NRECA Medical Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

High Deductible PPO Plan

PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE

01-26012-002

EFFECTIVE DATE: January 1, 2018

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 by the National Rural Electric Cooperative Association (NRECA) Medical High Deductible PPO Plan (the Plan) to participants.

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 National Rural Electric Cooperative Association's Group Benefits Program

Plan Identification Number:	501
Plan Type:	Medical High Deductible PPO Plan
Year End:	December 31
Plan Effective Date:	January 1, 2018

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.

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 and Named Fiduciary

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

Plan Administrator Employer Identification Number: 54-2072724

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 Plan Administrator responsibilities for your employer:

Benefits Administrator
PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE
PO BOX 509
Hayti, MO 63851

Your Employer's Employer Identification Number (EIN)

43-0452625

Plan Trustee

NRECA Group Benefits Trust

State Street Bank and Trust Company
225 Franklin Street
Boston, MA 02101

Agent for Service of Legal Process

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

Claims Administrator (Medical Benefits)

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

Claims Administrator (Prescription Drug Benefits)

CVS/caremark, Inc.
P.O. Box 686005
San Antonio, TX 78268-6005

Chapter 1: Contact Information

For Information About	Contact
Preauthorization for medical procedures and services	**Simplified Hospital Admissions Review (SHARE)** UMR P.O. Box 8042 Wausau, WI 54402-8042 Medical Review Coordinators 800.526.7322 (8am to 7pm ET Monday through Friday)
Medical claims and provider information	**United Medical Resources (UMR)** P.O. Box 30515 Salt Lake City, UT 84130-7105
Teladoc consultations	800.Teladoc (800.835.2362) Teladoc.com/NRECA
• **Clinical policy guidelines** • **Explanation of benefits (EOB)** • **General medical plan questions**	**Participants** Cooperative Benefit Administrators, Inc. (CBA) 866.673.2299, Option 1 contactcenter@nreca.coop www.cooperative.com **Providers** UMR 877.233.1800
Prescription drug benefits	**CVS/caremark, Inc.** P.O. Box 686005 San Antonio, TX 78268-6005 888.796.7322 customerservice@caremark.com (available 24/7) www.caremark.com
General benefit questions • Eligibility • Enrollment • When coverage begins or ends • Cost of coverage • Family Medical Leave Act (FMLA)	**Benefits Administrator** PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE PO BOX 509 Hayti, MO 63851
COBRA Administrator	**Benefits Administrator** PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE PO BOX 509 Hayti, MO 63851

Benefits questions, including creditable coverage for Medicare	**Member Contact Center** P.O. Box 6007 Lincoln, NE 68506 866.673.2299 Fax: 402.483.9300 contactcenter@nreca.coop
Transplant, bariatric and cancer treatment programs	**Centers of Excellence (COE)** 800.526.7322
Health and lifestyle issues and concerns	**MyHealth Coaches** 866.696.7322
Personal life concerns	**Life Strategy Counseling Program** 888.225.4289
Pregnancy support and resources	**First Steps Maternity** 800.526.7322
Designating a personal representative	**NRECA Privacy Officer** 4301 Wilson Boulevard Arlington, VA 22203-1860 Telephone: 703.907.6601 Fax: 703.907.6602 privacyofficer@nreca.coop

Chapter 2: High Deductible PPO Plan Highlights

This chapter includes the highlights of your benefits under the Plan. Full details about your medical and prescription benefits, including coverage amounts, limitations and exclusions are described in the chapters that follow.

Note: If you are a retiree, you and your dependents ages 65 and older are not eligible to participate in the Medical Plan (including prescription drug benefits). Please read the section titled *Coverage Under Medicare* in the *Prescription Drug Benefits* chapter.

Overview of Your Cost-sharing

Deductible[1,2]	
Individual Annual Deductible (in-network)	$3,000
Individual Annual Deductible (out-of-network)	$6,000
Family Aggregate Deductible (in-network/out-of-network)	$6,000/ $12,000
Coinsurance	
Coinsurance Level (in-network/out-of-network)	100% / 80%
Individual Annual Out-of-pocket Coinsurance Maximum (in-network)	$0
Individual Annual Out-of-pocket Coinsurance Maximum (out-of-network)	$3,000
Family Aggregate Out-of-pocket Coinsurance Maximum (in-network/out-of-network)	$0 / $6,000

Copayment	
Physicians' Office Visit	No copayment for physicians' office visit.
Teladoc Consultation	$45 per consultation until the family deductible is met. Paid at 100% after the in-network deductible is met.
Laboratory Coverage	Preventive laboratory services are paid at 100%. Laboratory services charges are paid as part of the medical benefit and are subject to your annual deductible, coinsurance, and copayments. Laboratory service charges count toward the annual deductible.

Emergency Room Copayment or Coinsurance	Emergency room visits are paid at the applicable coinsurance level after the deductible is satisfied.
Prescription Drugs	Covered on the same terms as any other medical expense and paid at the selected coinsurance level after the deductible is satisfied. Preventive drugs for certain conditions are not subject to the annual deductible (see the *Preventive Prescription Drug Coverage* chart in this chapter). See the *Prescription Drug Benefit Cost-sharing* chart in this chapter.

Total Cost-sharing Out-of-Pocket Limit	
Medical and Prescription Drug Expenses	**In-Network:** There is a combined in-network total cost-sharing out-of-pocket limit for medical and prescription drug expenses (deductibles and copayments). The total cost-sharing out-of-pocket limit for an individual enrolled in single coverage is $3,000. The total cost-sharing out-of–pocket limit for an individual enrolled in family coverage is $6,000. The family total cost-sharing out-of-pocket limit will be met when both the family deductible and the family coinsurance out-of-pocket maximum are met. **Out-of-network:** There is no out-of-network total cost-sharing out-of-pocket limit.

[1]The deductible does not apply to charges for preventive services.

[2] Under this Plan, covered services are not reimbursed for any family member (you and your covered dependents) until the family deductible noted above is met (if applicable). Amounts that count toward satisfying an in-network deductible also count toward satisfying an out-of-network deductible and vice versa.

Medical Benefit Highlights

Medical Service		Coinsurance Level[1,2]	
		In-network	Out-of-network
Preventive Care for Adults		100%	80%
Well-Child Care		100%	80%
Physician Services (includes services for Mental Health and Substance Related Disorders)		100% after deductible.	80% after deductible.
Diagnostic Lab & X-Ray	Diagnostic services	100% after deductible.	80% after deductible.

Medical Service		Coinsurance Level[1,2]	
		In-network	Out-of-network
	Preventive tests and screenings	100%	80%
Hospital Services (includes services for Mental Health and Substance Related Disorders)		100% after deductible.	80% after deductible.
Emergency Room Services (includes services for Mental Health and Substance Related Disorders)* *For Emergency Room charges, not hospital charges. Emergency Room visits for actual emergencies are paid at the in-network benefit level.		100% after deductible.	80% after deductible.
Ambulance Services		100% after deductible.	100% after deductible.
Convalescent Nursing Home Care		100% after deductible.	80% after deductible.
Hospice Care		100% after deductible.	100% after deductible.
Rehabilitation Services and Other Medical Services		100% after deductible.	80% after deductible.

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

[2] *Eligible expenses for covered services will be paid by the Plan at the coinsurance level.*

Prescription Drug Benefit Highlights

Prescription Drug Benefit Cost-sharing[1,2,3]		
Prescription Drug Benefit:	**Coinsurance Level**	
	In-network[4]:	**Out-of-network[5]:**
Generic and Brand Name Drugs Retail Pharmacy (30-day supply)	100% of the cost of the drug	100% of the cost of the drug minus the difference between the drug's actual cost and the cost if the drug had been obtained In-Network
CVS/caremark Mail Service Pharmacy *(90-day supply)*	100% of the cost of the drug	N/A

Prescription Drug Benefit Cost-sharing[1,2,3]		
Prescription Drug Benefit:	**Coinsurance Level**	
	In-network[4]:	**Out-of-network[5]:**

[1] *Eligible expenses for covered prescription drugs will be paid by the Plan at the coinsurance level.*

[2] *"In-network" means any participating retail network pharmacy. If you go "out-of-network," you will be responsible for your portion of the coinsurance plus the difference between the drug's actual cost and the cost of the drug had it been purchased at a participating retail network pharmacy. Contact CVS/caremark at the address listed in the* Contact Information *chapter to find a participating retail network pharmacy.*

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

[4] *Subject to the annual deductible and annual Out-of-pocket Coinsurance Maximum.*

[5] *Subject to the annual deductible.*

Preventive Prescription Drug Coverage			
Prescription Drug Benefit	**Participant Cost Share**		
	Exclusive Choice Retail Pharmacy	**Other Retail Pharmacy**	**CVS Mail Order**
Generic Drugs	$0 *(90-day supply)*	$5 *(30-day supply)*	$0 *(90-day supply)*
Preferred Brands	Greater of 25% or $30 of the drug cost *(1-30 days)* Greater of 25% or $65 of the drug cost *(90-day supply)*	Greater of 25% or $30 of the drug cost *(30-day supply)*	Greater of 25% or $65 of the drug cost *(90-day supply)*
Non-preferred Brands with a Formulary or Generic Alternative	Greater of 40% or $50 of the drug cost *(1-30 days)* Greater of 40% or $130 of the drug cost *(90-day supply)*	Greater of 40% or $50 of the drug cost *(30-day supply)*	Greater of 40% or $130 of the drug cost *(90-day supply)*
Non-preferred Brands	Greater of 25% or $30 of the drug cost *(1-30 days)* Greater of 25% or $65 of the drug cost *(90-day supply)*	Greater of 25% or $30 of the drug cost *(30-day supply)*	Greater of 25% or $65 of the drug cost *(90-day supply)*

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

To be eligible to participate in this Plan:

- You must be in a benefits-eligible status; and
- If your status is “active employee,” you must also satisfy one of the hours of service requirements for active employees.

Benefits-eligible Classifications

The following participant classifications are eligible for benefits:

- Active employees;
- Dependents of employees;
- Directors;
- Dependents of directors;
- One retained attorney;
- Dependents of retained attorney;
- 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 out 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, under age 65, who 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:

- Meter reader (including meter service assistant)
- Other: Pole Inspector

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.

As a **part-time active employee**, you must be classified as eligible for benefits and:

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

Benefits will begin on the date you complete 1,000 hours or at the end of the waiting period, whichever is later.

Coverage for Your Dependents

If you are eligible to participate in the Plan, then each of your eligible dependents may participate, if he or she individually satisfies one of the following requirements. You may be required to provide documentation to NRECA to support your dependents' 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 may be covered under the Plan if the child is otherwise eligible; and
- Your incapacitated adult child.

Note: 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.

Incapacitated Adult Child Requirements

If your child:

- Is at least 26 years of age;
- Is unmarried;
- Qualifies as your tax dependent on an annual basis because he or she is permanently and totally disabled (as defined by the Internal Revenue Service (IRS) in Publication 501); **and**
- Has been continually covered as your eligible dependent under the NRECA Medical Plan 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 to attest to your dependent's continued eligibility under the Plan. You also may be asked to provide additional documentation to verify your dependents' eligibility at any time.

You and Your Spouse or Child Work for Participating Employers

One person may not be simultaneously covered under the plan as an employee, director or retiree and as a dependent spouse or child and may not be covered under more than one NRECA-sponsored Medical Plan at one time.

