, meaning that it will be effective as of the date on which you were ineligible for coverage under the Plan.

Retained Attorney

One attorney retained as outside counsel by the participating cooperative on an ongoing basis.