Current Spouse

If both you and your current spouse work for a participating co-op and are eligible for coverage separately (as an employee, director or retained attorney), you will each be covered individually at your respective employers. However, if you wish to cover eligible dependent children, **four** options are available:

- You are enrolled in individual coverage while your spouse is enrolled in family coverage (including eligible dependent children);
- Your spouse is enrolled in individual coverage while you are enrolled in family coverage (including eligible dependent children);
- You are enrolled 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 is enrolled 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 Medical Plan at one time. You must choose whether you want to be covered as an employee, retiree, director or retained attorney under the respective employer.

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 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 to you:

- **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 has the option 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: 90 days.

Directors and/or retained attorneys who are eligible for this Plan do not need to satisfy a waiting period. Coverage begins on the date that the director's term commences or the retained attorney's date of hire (if election requirements are met). Directors and/or retained attorneys who do not enroll in the Plan within 31 days of such term commencement or date of hire must wait for the next life event, employment event or annual enrollment period.

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

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

- If your employer **excludes part-time employees** from eligibility for benefits, then your eligibility waiting period begins the date you move into an eligible status; or
- If your employer **includes part-time employees** in eligibility for benefits, then your eligibility waiting period began the first day you were actively at work in a benefits-eligible status. If you have already met the eligibility waiting period, then you are eligible for coverage immediately.

Rehired Former Employees and Rehired Retirees

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

- 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 the later of: the effective date of the Plan or the date you meet the eligibility criteria (see the sections titled *Eligibility to Participate* and *Eligibility Waiting Period* in this chapter).

Cost of Coverage

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

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

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

Making Changes During the Year and Special Enrollment

If you experience one of the events noted below, you may be able to add, change or drop coverage for yourself or your dependents.

If you decline coverage during your initial enrollment period and later experience one of the life events listed here, you may qualify to add coverage for yourself and your eligible dependents. Those life events include:

- Marriage, birth, adoption, placement for adoption or legal guardianship if
  - You enroll within 31 days after the event, **and**
  - Your new dependents meet the requirements for eligibility;

- Divorce or death of your spouse or dependent child, if you enroll within 31 days after the event date;
- Eligible dependent children may also add, change or drop coverage within 31 days of their loss of or enrollment in other group health plan coverage (see *Losing Other Coverage* below);
- Changes in employment status that would make you eligible to participate in the Plan; or
- Annual enrollment, if offered by your employer.

Such coverage, if elected on time, will become effective retroactively to the date of the divorce, marriage, birth, adoption, placement for adoption or legal guardianship. If you, as an active employee, or your spouse are not currently enrolled, you may enroll yourself and your spouse when you add a new dependent child.

If you do not enroll new dependents within **31 days**, you must wait until the next life event (e.g., marriage, birth or adoption), change in employment status or annual enrollment to obtain coverage for the new dependent.

Note: If you are an active employee or a dependent of an active employee who is covered under this Plan and you become eligible for Medicare and this Plan does not provide creditable prescription drug coverage, you may be eligible to elect an alternate NRECA Plan (if your employer offers another NRECA medical plan option). You must make this change within 31 days of Medicare eligibility. If you believe you qualify, contact NRECA Employee Benefit Services at 866.673.2299 for further information and eligibility requirements.

Losing Other Coverage

If you decline medical coverage for yourself or your dependents because you or your dependents have other medical coverage and if either you or your dependents later lose the other medical 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 medical coverage is lost.

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

- You, as an active employee, and/or your dependents were covered under another group or individual medical plan or group or individual medical insurance policy (through or outside of a Marketplace) at the time you were eligible for medical 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, and/or your dependents lost the other group medical coverage because you exhausted COBRA continuation coverage, and you were no longer eligible under that plan or an employer's contributions under that plan stopped.

NOTE: You and/or your dependents would not have a special enrollment right if you/they lost coverage due to a failure to pay premiums on a timely basis or due to a termination of coverage 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 (you must notify your benefits administrator within **31 days** of the requested date of coverage change); however, if you drop your coverage or your dependents' coverage, you are not permitted to re-enroll yourself or your dependents in such coverage.

If you are a covered dependent of a retiree 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 if the retiree is currently enrolled in the Plan.

Note: Retirees and dependents of retirees are not eligible for special enrollment opportunities due to loss of other coverage.

Special Rules for Covered Directors and Retained Attorneys

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

If you are a director and your employer offers retiree coverage, you must be covered on the day your directorship ends to be eligible to continue coverage as a retired director.

Special Enrollment Rights Under CHIP

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, you and your dependents (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 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 such case, the 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 *Rescission of Coverage* 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; or

- 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 your last day of your employment or the last day of the month if retiree coverage is elected. 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 dependent child eligibility requirements under the Plan.
- **If you are a Medicare-disabled employee or the Medicare-eligible spouse of a Medicare-disabled employee** for whom Medicare is the primary payer, you are no longer eligible for prescription drug coverage under the Plan unless suitable replacement Medicare prescription drug coverage is not available. You will have no form of creditable prescription drug coverage as defined under Medicare.

Your coverage ends on the date the Plan or benefit option is no longer offered by your employer. 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.

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 the date 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/are 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. They do not require the Plan to give you 30 days' advance written notice of coverage termination.

1. 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.
2. You failed to pay required Plan premiums or contributions for coverage under the Plan on a timely basis, and 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.
3. The Plan terminates your former spouse's and/or any 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.

For unintentional mistakes or errors which result in the Plan's coverage of you (or your dependents) which should not have occurred, the Plan will terminate your 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.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services 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 you or your dependent(s) is 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 the ineligible dependents' behalf. 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

Your employer offers various types of leaves of absence. A leave of absence means time away from work, as permitted by your employer, for reasons such as military duty, family care or personal needs. Time away from work does not include time off as a result of injury, sickness or disciplinary suspension.

Depending on the type of leave, 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);
- Remuneration for your services as a director;
- Short term disability benefits from your employer;
- Long term disability benefits from your employer;
- Military supplement pay; or
- Salary continuation programs and extended illness benefits.

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

Eligibility to Participate During Your Leave of Absence

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

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

Note: If you participate in your employer's long-term disability (LTD) plan and you either have a claim pending with that plan (whether the 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 you return to work immediately following the end of your approved leave, you are eligible to be re-enrolled in this Plan. Your coverage is effective on the date you return to work. For additional information, contact your benefits administrator or 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 benefits coverage upon going on 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 upon going on a military leave or if your coverage lapses or terminates due to nonpayment, but you return to work within the applicable job reinstatement period in a benefits-eligible position, 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, 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: Medical Plan Benefits

How the Plan Works

This Plan provides medical benefits and services to eligible employees and their covered dependents. Your Plan benefits include medical and surgical services and supplies, medications, mental health and substance abuse benefits, along with certain other services and programs (such as chiropractic care) as elected by your employer and described in detail later in this chapter.

Your Plan benefits are administered by Cooperative Benefit Administrators (CBA) and prescription drug claims by CVS/caremark.

Cost-sharing

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

- A **deductible** is the amount of eligible health care expenses that you must pay in a calendar year before the Plan begins to pay benefits. The annual deductible applies to your annual out-of-pocket maximum.
- **Coinsurance** is a percentage that you pay toward eligible expenses for covered health services, generally after you have met your deductible. Coinsurance is typically a percentage of the eligible expense. Your coinsurance amount may vary depending on the provider you visit; and
- **Eligible expenses** (or covered charges) are the charges for services that are covered and provided by the Plan, subject to the claims administrator's guidelines.

The deductible

The annual deductible applies to all services except preventive services.

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

If you are enrolled in family coverage, then you will have to meet the family deductible before the Plan begins to pay benefits. Covered expenses for all family members count toward the family aggregate deductible.

The family deductible must be satisfied before the Plan begins to pay coinsurance. There is no individual deductible if you have family members covered by the Plan. Here is an example of how Pam and her family can meet the family deductible. Once Pam's family reaches the $4,000 family deductible, coinsurance applies for both Pam and the other members of her family. Pam is not eligible for coinsurance until the $4,000 is met even if Pam reaches the individual deductible amount.

Family Member	Deductible Paid
Pam	$2,000
Pam's Spouse	$1,500
Pam's Child	$500
Total	**$4,000** (meets family deductible)

Coinsurance and copayments (if applicable)

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

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

See the *Plan Highlights* for a list of the coinsurance percentages and any applicable copayment amounts for the various medical treatments and services covered under the Plan.

Annual out-of-pocket coinsurance maximum

There is a limit to how much you and your family must pay toward covered medical treatments and services in a calendar year. This limit is called the annual Out-of-pocket (OOP) Coinsurance Maximum.

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

- Amounts above R&C rates;
- The 20% reduction in eligible expenses for failure to preauthorize through SHARE (see the section titled *Services and Supplies Requiring Preauthorization by SHARE* for details); and
- Expenses for services not covered by the Plan.

If you are enrolled in family coverage and you have reached the annual family OOP Coinsurance Maximum, the Plan will pay covered expenses at 100% for all covered family members (as outlined in the *Overview of Your Cost-sharing* chart in the *Plan Highlights* chapter) for the remainder of the calendar year. Amounts that count toward the in-network OOP coinsurance maximum also count toward the out-of-network OOP coinsurance maximum and vice versa.

Note: The family annual OOP Coinsurance Maximum is the accumulated out-of-pocket expenses for all family members. Each family member never has to meet more than the individual annual OOP Coinsurance Maximum.

Total Cost-sharing Out-of-Pocket Maximum

There is a limit to how much you and your family must pay toward covered medical treatments and services in a calendar year. This limit is called the total cost-sharing out-of-pocket (OOP) maximum.

Once you have reached your total cost-sharing out-of-pocket maximum for medical and prescription drug expenses, your eligible expenses are paid by the Plan for the remainder of the calendar year as outlined in the *Overview of Your Cost-sharing* chart.

Because medical claims are processed by Cooperative Benefit Administrators (CBA) and prescription drug claims by CVS/caremark, there may be a short time before the Plan's records reflect your total cost-sharing out-of-pocket expenses. As a result, you may be asked to pay for either a medical or a prescription drug expense even if you have actually met the annual OOP Coinsurance Maximum. If this occurs, a refund will be issued by CBA.

Provider Networks and Reimbursement Rates

The Plan will pay covered charges for physicians' visits and for hospital, surgical and other medical services and supplies (including prescription drugs) at the coinsurance level outlined in the *Overview of Your Cost-sharing* chart (located in the *Plan Highlights* chapter). Under

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

Reasonable and customary (R&C) rates

The R&C rate for any service or supply is the amount usually charged by providers for the same service or supply. R&C rates do not apply to services you receive from primary Preferred Provider Organization (PPO) network providers because in-network providers have pre-negotiated contracted fees for their services. Any charges that you or a covered dependent incur from providers that are not in your primary PPO network(s) (also called non-participating providers) are subject to R&C rates. If your provider charges above the R&C rates, you will be responsible for paying any amounts over those limits. In some cases, the Plan may require a copayment when you visit a physician or the emergency room. *See Appendix A: Key Terms* for the definition of R&C rates.

Evaluation of Services

When the plan evaluates submitted or billed charges to determine which are eligible, the plan will also review how the procedure or service is coded. When charges are presented in a format that clearly lists and bills separately for procedures and services that are commonly considered to be either incidental to a primary procedure or a combined service or procedure, benefits are paid based on the industry coding standards for the procedure(s) and service(s) provided.

In addition, while each physician has a right to determine how much to charge for services, the Plan will cover the industry standard valuation for the services provided.

Preferred Provider Organization (PPO) Network Discounts

This Plan affords you and your family certain discounted coverage through PPO network medical services. The Plan allows you to go to any health care provider. However, if you use health care providers that are in the Plan's PPO network (known as preferred providers) you will receive greater benefits than if you go to other providers, and you will not have to fill out claim forms.

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

There are several ways for you to find providers who participate in the Plan's local or out-of-area PPO network(s).

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

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

Remember these facts about the primary PPO networks:

- The medical plan pays 100% of eligible preventive care services received from in-network providers (there is no annual deductible to satisfy).
- PPO in-network physicians and hospitals are not affiliated with, and have not been selected, by your employer. In-network providers have no contract with your employer. The Plan pays PPO in-network providers according to contracted rates that apply only to such in-network providers;
- Neither the Plan nor your employer provides or guarantees the quality of the health care that you or a covered dependent receive under the Plan;

- You always have the choice of what services you receive and who provides your care, regardless of what the Plan covers or pays; and
- Even if a hospital is a PPO in-network provider, note that the physicians and other health care providers that practice in that hospital may not be PPO in-network providers, and vice-versa. Services provided by out-of-network providers will not be covered at the in-network benefit level, except in the situations discussed in the section below.

When In-network Benefits are Paid for Out-of-network Providers

Inpatient or outpatient hospital covered services rendered by ancillary providers (such as surgical assistants, anesthesiologists and radiologists) are covered at the in-network benefit level. Benefits for covered services rendered by all other specialists (such as cardiologists and oncologists) are paid according to their participation status with the PPO network.

Eligible emergency room charges associated with an actual medical emergency will be covered at the in-network benefit level. Emergency surgery or procedure(s) in direct relationship with the episode of care for the emergency room admission will be covered at the in-network benefit level.

All eligible expenses are subject to possible reduction due to reasonable and customary (R&C) rates.

When Medicare is your primary plan (and this Plan is secondary), for purposes of coordinating benefits with Medicare, the covered medical charges are always covered at the in-network benefit level under this Plan.

In all other cases, the benefit level is determined by the PPO network participation status of the provider rendering the service.

Even if a hospital is a PPO in-network provider, note that the physicians and other health care providers that practice in that hospital may not be in-network providers, and vice-versa. Services provided by out-of-network providers will not be covered at the in-network benefit level, except in the situations discussed in the section above

Secondary networks

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

Each secondary network has a group of participating acute-care hospitals, ancillary providers and practitioners. The secondary network logo that appears on the back of your health ID card lets the provider know that you qualify for a discount. Providers within the secondary network agree to accept the discounted amount as the total eligible charge and will not bill the discount.

Benefits for visits to secondary network providers are paid at the out-of-network level. You are not responsible for balances above the discounted charge for covered services; however, you are responsible to pay any part of the discounted amount that is applied to your out-of-network deductible and coinsurance.

Note: The Plan will pay the lesser of the secondary network discounted amount or the R&C rate. If the Plan pays the R&C rate, the provider may bill you for the amount above the R&C rate in addition to your out-of-network deductible and coinsurance. The explanation of benefits (EOB) you receive from CBA will show either the secondary network discount or the R&C rate.

Negotiated discounts

NRECA may also negotiate directly with an out-of-network provider to obtain a discount on the provider's standard billed charge. Providers must agree to accept the negotiated amount

as payment in full. You are not responsible for balances above the negotiated discounted charge for covered services; however, you are responsible to pay any part of the discounted amount that is applied to your out-of-network deductible and coinsurance.

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

Important facts about secondary networks and negotiated discounts

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

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 the U.S. currency rate.

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

The Simplified Hospital Admission Review (SHARE) Program

Coping with an illness or injury that requires hospitalization can be stressful, confusing and costly. Understanding your treatment options and which expenses your insurance will cover is important. To help you reduce the confusion and costs associated with hospitalization and other medical services, the Plan includes the SHARE program.

SHARE is responsible for preauthorizing certain services and supplies for medical necessity. Specific services for which you must contact SHARE are noted in the section of this chapter titled *What the Plan Covers*.

Four benefits of SHARE

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

Hospital Confinement Review

The SHARE program provides a hospital confinement review service. A SHARE medical review coordinator will contact your physician as soon as hospitalization has been prescribed. The SHARE medical review coordinator will evaluate the proposed treatment plan and make sure that the length of your stay and any recommended convalescent treatments, facilities or both are medically appropriate.

The SHARE medical review coordinator will discuss with your physician the reason for your hospitalization and an appropriate length of confinement. The coordinator will then mail a hospital admission confirmation to both you and your physician.

The hospital admission confirmation approves the medical appropriateness of the proposed hospitalization. However, this approval does not guarantee either the payment or amount of benefits. Eligibility for and payment of benefits are subject to all of the Plan terms. A hospital admission confirmation is binding, unless the information furnished to the SHARE medical review coordinator was misleading.

Under the terms of the Plan, eligible expenses **do not** include expenses for services or supplies that are not medically necessary. In addition, no benefits are payable for days of inpatient hospital confinement found not medically necessary. This could include all or some days of inpatient hospital confinement.

It may be possible to extend the approved number of days of inpatient hospital confinement, if needed for your condition. You must call the SHARE medical review coordinator before the previously approved length of stay is over to arrange for your physician to request such an extension.

When you request an extension, the SHARE medical review coordinator will determine the need based on the information given by the physician. The physician will be told how many days, if any, are approved. A written notice confirming the extension will be sent to you, the physician and the hospital.

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

Medical Case Management

If a hospital admission has the potential to require long-term care, a SHARE case manager will be assigned to you. A SHARE case manager provides guidance and information on available resources. The patient and family select the most appropriate treatment plan and the SHARE case manager coordinates and implements the program.

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

Discharge Planning

SHARE monitors your progress in the hospital; and when you need continuing care after your release, SHARE works with the hospital to arrange your transfer to an extended-care facility, nursing home or your own home. In order for the Plan to cover these transportation services, CBA must determine the transportation to be medically necessary. SHARE also arranges for wheelchairs, hospital beds, home care nurses, pharmaceuticals and other health aids. Through discharge planning, SHARE monitors your treatment and progress throughout recovery.

First Steps Maternity Program

Through the Plan's First Steps Maternity Program women will have access to a highly specialized maternity program designed to monitor low risk pregnancies for complications

and identify health risk factors early in the pregnancy so that they can be directed to, and receive, proper prenatal care specifically for high risk pregnancies.

The First Steps Maternity Program will provide expectant mothers access to experienced OB/GYN nurses who will provide individualized one-on-one telephonic consultations and act as a trusted resource for pregnancy-related questions and support. As an incentive to enroll, mothers-to-be may receive up to $150 in MasterCard gift cards (dependent on the trimester enrolled); are eligible for prescription prenatal vitamins (with a doctor's prescription) at no cost; have a choice of a free pregnancy book from a number of best-selling titles; have access to online educational content; and receive a NRECA Willie Wiredhand baby blanket and more free items included in the First Steps Maternity welcome package.

To enroll in the First Steps Maternity Program, call 800.526.7322. The program is available at no additional cost and is confidential. A maternity specialist will explain how the maternity program works and how it can help protect both the mother's and the baby's health.

Services and supplies that require preauthorization by SHARE

The SHARE program reviews and coordinates your treatment and helps you make informed decisions about medical treatment and Plan use. **Note**: If you access the Choice Plus network, the provider, the facility or both are responsible for preauthorizing inpatient hospital admissions.

SHARE must preauthorize the following services and supplies **for medical necessity:**

- All inpatient hospital admissions (emergency or non-emergency), including:
  - Behavioral health; and
  - Skilled nursing facilities and extended care stays;
- All outpatient, non-emergency high-end radiology (e.g., CT, MRI, MRA, PET and nuclear cardiology scans);
- Home health care;
- Durable medical equipment (excluding braces and orthotics), including:
  - Equipment purchases over $1,500;
  - Prosthetics over $1,000; and
  - Equipment rentals over $500;

  Note that purchases of durable medical equipment over $1,500 and equipment rentals over $500 per month must be preauthorized.
- Clinical trials; and
- Maternity services if the hospital stay exceeds the 48-hour or 96-hour guidelines (including stays for a newborn that continues after the mother has been discharged).

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

- If SHARE does not preauthorize for medical necessity the services or supplies that require preauthorization, the amount of your eligible expenses that would normally be covered by the Plan will be reduced by 20%. You will be responsible for these ineligible expenses. **For example**, if you go into the hospital and incur $10,000 in charges that would normally be eligible expenses under the Plan, but you failed to call SHARE, those eligible expenses would be reduced by 20% ($2,000), making your eligible expenses for the hospital stay $8,000 ($10,000 minus $2,000). You would have to pay the $2,000 in uncovered hospital expenses out of pocket; in addition, that $2,000 would not be applied to your annual OOP Coinsurance Maximum or deductible; or

- If such services or supplies are later determined not to be medically necessary, the services or supplies will not be covered under the Plan. You will be responsible for the entire cost of the service or supply.

Clinical trials

The Plan covers participation in **approved** clinical trials, including routine patient costs for items and services furnished in conjunction with participation in the approved clinical trial. Participation in a clinical trial must be preauthorized for medical necessity.

If a covered individual is accepted in an approved clinical trial, the Plan requires all items and services related to the clinical trial to be provided by participating in-network providers.

Clinical policy guidelines

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

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

How and when to contact SHARE

If you access the Choice Plus network, the provider or facility is responsible for obtaining preauthorization of an inpatient admission. If you do not access a Choice Plus network facility, the patient or a member of the patient's family is responsible for notifying SHARE.

Contact SHARE during normal business hours (8 am and 7 pm ET, Monday through Friday) to speak with a SHARE medical review coordinator. Use the phone number provided in the *Contact Information* chapter or refer to the preauthorization contact number on the back of your health ID card.

Outside of normal business hours, callers with urgent or life threatening situations will be given the option to speak to a live representative. All other callers will be directed to call back on the next business day.

The SHARE medical review coordinator will ask for the:

- Patient's name;
- Name, address and phone number of the attending physician;
- Group insurance coverage number; and
- Member ID number

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

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

Centers of Excellence (COE) Programs and Services

Transplant Centers of Excellence Program

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

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

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

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

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

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

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

The transplantation period is defined as the day of transplantation through 365 days following the surgery. When CBA deems that a transplant is medically necessary (and the Transplant COE Program is used), transplant benefits begin with the first appointment with the physician or COE facility and continue through the transplantation period. **Note**: The patient must not have used drugs or alcohol for a minimum of six months before the Plan will begin covering transplant-related expenses. The Plan will not cover transplant-related expenses during the six-month period prior to drug or alcohol sobriety.

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

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

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

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

Bariatric Centers of Excellence Program

The NRECA Bariatric Centers of Excellence (COE) Program is a designated COE program provided by the Plan's contracted vendor. The Bariatric COE Program is **mandatory** for Plan participants who obtain bariatric surgery. Benefits for bariatric surgery are available **only** from practitioner(s) within the Bariatric COE Program's designated COE network with case management provided by the Plan's contracted vendor. Charges for services provided by a Bariatric COE facility will be covered by the Plan but will still be subject to all other Plan limitations and provisions. Deductible, copayment and coinsurance provisions (as applicable to your Plan) apply to bariatric services.

Bariatric surgeries must be performed at COE facilities designated by the Plan's contracted vendor with approved COE practitioners. The facilities and practitioners within the Bariatric COE Program emphasize quality and improved outcomes for bariatric procedures.

To inquire about the NRECA Bariatric COE Program, contact CBA. Once the decision is made to proceed with bariatric surgery, CBA will notify the Plan's contracted vendor to begin coordinating pre-surgery and case management services.

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

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

The Plan's contracted vendor provides personalized case management through dedicated case managers who serve as patient advocates throughout the process and work with the patient to determine the most appropriate surgical facility.

Note: The Bariatric COE Program case manager will discuss the bariatric surgery process, answer questions about COE referrals and outline the specific criteria and requirements for program eligibility. The COE surgeon determines whether a patient is a surgical candidate.

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

The Plan does not cover the following services at any time:

- Services for surgical follow-up care for a bariatric surgery not covered by the Plan;
- Bariatric surgery for a patient who has had previous bariatric surgery, whether or not the previous bariatric surgery was covered by the Plan;
- Bariatric surgery for a patient under the age of 18;
- Unapproved bariatric surgeries;
- Surgeries performed at facilities other than those designated as COEs by the Plan's contracted vendor; and
- Surgeries that are not coordinated or managed by the Plan's contracted vendor.

Cancer Centers of Excellence Program

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

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

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

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

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

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

Centers of Excellence Travel Benefits

The plan pays travel benefits for bariatric services, organ and tissue transplant services, ventricular assist device implantation services or treatment at a Cancer COE. The travel benefit covers round-trip transportation expenses for the evaluation, COE procedure and follow-up visits to the treatment facility that are completed within the applicable benefit period after the deductible has been met.

The travel benefit also covers reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion (two if the patient is a minor) during the applicable benefit period after the deductible has been met.

Follow-up care and medical appointments after the benefit period has ended are not included in this benefit.

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

Travel benefits are limited as follows:

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

What the Plan Covers

The Plan covers eligible expenses for medical service categories that are listed in the *Plan Highlights* chapter and described in detail within this chapter. These categories of services and supplies, each of which is subject to varying cost-sharing amounts that you pay out of your own pocket, include:

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

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

Preventive Care

Under Section 2713 of the Affordable Care Act, the plan must cover a range of preventive services and may not impose cost-sharing (such as copayments, deductibles or coinsurance) for these services **if they are administered by an in-network provider**. The Plan covers adult physical examinations, well-child care, women's preventive services; and age-and gender-appropriate screenings, tests and Immunizations for adults and children.

Preventive medical care benefits and screenings from in-network providers are covered by the Plan at 100%. All out-of-network preventive medical care benefits and screenings are subject to coinsurance and R&C rates.

Note: Refer to *Appendix B: Preventive Services* for a detailed list of covered and excluded preventive services.

Adult Physical Examinations and Well-child Care

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

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

Well-child (or baby) examinations include, but are not limited to, the establishment and maintenance of a medical history; height, weight and body mass index measurements; developmental screenings (including autism); behavioral assessments; and immunizations.

The Plan does not cover physical exams (including Department of Transportation exams) that are a condition of employment, for aviation or for other certain situations. The Adult Physical Examination benefit is intended to be for comprehensive checkups for the purpose of monitoring your health.

Women's Preventive Services

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

In-network Women's Preventive Services Covered at 100%		
Service	**Coverage**	**Frequency and Limitations**
Well-woman visits	Covered annually for adult women to obtain age- and developmentally appropriate services, including preconception and prenatal care	Annually. Several visits may be needed to obtain all necessary recommended preventive services, depending on health status, needs and other risk factors.
Gestational diabetes screening	Screening for gestational diabetes	In all pregnant women at 24 to 28 weeks of gestation and at first prenatal visit for pregnant women at high risk for diabetes
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results	Once every 3 years at age 30 and older
Counseling for sexually transmitted infections	Counseling for all sexually active women	Annually. Must be provided by an in-network trained provider licensed in the state where provided.
Counseling and screening for human immunodeficiency virus	Counseling and screening for all sexually active women	Annually. Must be provided by an in-network trained provider licensed in the state where provided.
Contraceptive methods and counseling	All Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, patient education and counseling for all women with reproductive capacity	As prescribed. • Oral generic contraceptives covered at 100% under the Plan's prescription drug benefit • Brand-name oral contraceptives subject to brand-name prescription drug copayment and coinsurance, as applicable • Over-the-counter methods and supplies not covered • Services for male contraceptive methods (e.g., vasectomy) covered based on normal coverage provisions and subject to applicable copayments and cost-sharing provisions

In-network Women's Preventive Services Covered at 100%		
Service	**Coverage**	**Frequency and Limitations**
Breastfeeding support, supplies and counseling.	Comprehensive lactation support and counseling by a trained provider during pregnancy or in the postpartum period; costs for renting breastfeeding equipment	For each birth: • Breast pump and supplies must be purchased at an in-network durable medical equipment supplier. One manual or electric grade breast pump per pregnancy • Other breastfeeding supplies (e.g., maternity bras, nursing pads, bottles, etc.) are not covered • Lactation counseling and classes must be provided by an in-network, licensed International Board Certified Lactation Consultant (IBCLC)
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence	Annually. Counseling must be provided by an in-network trained provider licensed in the state where provided.
All services in this table should be included with the well-woman visit where appropriate.		

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

- Physician visits and follow-up care;
- Counseling for natural family planning-services;
- Screening and counseling for interpersonal and domestic violence;
- Counseling for breastfeeding and contraceptive methods;
- Counseling and screening for human immunodeficiency virus;
- Counseling for sexually transmitted infections;
- Diaphragms and cervical caps (device and fitting);
- Implants, such as implanon (drugs, insertion and removal);
- Injections, such as depo-provera (drug and administration);
- Intrauterine device (device, insertion and removal); and
- Tubal ligation (surgical procedure and related services when performed as the primary procedure).

Age-and Gender-appropriate Screenings, Tests and Immunizations

Certain screenings, tests and immunizations are covered by the Plan if they are recommended based on age and gender (e.g., colon cancer screening for participants ages 50 to 74 or a mammogram, including 3-D mammography, for women ages 40 and older), if they are preventive in nature and if they are coded appropriately by the billing provider.

In some cases, where family history warrants a screening earlier than recommended for a particular health problem, an eligible screening may be covered. Call CBA to verify.

Some preventive screenings are **not covered** due to the lack of clinical evidence for effectiveness (e.g., routine chest x-rays, full-body x-rays). Details about NRECA's preventive benefits, including charts of some key recommended preventive services based on age and gender, are located on the Employee Benefits website.

Preventive Services Excluded from Coverage

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

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

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

Excluded Preventive Services			
Service	**Gender**	**Age**	**Policy**
Peripheral Artery Disease (screening using ankle brachial index)	Both	All	Not covered
Synagis shot to prevent Respiratory Syncytial Virus (RSV) infection[1]	Both	Infants under age 2	Not covered under medical benefits unless billed by the hospital during a premature infant's initial inpatient confinement May be covered under the prescription drug benefit, subject to Medical Necessity review by CVS/caremark

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

Preventive Services with Coverage Limitations

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

Preventive Procedures with Policy Limitations			
Service	**Gender**	**Age**	**Policy (age limit applies)**
Colonoscopy (including prescribed preparations)	Both	50 to 75	Every 10 years
Double contrast barium enema	Both	50 and older	Every five years
Flexible sigmoidoscopy and sigmoidoscopy	Both	50 to 75	Every five years
Herpes Zoster (shingles) vaccination	Both	50 and older	Once per lifetime
Human papillomavirus vaccination	Both	9 to 26	Three doses total

Preventive Procedures with Policy Limitations			
Service	**Gender**	**Age**	**Policy (age limit applies)**
Mammogram (including 3-D Mammography)	Women	40 and older; Under 40 with risk factors such as a certain family history of breast cancer	Every year
Osteoporosis	Women	60 and older	Every year
Prostate-specific Antigen (PSA) blood test	Men	50 and older	Every year

Physician Services

The Plan covers services provided by a physician in a variety of settings for purposes of evaluating and managing health conditions. Covered charges for physician services include services rendered during:

- **Office visits:** Visits to a physician's office or an urgent care clinic. Covered charges include evaluation, x-ray and laboratory charges billed by the same physician or the urgent care clinic on the same day of service;
- **Surgery, hospital visits and hospital services:** The Plan will pay benefits toward surgeon and anesthesiologist fees (inpatient or outpatient); inpatient, outpatient, and emergency room and urgent care physician charges; and second surgical opinions; and
- **Allergy immunizations:** Physicians' charges for allergy immunizations.

Teladoc Consultations

The Plan covers medical consultations provided by a Teladoc physician for purposes of evaluating and treating health conditions.

Availability and delivery method (phone, video or both) of Teladoc consultations are determined by the state regulations in the state where the patient is located at the time the consultation is provided.

Teladoc provides medical care consultations via telephone or online video consultations for acute non-emergency medical issues such as:

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

Teladoc is available 24 hours a day, 7 days a week, 365 days a year and provides access to a national network of U.S. board-certified physicians who can resolve many acute non-emergency medical issues via telephone or online video consultations. Teladoc physicians can prescribe prescription drugs for a variety of acute non-emergency medical conditions, by

telephoning the prescription in-to the pharmacy you choose for easy pickup. All consultation fees you pay to Teladoc count toward meeting your annual deductible and annual out-of-pocket maximum.

Eligible participants must register with Teladoc on-line at Benefits.cooperative.com/Teladoc, at Teladoc.com/NRECA or by calling toll free 800.Teladoc (800.835.2362), and provide a brief medical history, in order to use the consultation services. To set up an account, go to Benefits.cooperative.com/Teladoc or Teladoc.com/NRECA, and click Set up account, and then provide the required information.

Important Notes (Subject to State Regulations):

- Arkansas law requires video consultation for the first Teladoc consultation;
- Delaware law requires video consultation for the first Teladoc consultation;
- Phone consultations are not available in *Idaho* per state regulations. Only video consultations are available in Idaho; and
- *Georgia* law prohibits a physician from prescribing medication for longer than 3 days for any consultation, whether it is with Teladoc or with a cross-covering physician chosen by the patient's provider.

Treatment of Complications from Non-covered Procedures

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

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

Diagnostic Lab and X-ray Services

The Plan covers the cost of diagnostic x-ray and laboratory services that are medically necessary for the treatment of sickness or injury. However, preauthorization for medical necessity is required for the Plan to cover the following high-end radiology services on a non-emergency, outpatient basis:

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

For additional information, review the section titled *Services and Supplies Requiring Preauthorization by SHARE* in this chapter**.**

You must call SHARE for preauthorization before obtaining all non-emergency, outpatient CT, MRI, MRA, PET and nuclear cardiology scans.

SHARE will need a diagnosis code and procedure code for any radiological procedure, along with the patient's name, member number, group number, employer name and the provider's contact information.

Hospital and Surgical Services

All hospital admissions require preauthorization for medical necessity. For additional information, review the section titled *Services and Supplies Requiring Preauthorization by SHARE* in this chapter**.** If you access the Choice Plus network, the provider or facility is responsible for preauthorization of an inpatient admission. The Plan covers a variety of treatments that you or a covered dependent may receive in the hospital, including:

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

The Plan provides additional benefits for expenses you or a covered dependent incur during a hospital confinement, subject to the following:

- The Plan will consider payment for room and board up to the hospital's standard rate for a semi-private room;
- An emergency admission means an admission to the hospital for a condition that, unless promptly treated on an inpatient basis, would put the patient's life in danger or cause serious damage to a bodily function of the patient; and
- The Partial Hospitalization Program (PHP) provides a short-term, intermediate level of care for the treatment of mental health and substance-related disorders. PHPs are typically offered within a psychiatric hospital or behavioral health department of a hospital. Patients generally participate on weekdays for six to eight hours at a time as prescribed by their physician. The Plan counts a partial day as one inpatient day.

Inpatient Care and Surgical Expenses

Inpatient hospital care requires preauthorization for medical necessity. The Plan covers the following for inpatient hospital care:

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

Eligible Surgical Expenses

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

- Incision, excision or electro-cauterization of any organ or body part;
- Reconstruction of any organ or body part or the suture repair of lacerations;

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

In addition, the Plan will cover assistance with the surgical procedure when medically necessary. Coverage of charges for surgical assistants will be limited to 20% of the surgeon's rate allowance.

Outpatient Surgical Expenses

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

Childbirth Services

- Charges for childbirth services must be preauthorized by SHARE for medical necessity. The Plan pays benefits for a pregnant mother in the same way that it pays any non-maternity benefits;
- If you request to cover a newborn (whether your natural child or one for whom adoption is being processed) within 31 days of the birth of the child, coverage will automatically be effective on the date of birth provided that you have met any waiting period;
- Hospital charges for a newborn baby are separate from the mother's expenses. The Plan covers charges for the newborn only if the newborn is an eligible dependent. You have 31 days following the birth of the child to add the newborn to your coverage; and
- The Plan also covers birthing center expenses, provided the services and supplies you receive at a birthing center would have been covered if furnished in a hospital.

Length of Maternity Hospital Stay

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

Mastectomy Expenses

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

Ambulance Services

The Plan provides benefits for ambulance services after the deductible has been met.

Ambulance service must be to the nearest appropriate medical facility qualified to treat the covered patient's sickness or injury. Use of the ambulance must be medically necessary and must be the most reasonable method of transportation available. This includes air ambulance service in the event of immediate admission to a medical facility and a life-threatening condition as determined by CBA.

For participants residing in Alaska, ambulance services include non-emergency commercial airline trips to obtain medical care in non-emergency situations when inpatient benefits or surgical medical care is rendered. Up to $1,000 round-trip coach airfare is covered by the Plan for not more than four non-emergency commercial airline trips per calendar year. Please see your benefits administrator to find out if you qualify for this service. For children under age 19, the child's parent or legal guardian may also accompany the child, and coverage will be extended to the parent or legal guardian of up to $1,000 round-trip coach airfare and for not more than four non-emergency commercial airline trips per calendar year.

Emergency Room Services

The Plan provides benefits (as described in the *Plan Highlights* chapter) for the use of a hospital's emergency room. Emergency room services, however, are very expensive and should be used only in a medical emergency.

Emergency services include medical screening examinations that are within the capability of the emergency department to provide and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize you or your dependents.

If the Plan requires a copayment for emergency room visits (see the *Plan Highlights* chapter), the copayment will be waived if you or your dependent is admitted to the hospital.

Mental Health and Substance Abuse Benefits

Mental health and substance abuse benefits are designed to help you and your covered dependents receive the appropriate care for mental health, substance-related disorders and chemical dependency problems. Charges incurred to treat mental, psychoneurotic and personality disorders and substance-related disorders are covered expenses, subject to benefit levels for physician services, hospital services or emergency room services, depending on the type of service(s) received (see the *Plan Highlights* chapter).

The Partial Hospitalization Program (PHP) provides a short-term, intermediate level of care for the treatment of mental health and substance-related disorders. PHPs are typically offered within a psychiatric hospital or the behavioral health department of a hospital. Patients typically participate on weekdays for six to eight hours at a time as prescribed by their physician. The Plan considers a partial day to count as one inpatient day, subject to the Plan's inpatient hospital benefit limitations.

Hospital admissions under the Plan's mental health and substance abuse benefits must be preauthorized by SHARE for medical necessity. For information about SHARE, please see the section titled *The Simplified Hospital Admission Review (SHARE) Program* in this chapter. Information about appeals for mental health and substance abuse benefits are located in the *Medical Claims and Appeals* chapter.

Convalescent Nursing Home Care

Convalescent nursing home care must be preauthorized by SHARE for medical necessity. The Plan covers convalescent nursing home care following certain hospitalizations. A 90-day limit applies to coverage for all convalescent nursing home care due to the same or related causes. The Plan does not cover custodial care.

The Plan covers eligible expenses incurred during a covered convalescent nursing home care confinement that follows an inpatient hospital stay that lasted at least one day and was covered by the Plan. The confinement must start within 15 days after release from the hospital and must be recommended by the physician attending the condition causing the hospitalization. The Plan covers two types of expenses:

- **Room and board:** Charges for convalescent nursing home room and board are limited to 80% of the standard (most common) semi-private room rate of the hospital stay that immediately preceded transfer to skilled nursing care; and
- **Ancillary services and supplies:** These are services and supplies other than personal items that are furnished by convalescent nursing home for medically necessary care while the patient is under the continuous care of a physician and requires 24-hour skilled nursing care.

Hospice Care

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

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

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

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

Covered Hospice Services

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

- Provided while the terminally ill person is covered under the Plan;
- Ordered by the supervising physician as part of the hospice care program;
- Billed by the hospice care program; and
- Provided within six months of the terminally ill person’s entry or re-entry (after a remission period) in the hospice care program.

The Plan will pay benefits for **hospice care** as outlined in the *Plan Highlights* chapter, up to a lifetime maximum of $50,000. Eligible hospice charges for this purpose include both inpatient and outpatient charges.

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

- Ordered and received under the hospice care program, and
- Incurred within three months after the terminally ill patient’s date of death.

A family unit consists of you and your covered dependents.

Bereavement benefits will be paid if, on the day prior to his or her death, the terminally ill person was:

- In the hospice care program;
- A member of the family unit; and
- A covered individual.

Hospice Services Not Covered

The following services are not covered:

- Charges for the treatment of a diagnosed sickness or injury for you or your dependent if the benefits are payable under another part of the Plan. If benefits for such coverage are expressed as a percent of charges, this exclusion will apply at a rate of 100%;
- Charges for services provided by you or your spouse or someone related to you or your spouse by blood or marriage; and
- Charges incurred during a remission period. This applies if, during remission, the terminally ill person is discharged from the hospice care program.

Outpatient Rehabilitation Services

Outpatient rehabilitation services must be medically necessary and are subject to a 25-visit annual limit. **In addition, CBA must preauthorize the following services for medical necessity after the allotted number of visits has been reached:**

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

Physical therapy (PT), occupational therapy (OT), massage therapy and acupuncture services

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

If a covered individual has more than 25 combined PT, OT, massage therapy and acupuncture visits within a calendar year, any additional visits must be preauthorized by CBA to ensure medical necessity. Failure to obtain preauthorization will result in the denial of charges that do not meet the Plan's medical necessity requirement. The 25-visit limit applies to a combination of all PT, OT, massage therapy and acupuncture visits for the same or unrelated conditions.

Restorative Speech Therapy

The Plan covers eligible charges for restorative speech therapy. If a covered individual has more than 25 visits within a calendar year, additional visits must be preauthorized by CBA to ensure appropriate medical necessity. Failure to obtain preauthorization will result in denial of services.

Chiropractic Care

Chiropractic services are covered only if they are medically necessary and the practitioner is licensed in your state. If a covered individual has more than 25 visits within a calendar year, any additional visits for that individual must be preauthorized by CBA to ensure appropriate medical necessity. Failure to preauthorize chiropractic services will result in denial of services.

Habilitation Services

Habilitation services are health care services delivered by a licensed or certified provider to help a person learn, improve or maintain skills that were never previously learned or acquired and are necessary for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and

occupational therapy, speech-language therapy, and other services for people with disabilities in a variety of inpatient and outpatient settings.

Habilitation services and *re*habilitation services can be similar but are performed for different purposes. While rehabilitation services help a patient *regain* function that they have lost, *habilitation* services help someone maintain, learn or improve skills they need for daily living functions but did not learn or acquire (often in childhood) due to a developmental, cognitive, or other condition. See the definitions for both habilitation and rehabilitation services in *Appendix A: Key Terms.*

The Plan will cover habilitation services if those services are **both** preauthorized by CBA and found to be medically necessary. Failure to obtain preauthorization will result in a denial of services.

Custodial Care Services

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

Other Medical Services

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

Chemotherapy and Radiation Therapy

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

Dental Anesthesia Services and Facility Charges

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

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

- Radical excision of lesions in excess of 1.25 cm (1/2 in.);
- Radical resection or ostectomy with or without bone graft;
- Patients exhibiting physical, psychological, intellectual or medical conditions for which dental treatment under local anesthesia (with or without additional adjunctive techniques and modalities) cannot be expected to provide a successful result and for which treatment under anesthesia can be expected to produce a superior result. Such conditions include, but are not limited to, cerebral palsy, epilepsy, cardiac problems and hyperactivity (verified by appropriate medical documentation);

- Chronic disability that is attributable to a mental or physical impairment or combination of both; is likely to continue indefinitely; and results in substantial functional limitations in one or more of the following: self-care, respective and expressive language, learning, mobility, capacity for independent living and economic self-sufficiency (verified by appropriate medical documentation);
- Patients who have sustained extensive oral-facial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised;
- A child 6 years old or younger, with a dental condition (such as baby bottle syndrome) that requires repairs of significant complexity (e.g., multiple amalgam or resin-based composite restorations, pulpal therapy, extractions or any combinations of these noted or other dental procedures); or
- If local anesthesia is ineffective because of:
    - Acute infection;
    - Anatomic variation (e.g., due to previous surgery, trauma or congenital anomaly); or
    - An allergy to local anesthesia.

Diabetic Retinopathy Screening

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

Diabetes Self-care Programs

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

- The program is specifically ordered by the physician treating the participant's diabetes;
- The program is composed of services provided by healthcare professionals who are licensed, certified or qualified by professional credentials or degrees (physicians, registered nurses, registered pharmacists, registered dieticians); and
- The program is designed to educate the participant about medically necessary aspects of diabetes self-care.

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

- When the patient has been newly diagnosed with diabetes;
- No more frequently than every three years after initial diagnosis; or
- When a change in the patient's condition warrants a significant adjustment in treatment modality. Such changes may include:
    - Introducing new medications that may affect blood glucose levels, including those used in the treatment of other conditions (e.g., corticosteroids);
    - Introducing a new class of anti-diabetic medications (adding insulin to oral anti-diabetic medications);
    - Diagnosis with a separate chronic condition that may affect blood glucose levels;
    - Stress;
    - Hospitalization or acute illness;
    - Gestational diabetes;
    - Surgery; or
    - Significant change in body mass index (BMI).

The portion of the diabetes outpatient medical self-care program that is medically necessary will vary depending on the goals and objectives of the program but shall not exceed 10 visits

within a 12-month period, to a yearly maximum of $1,000 in eligible charges. A maximum of one day of follow-up training, not exceeding $250 in eligible charges, will be allowed annually after the initial training year, when recommended by your physician. Covered charges for diabetes outpatient medical self-care programs are subject to the annual deductible and the in-network and out-of-network benefit levels (if applicable for this Plan) for physician benefits (for surgery, hospital visits and services).

Participants are strongly encouraged to contact MyHealth Coaches for help managing their diabetes (for details, see the *MyHealth Coaches®* section of the *Wellness Benefits and Resources* chapter).

Durable Medical Equipment

The Plan will cover charges for eligible durable medical equipment. Purchases over $1,500 and equipment rentals over $500 per month must be preauthorized.

Hearing Aids

Hearing aids are considered medical equipment, and are subject to Plan requirements such as medical necessity, deductible(s) and cost-sharing requirements. The Plan will cover a maximum of $10,000 in expenses for eligible hearing aids for a covered person's lifetime. Eligible hearing aids include wearable hearing aids, including hearing aid maintenance. Hearing aid maintenance includes ongoing fitting, orientation or checking of a hearing aid, including repair or modification of a hearing aid, but does not include hearing aid batteries. Hearing aids other than wearable hearing aids, such as implanted hearing aids, will be subject to medical necessity under the Plan, and are not subject to the hearing aid maximum benefit. Hearing aid exams are covered under the Plan as an office visit for a non-preventive service, and are not subject to the hearing aid maximum benefit.

Home Health Care Agency Benefits

The Plan will cover home health care services if those services are **both** preauthorized and found to be medically necessary. The Plan does not cover home health care services that are:

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

The following limits apply to eligible charges made by a home health care agency:

- Benefits will be paid for up to 100 visits in one calendar year that are services furnished directly to a person during home health care agency visits;
- A visit of four hours or less is counted as one visit. If a visit exceeds four hours, each four hours or fraction thereof is counted as a separate visit; and
- For other services and supplies, the benefit will not exceed the amount that would have been paid had they been furnished by a hospital during an inpatient confinement. For this purpose, a hospital confinement is considered a continuous period during which inpatient care in a hospital, convalescent nursing home or skilled nursing facility would be required were it not for the home care.

Miscellaneous Benefits

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

- **Blood and blood plasma** not replaced by or for the patient;

- **Medical devices** such as artificial limbs, eyes and larynx; electronic heart pacemaker; and surgical dressings, casts, splints, trusses, braces, crutches, oxygen and rental of equipment for its administration. Prosthetics over $1,000, during a calendar year, are subject to preauthorization. Failure to preauthorize medical devices over $1,000 will result in denial of service;
- **Contact lenses or eyeglasses** necessitated by and obtained immediately following a cataract operation. Benefits will not exceed the R&C rate and no benefit will be payable unless medically necessary. No benefits will be paid for replacement of contact lenses or eyeglasses due to loss, breakage or prescription change; and
- **Implantable contraceptive devices,** including insertion and removal of the devices.

Private Duty Nursing

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

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

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

Benefits will not be paid for any services that are primarily custodial care and:

- Are mainly to assist the patient with the functions of daily living or to dispense oral medication; and
- Could be properly furnished by someone who does not have the professional qualifications of a registered graduate nurse.

Travel Vaccinations

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

General Exclusions

The Plan 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;
- Higher than R&C rates; or
- For services rendered by yourself or by anyone related to you or your dependents by blood or marriage.

Specific Exclusions

Blood

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

Dental Expenses

The Plan will not cover dental expenses, including charges for physician's services or x-ray exams involving one or more teeth, the tissue or the structure around them or the gums.

This exclusion for dental expenses applies even if a condition requiring any of these services involves a part of the body other than the mouth such as the treatment of temporomandibular joint disorders (TMJD) or malocclusion involving joints or muscles by methods including but not limited to, crowning, wiring or repositioning teeth.

However, this exclusion does not apply to charges for:

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

Elective Abortions

Elective abortions will not be covered under the Plan, unless medically necessary.

Eye Care

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

Foot Conditions

The Plan will not cover charges for physicians' services in connection with weak, strained or flat feet, any instability or imbalance of the foot or any metatarsalgia or bunion, unless the charges are for an open cutting operation that is otherwise covered. Further, the Plan will not cover charges in connection with corns, calluses or toenails unless the charges are for the partial or complete removal of nail roots or the services are reasonably necessary in the treatment of a metabolic or peripheral-vascular disease.

Government Plan Charges

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

Impregnation or Fertilization

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

Manipulation Therapy

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

Occupational Injury or Disease

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

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

Charges that would be excluded under the above items may be paid by CBA, at its discretion, if:

- Payment has not been made;
- There is a dispute between the participant and the party responsible for payment of occupational injury and disease charges as to whether the charges are payable or regarding the amount that should be paid; and
- The participant (or, if incapable, a legal representative) involved agrees in writing on forms provided by CBA to pay back the benefits advanced at a rate of prime plus 3% interest, to the extent of any future payments made by or on behalf of the party responsible for occupational injury or disease within 30 days of receipt of payment.

Prescription Drugs and Diabetic Supplies

Outpatient prescription and non-prescription drugs are not covered under the Plan's medical benefit. Outpatient prescription drugs should be filled through CVS/caremark (see the *Prescription Drug Benefits* chapter).

Diabetic supplies are not covered under the Plan's medical benefit. These supplies may be obtained through CVS/caremark (see the *Prescription Drug Benefits* chapter).

Select specialty drugs are not covered under the medical benefit and will not be filled by any pharmacy except for CVS/caremark Specialty Pharmacy, regardless of prior approval, medical necessity or whether the drug was prescribed by a physician or another provider. In limited circumstances, however, coverage may be allowed under the medical benefit. Those circumstances include:

- Specialty medications billed by a facility as part of an inpatient hospital stay;[1]
- Specialty medications billed as part of an emergency room visit;[1]
- Situations in which Medicare is the primary carrier;[1]
- Situations in which NRECA is not the primary carrier;[1]
- Circumstances where homecare is not clinically appropriate (either due to the member's clinical history or due to characteristics of the drug that require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less);[2] and
- When the treating physician has provided written documentation outlining the clinical rationale for the requirement that the member be treated at the designated facility and

confirming that the designated facility is unable to accept drugs dispensed by CVS/caremark. The written documentation will be reviewed and approved by appropriate CVS/caremark clinical personnel **before** allowing coverage for the requesting provider under the medical benefit.[2]

[1] *Prior approval by CVS/caremark is not required.*

[2] *Situation will be evaluated by CVS/caremark clinical staff*

Select specialty medications will be covered only under the *pharmacy* benefit through CVS/caremark Specialty Pharmacy. As part of this policy, these specialty medications will be excluded from coverage under the *medical* plan. Prior authorization may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug.

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

Sterilization Reversal

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

Surgical Expenses Not Covered by the Plan

The following surgical expenses are **not** covered by the Plan:

- Surgeries that are investigational or experimental in nature; and
- Cosmetic procedures, unless due to either a congenital defect that impairs the function of a body organ or an accident.

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. Participants are required to notify the Plan of any other medical coverage on himself or herself by calling the Member Contact Center at 866-673-2299 or emailing ContactCenter@nreca.coop. Under the general coordination of benefits rule, the total benefits paid by all plans will not exceed 100% of allowable expenses. 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.

An allowable expense for coordination of benefits means any necessary expense covered by the NRECA Medical Plan at least in part.

Primary and Secondary Plans

When a claim is made, the primary plan pays its 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 similar to this Plan's 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 in which they are presented:

- **Employee/dependent:** The plan covering an individual, other than as a dependent, is primary to the plan covering an individual as a dependent.
- **Dependent child/parents 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/parents 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 plan (i.e., the plan of the custodial parent's spouse); or
  4. The non-custodial parent's plan.
- **Active/inactive:** The plan covering an individual through active employment is primary to the plan covering the individual through retirement or layoff status.
- **Longer/shorter length of coverage:** If none of the above applies, then the plan covering the individual for the longest period is primary.

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

To receive payment on a claim when this Plan is secondary, you must submit an EOB from the primary plan and attach it to the itemized bill.

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);
  - If you are disabled and have not yet qualified for Medicare coverage; or
  - If you are 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;
- Medicare is the primary plan (and this Plan is secondary) after the first 30 months of your Medicare coverage for kidney dialysis treatment or a kidney transplant;
- Medicare is the primary plan (and this Plan is secondary) if you are approved for long-term disability and have Medicare (for a reason other than kidney dialysis or kidney transplant); and

- Medicare is the primary plan on a covered dependent (and this Plan is secondary) if you are approved for long-term disability and your dependent has Medicare (for a reason other than kidney dialysis or kidney transplant).

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

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

Chapter 6: Prescription Drug Benefits

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

How the Benefit Works

CVS/caremark is the Plan's Pharmacy Benefit Manager (PBM). The PBM:

- Provides the Exclusive Choice Network of over 24,000 preferred retail, mail order, and specialty pharmacies;
- Manages the plan's formulary which is the list of drugs that the Plan covers; and
- Provides a dedicated customer service team for plan participants and their covered dependents.

Exclusive Choice Network

The Exclusive Choice Network is the Plan's preferred group of pharmacy providers. It includes CVS/pharmacy, Walmart, Sam's Club, Cardinal Health (Leader Drugs, Medicine Shoppe, Brookshire Drugs and BI-LO Pharmacy) and the CVS/caremark Mail-order Pharmacy. You can have your prescriptions filled at any pharmacy; however, you will receive a discount by using a pharmacy in the Exclusive Choice Network. To find a participating retail network pharmacy, contact CVS/caremark.

Performance Drug List

Because there are thousands of prescription drugs on the market with similar therapeutic effects at varying costs, CVS/caremark developed a Performance Drug List. It contains brand prescription drugs, for which no generic equivalent is available, and generic prescription drugs. The Performance Drug List is updated each quarter, taking into account both therapeutic factors as well as price. Under three-tier plan designs, when using preferred brand drugs on the list, the participant pays a lower copayment or coinsurance amount compared to non-preferred brands not on the list. This helps control costs by encouraging participants to choose quality drugs that usually have the best price. With three-tier prescription drug plans, participants have a choice to:

- Pay the lowest copayment or coinsurance for a generic drug;
- Pay a Higher copayment or coinsurance if you prefer a brand-name drug on the list; or
- Pay the Highest copayment or coinsurance for a non-preferred brand-name drug.

The Performance Drug List is located on cooperative.com at My Benefits > Education & Resources > Insurance Plan Documents (check Prescription Drugs under the Filter dropdown). If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list.

Preventive Drug List

The Plan's formulary also includes a list of preventive drugs that are not subject to your HDHP annual deductible. For these drugs, you will pay either the coinsurance or copayment, as applicable to your plan.

CVS/caremark maintains the preventive drug list and updates it each quarter. Access the list on cooperative.com at My Benefits > Education & Resources > Insurance Plan Documents (check Prescription Drugs under the Filter dropdown). Or call NRECA's MCC for a copy.

Formulary Updates

A new-to-market product or a new variation of a product already in the marketplace will not be added to the formulary until that product has been evaluated, determined to be clinically appropriate and cost-effective and approved by the CVS/caremark Pharmacy and Therapeutics Committee or other appropriate reviewing body.

As new specialty and hepatitis-C products launch, all existing products in the class will be re-evaluated to determine appropriate placement and whether they will be excluded, added back or not listed.

Coinsurance and Copayments (if Applicable)

For most prescription drug benefits, you and the Plan will share the cost. You will pay a percentage of the cost and the Plan will pay the remaining percentage. This is called coinsurance.

You will pay less when you use a participating retail network pharmacy (in-network). If you do not use participating retail network pharmacies (out-of-network), you will be responsible for any difference between what the cost would have been In-network and the actual cost of the prescription.

For most prescription drug benefits you and the Plan will share the cost of the prescription drug expenses once your deductible is satisfied. You will pay a percentage of the cost and the Plan will pay the remaining percentage of the cost. This is called coinsurance. Once you have satisfied your annual Out-of-Pocket (OOP) Coinsurance Maximum, the Plan will pay 100%.

You may pay less when you use a participating retail network pharmacy (in network). If you do not use a participating retail network pharmacy (out of network), you will be responsible for any difference between what the cost would have been in network and the actual cost of the prescription.

Covered generic drugs are reimbursed at 100% once the deductible is met when filled at an Exclusive Choice Pharmacy.

Generic drugs that are on the preventive drug list are not subject to the deductible and are reimbursed with no copayment. The list of preventive drugs is available at cooperative.com. Go to My Benefits > Education & Resources > Insurance Plan Documents (check Prescription Drugs under the Filter dropdown).

See the *Plan Highlights* chapter for a list of the coinsurance percentages and applicable copayment amounts for the various types of prescription drugs provided under the Plan.

Maintenance Medications

Maintenance medications are prescription drugs that are taken for more than 30 days for a chronic condition. By using the mail-order service for long-term maintenance drugs, you can save money.

You have two options for filling prescriptions for maintenance medications. You can fill a 90-day prescription from either the CVS Caremark Mail-order Pharmacy or from an Exclusive Choice pharmacy.

CVS/caremark Mail-order Pharmacy

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

- You can order up to a 90-day supply for a lower copayment than three separate 30-day prescriptions at a retail pharmacy. At a non-Exclusive Choice pharmacy, the most you can order is a 30-day supply;

- Ingredient costs are lower and drug discounts are greater than at a retail pharmacy; and
- There is no dispensing fee, which lowers the prescription price. (A dispensing fee is charged at retail pharmacies.)

Maintenance medications are prescription drugs that are taken for more than 30 days for a chronic condition. The CVS/caremark Mail-order Pharmacy provides a convenient and cost-effective way for you to order maintenance or long-term medication for direct delivery to your home. Mailing cost is included when drugs are obtained through the CVS/caremark Mail-order Pharmacy, unless you specify a special method of shipping (e.g., UPS, FedEx), in which case you will be responsible for the extra shipping charges.

If you take a maintenance medication, ask your physician to write a prescription for 90 days with three refills (total of one year). Complete the mail-service order form and send it to CVS/caremark with your original prescription. Credit card is the preferred method of payment.

You may elect to pay your prescription cost-sharing amount upon delivery of the drug mail order and accompanying order invoice. However, to avoid potential order delays or canceled orders participants are encouraged to pre-pay the cost-sharing amount when ordering from CVS/caremark Mail-order Pharmacy by phone, by mail or online. Pre-payment may be made by personal check, money order, bank card or credit card. CVS/caremark only permits a maximum outstanding mail-order account balance of $200 per family. If that limit is exceeded, CVS/caremark will hold the order and contact the participant to request a payment by bank card or credit card before releasing the order.

You can expect to receive your prescription approximately 10 to14 days after CVS/caremark receives your order. You will receive a new pre-printed order form and a return envelope with each shipment. Verify that your pre-printed name, identification number and mailing address are all correct on the order form. When re-ordering, send the form to the CVS/caremark mailing address on the order form you received.

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

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

CVS/caremark Specialty Pharmacy

Specialty medications are specific, often expensive medications that are used to treat and manage chronic or complex conditions.

Specialty and biotech drugs are not eligible for coverage through retail pharmacies. The Plan covers a maximum supply of 30 days' supply of specialty medication at a time, and all specialty or biotech drug prescriptions must be filled by mail using CVS/caremark Specialty Pharmacy mail service. This allows a dedicated care team to work closely with patients and physicians to encourage a higher level of participant adherence to treatment, achieve better outcomes and reduce medical costs.

You or your dependents must enroll before using CVS/caremark Specialty Pharmacy mail service to fill and refill both biotech and specialty drug prescriptions. Enroll by calling CVS Specialty Connect® at 800.237.2767 or online through Caremark.com.

After you enroll, a CareTeam specialist will work with you, your physician and the Plan to confirm coverage and conduct a clinical review of the needed medicines. Thereafter, you can refill prescriptions online, by phone or by mail.

Prior Authorization

The Plan requires prior authorization for:

- Certain non-preferred brands;
- All specialty and biotech prescription drugs;
- Certain ingredients present in compounded drugs;
- Compounded drugs exceeding $300; and
- Drugs that are not on the formulary.

Prior authorization means that your physician must call CVS/caremark to confirm that the medication is medically necessary before your prescription is covered by the Plan. Certain other drugs must be preauthorized by the CBA nurses' unit before they can be dispensed. See the section in this chapter titled *What the Plan Covers* for lists of the medications that require preauthorization by either CVS/caremark or the CBA Nurses' unit.

Medication Monitoring Program

To encourage the safe and appropriate use of prescription drugs, the Plan participates in a monitoring program through its prescription benefit manager, CVS/caremark. This program proactively identifies potential cases of fraud, waste or abuse by flagging participant behaviors of concern related to controlled substances and drugs of potential misuse. Such behaviors include, but are not limited to, high numbers of claims, use of multiple prescribers, use of multiple pharmacies and excessive use of the medication or excessive claim cost. A pharmacist reviews the flagged situations, may contact prescribers to gather more information and determines the need for intervention, if any. To support the safe and appropriate use of medications, the Plan reserves the right to limit a participant (or a covered spouse or dependent) to the use of one pharmacy for all of such individual's prescriptions for an indefinite period of time, in which case the Plan will notify the participant by letter of the restriction.

Prescription Drug Support Online

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

Chronic Condition Management

If you or your dependents have chronic conditions, you will receive occasional mailings to help you and your dependents use medications appropriately and improve the quality of your lives. For example, diabetes-related mailings offer free blood glucose monitors to participants living with diabetes.

Pharmacy Clinical Support

Pharmacy clinical support, also known as cost containment, is part of the Plan. Pharmacy clinical support adds another level of quality review by encouraging drug therapy compliance and proper use of the prescription drug benefit, and helps manage costs. Under this program, CVS/caremark reviews prescription claims and, in some cases, contacts the prescribing physician to suggest drug therapy changes based on national clinical guidelines and standards of care. The physician decides if he or she will follow the recommendations and approve the suggested changes.

Consider the following intervention example. A medication will be reviewed when it is prescribed for a longer time than is recommended for its particular drug class. Examples include muscle relaxants and gastrointestinal (GI) medications (e.g., Nexium, Aciphex and Omeprazole). Refills of medications like these that are deemed excessive may be removed from a prescription if agreed to by your physician.

Every effort is made to ensure minimal disruption to you and your dependents. If you disagree with a physician-approved change, you can request to have the refill reinstated by having your medical provider call CVS/caremark at 888.796.7322.

If changes are made to prescriptions filled through the mail-order service, you or your dependent will receive a letter notifying you of the change along with the filled order. When using the mail-order service, a short delay may occur while CVS/caremark attempts to contact your physician to discuss potential changes.

The clinical support program also reviews claims for retail prescriptions after they have been filled and communicates recommendations or concerns to the prescribing physician, who will then decide whether to implement CVS/caremark's recommendation for future prescriptions.

What the Plan Covers

Diabetic Supplies

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

Drugs that Require Prior Authorization

Prior authorization is required for certain prescription drugs or drug categories to ensure safe, effective and appropriate use. For example, prior authorization is most often required for medications that are:

- Subject to overuse or misuse;
- Limited to a specific patient population;
- Limited to a specific diagnosis or condition;
- Subject to significant safety concerns;
- Expensive;
- Subject to additional criteria requirements or documentation needed to approve coverage; or
- Subject to Plan quantity limitations and the physician determines that a larger quantity is needed.

When the Plan denies coverage for a drug at a retail pharmacy because it has not been pre-authorized, the rejected claim message from the Pharmacy Benefit Manager to the pharmacist will provide the phone number that the prescriber must call to obtain prior authorization.

The following drugs require prior authorization by the CBA Nurse's Unit before they can be dispensed:

Drugs Requiring Prior Authorization by CBA Nurses' Unit[1]
Dietary (nutritional) supplements, which may be approved to treat transplant patients or patients on renal dialysis

Obesity or weight-loss drugs, appetite suppressants and anorexiants such as Xenical, Phentermine, Meridia and Lonamin
Prescription vitamins, minerals and vitamin/mineral combinations for transplant patients or patients on renal dialysis
[1:] *Contact the CBA Nurses' Unit at 866.673.2299*

Drugs Requiring Prior Authorization by CVS/caremark

The *Drugs Requiring Prior Authorization by CVS/Caremark* lists medicines by drug class that will not be covered without a prior authorization for medical necessity. If you continue to use one of these drugs without prior approval for medical necessity, you may be required to pay the full cost. If your doctor believes you have a specific clinical need for one of these drugs, your doctor should contact the CVS/caremark Prior Authorization Department toll-free at 855.240.0536. If you have any questions you may call CVS Caremark Customer Care at 888.796.7322.

CVS/caremark maintains the prior authorization drug list and updates it each quarter. Access the list on cooperative.com at My Benefits > Education & Resources > Insurance Plan Documents (check Prescription Drugs under the Filter dropdown). If you are unable to access this website, call NRECA's Member Contact Center (MCC) for a copy of the list.

Multi-ingredient Compound Prescriptions and Bulk-compounding Powders

A "compound drug" is one that is made by combining, mixing or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available.

To be covered. All ingredients in the compounded medication as well as the compounded formulation must be covered and, if the medication is reformulated, it must meet FDA-approved guidelines for the treated condition.

The Plan covers compound drugs when they are used for FDA-approved indications, for uses and routes of administration supported by or found in medical compendia or for other currently accepted practice guidelines. All other plan provisions apply.

All compound drugs with a total cost of $300 or greater require prior authorization. The main or most expensive ingredient determines your copayment or coinsurance (as applicable).

Preventive Drugs

Certain drugs are considered preventive in nature. These drugs are covered at a special cost-sharing arrangement outside the deductible and coinsurance (see the *Plan Highlights* chapter). The preventive drugs list includes drugs meant to treat the following conditions:

- Asthma;
- Anti-rejection agents;
- Cholesterol;
- Diabetes;
- Hypertension;

- Osteoporosis;
- Smoking cessation;
- Stroke;
- Weight loss (anti-obesity); and
- Women's health (e.g., prenatal vitamins with a doctor's prescription up to one year after birth).

A complete list of preventive drugs can be found cooperative.com at My Benefits > Education & Resources > Insurance Plan Documents (check Prescription Drug under the Filter dropdowns). If you are unable to access this website, call NRECA's MCC for a copy of the list.

Specialty and Biotech Drugs

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

There is a 30-day maximum supply limit for specialty/biotech drugs.

The CVS/caremark Specialty Pharmacy service helps participants use these drugs safely and effectively adhere to the challenging treatment regimens associated with taking a specialty medication. You will have access to educational materials, phone consultation and refill reminders to help with specific treatments. CVS/caremark's Specialty Pharmacy Services include conditions related to:

- Asthma;
- Cancer;
- Crohn's Disease;
- Enzyme Replacement for Lysosomal Storage Disorders;
- Growth Hormone Disorders;
- Hematopoiesis Disorders;
- Hemophilia and von Willebrand Disease;
- Hepatitis C;
- Immune Disorders;
- Multiple Sclerosis;
- Psoriasis;
- Pulmonary Arterial Hypertension (PAH);
- Pulmonary Disorders;
- Respiratory Syncytial Virus (RSV); and
- Rheumatoid Arthritis.

A complete list of specialty drugs can be found cooperative.com at My Benefits > Education & Resources > Insurance Plan Documents (check Prescription Drugs under the Filter dropdown). If you are unable to access this website, call NRECA's Member Contact Center (MCC) at 866.673.2299 for a copy of the list.

Vaccines

Coverage for Flu, Zostavax, and Pneumonia vaccines is available through the vaccine network, which consists of any retail pharmacy that is both part of the national CVS/caremark retail pharmacy network and offers vaccines. There is no cost and no copayment because the Plan covers these vaccines at 100%.

Call ahead for availability and to make an appointment, if required. Take your medical ID card and a valid photo ID and inform the provider that vaccines are covered at 100% under your prescription drug benefit.

If you have questions about network access, visit www.caremark.com to find a network pharmacy in your area or call CVS/caremark Customer Care toll-free at 888.796.7322.

Specific Exclusions

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

- Allergy serums;
- Anabolic steroids;
- Blood or plasma;
- Charges for the administration or injection of any drug, unless related to specialty pharmacy administration or injection;
- Dietary (nutritional) supplements such as Ensure, Limbrel and Vanachol or specialized infant formula;
- Drugs administered in and billed by a physician's office;
- Drugs prescribed, filled or obtained by a physician, pharmacist or pharmacy that is not licensed in the United States;
- Drugs purchased outside of the United States (see the section titled *Coverage While Traveling Outside the United States* in the *Medical Plan Benefits* chapter);
- Drugs that do not require a prescription (over-the-counter drugs unless listed in the section titled *Prescription Drugs and Supplies Covered Under the Plan*);
- Drugs that are administered to a patient while he or she is in a hospital, nursing home, extended care facility or similar institution that operates a pharmacy on its premises;
- Immunization agents and biological sera (drugs which are obtained, purified and standardized from human serum or plasma);
- Infertility drugs;
- Insulin pumps, blood glucose monitors (unless covered under the medical plan benefits);
- Investigational or experimental drugs;
- Non-prescription vitamins and minerals;
- Ostomy supplies (unless covered under the medical plan benefits);
- Avage;
- Therapeutic devices or appliances, support garments and other non-medical substances;
- Topical fluoride preparations;
- Topical Minoxidil (such as Rogaine);
- Vaccines other than Flu, Zostavax, and Pneumonia; and
- Depigmenting agents.

Coverage Under Medicare

Retirees: If you are a retiree, you and your dependents ages 65 and older are not eligible to participate in the Medical Plan, including prescription drug benefits.

Medicare-disabled: If you are a Medicare-disabled participant or a participant with end-stage renal disease, you will no longer be covered under the prescription drug benefit of the Plan if you:

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

If you are a Medicare-disabled participant for whom Medicare is the primary payer, you are no longer eligible for prescription drug coverage under the plan unless suitable replacement Medicare prescription drug coverage is not available. If suitable prescription drug coverage is not available, you may enroll for prescription drug coverage during annual enrollment.

Participants with ESRD will remain covered under the prescription drug benefit of the Plan for the first 30 months of ESRD disability as long as they are under age 65 and not retired. After 30 months of ESRD disability, when Medicare becomes the primary insurer, the participant will no longer be covered under the prescription drug benefit of the Plan and must enroll in a Medicare Part D prescription drug plan or another creditable plan. If suitable prescription drug coverage is not available, you may enroll for prescription drug coverage during annual enrollment.

For Medicare-disabled participants, preventive drugs will be covered under the Medical Plan at 100%. Paper claims must be submitted to the address located on the back of your medical ID card.

Note: If you are eligible for Medicare and your covered dependents are not Medicare-eligible then your dependents will remain covered under the prescription drug benefit of the Plan until Medicare becomes their primary insurer.

Creditable Coverage for Medicare

Creditable prescription drug coverage is coverage that expects to pay at least as much as the standard Medicare Part D prescription drug plan will pay. Many of the prescription drug plans offered by NRECA are considered creditable prescription drug coverage; however, prescription drug plans associated with high-deductible medical plans are not.

It is important to note that it is not a requirement under Medicare rules for an individual to sign up for Medicare at age 65. An individual does not need to sign up for Medicare at age 65 (and will not incur a penalty) if he or she (i) has not yet signed up for Social Security benefits or Railroad Retirement income benefits, and (ii) has employer-sponsored medical coverage based on his or her active work status or that of a spouse. All participants who are enrolled in Medicare should consider enrolling in a creditable prescription drug plan to avoid paying higher premium charges when enrolling in a Medicare Part D prescription drug plan. If you or a dependent become eligible and enroll in Medicare benefits and you or your employment status is active or disabled, it is important to check with your employer or contact NRECA's MCC to verify whether the prescription drug benefit offered by your employer is considered creditable prescription drug coverage. If you remain enrolled in a prescription drug plan that is not considered creditable coverage after you become eligible for Medicare or you have a break in creditable coverage of 63 continuous days or longer before enrolling in a Medicare Part D prescription drug plan, you may have to pay a higher premium when you enroll in a Medicare Part D prescription drug plan. You may request a Certificate of Creditable Drug Coverage from the Plan by contacting the Member Contact Center using the information listed in the *Contact Information* chapter.

Note: If you are an active employee or a dependent of an active employee covered under this Plan and you become eligible for Medicare and this Plan does not provide creditable drug coverage, you may be eligible to switch to coverage under another NRECA Plan (if your employer offers another NRECA medical plan option). You must make this change

within 31 days of Medicare eligibility. If you believe you qualify, contact NRECA Employee Benefit Services at 866.673.2299 for further information and eligibility requirements.

Coordination of Benefits

The Plan does not provide for coordination of benefits for prescription drug charges. This means that the Plan will pay for drug charges submitted first to NRECA. If the participant first submits drug charges to his or her other insurance and subsequently submits them to NRECA as a secondary payer, NRECA will not consider those drug charges for payment.

Chapter 7: Medical Claims and Appeals

General Information

This chapter describes the steps you must take to file claims for plan benefits and seek an appeal when plan benefits are denied.

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

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

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

After you or your provider file a claim, the claims administrator reviews 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 appeals administrator to review that decision through what is called an **internal appeal**. If your internal appeal is denied, you may request a second-level appeal review of your denied internal appeal.

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

Claims and Appeals Contacts	
Type	**Name and Address**
Authorizing a representative	**NRECA Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard, Arlington, VA 22203-1860 703.907.6601 (phone) 703.907.6602 (fax) privacyofficer@nreca.coop

Claims and Appeals Contacts	
Type	**Name and Address**
Filing a claim	**UMR** 877.233.1800 PO Box 30515; Salt Lake City, UT 84130-0515 877.233.1800
Filing a pre-service appeal for services that require prior authorization through SHARE	**UHC Appeals - UMR** P.O. Box 400046 San Antonio, TX 78229 800.808.4424, ext 15227 (phone) 888.615.6584 (fax)
Filing an expedited pre-service appeal for services that require prior authorization through SHARE	**UHC Appeals – UMR** 800.808.4424, ext 15227 (phone) 888.615.6584 (fax)
Filing an internal appeal	**CBA – Appeals Administrator** P.O. Box 6249 Lincoln, NE 68506 866.673.2299 (phone) 402.483.9201 (fax)
Requesting an external review or an expedited external review	**CBA – Appeals Committee (External 9222)** P.O. Box 6249 Lincoln, NE 68506 866.673.2299 (phone) 402.483.9201 (fax)

Authorizing a Representative

An authorized representative is an individual you have designated in writing to represent you in the claims or appeals process. You have the right to have someone (including your physician) file a claim or appeal on your behalf or represent you in the appeal process. Within this chapter, references to “you” include your authorized representative or your provider if your provider is submitting a claim on your behalf.

To authorize someone to represent you through the claim or appeals process, 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 at cooperative.com > My Benefits. After processing your form, the Privacy Officer will provide you with a copy for your records.

Contact the NRECA Privacy Officer if you have questions about authorizing a representative or about the use and disclosure of your protected health information. For urgent care claims, a health care professional with knowledge of your medical condition shall be permitted to act as your authorized representative.

Note: Neither the insurer, NRECA nor any participating employers are responsible for how your authorized representative discloses your protected information or for his or her failure to protect such information.

Claims

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

There are four types of claims under this plan:

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

These claim types are defined in *Appendix A: Key Terms* at the end of this SPD.

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

Filing a Claim

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

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

- Patient's name, date of birth and relationship to the participant;
- Group number and individual member number;
- Condition (diagnosis) and the treatment or service for which approval is being requested;
- Service provider's name, address and tax identification number;
- Records or other documentation to support the request for approval;
- Date(s) service was rendered or purchase was made;
- Diagnosis code, procedure codes and descriptions of each service or supply; and

- Original copies of the itemized charge(s) for each service or supply. Photocopies are acceptable only if you are covered by two plans and you sent the original bill to the primary payer. Note that monthly statements, balance due bills and credit card receipts are not acceptable documentation for itemized charges.

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

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

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

Claims Review Timeline

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

Claims Review Timeline			
Claim Type[1]	**When you will be notified of a determination**	**Determination extension period**	**Deadline to supply more information**
Post-service	Within **30 calendar days** of claim receipt *(unless the claims administrator needs an extension or more information)*	One period of up to **15 calendar days**	**45 calendar days** from the request notice receipt date

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

Claim Determinations, Extensions and Requests for Additional Information

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

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

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

Content of the Determination Notice

Regardless of the type of claim, you will be notified of an adverse benefit determination in writing. The notice will include:

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

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

Appealing an Adverse Benefit Determination

If you disagree with an adverse benefit determination on a claim, you have the right to have your adverse benefit determination reviewed on appeal. This plan has an internal appeal process and an external review process for certain adverse benefit determinations. Generally, you must exhaust the internal appeal process before seeking an external review or bringing a civil action under Section 502(a) of ERISA.

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

Within this section, references to "you" may include your provider (if your provider is authorized to appeal on your behalf) or another authorized representative.

Documenting Your Appeal

The information in this section applies to both internal and external appeals. For purposes of this explanation, the "reviewer" means the CBA–Appeals Administrator (for internal appeals) and the Independent Review Organization or IRO (for external reviews).

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

- Your name;
- Name of the plan (that is, the Medical High Deductible PPO Plan);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

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

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

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

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

Filing an Internal Appeal

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

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

Internal Appeal Timeline	
Filing deadline	Within **180 calendar days** of the date you receive the written adverse benefit determination from the claims administrator

Internal Appeal Timeline		
When you will be notified of a determination	**Urgent care**	Within **72 hours** from receipt of the appeal
	Pre-service	Within **30 calendar days** from receipt of the appeal
	Concurrent care	In the appeal time frame for pre-service, urgent care or post-service claims as appropriate to the request
	Post-service	Within **60 calendar days** from receipt of the appeal

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

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

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

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

Internal Appeal Review and Determination

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

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

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

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

External Review

If the CBA–Appeals Administrator issued a denial in response to your internal appeal and if that determination was based on medical judgment or if you have otherwise exhausted the internal appeals process for a claim involving medical judgment, you have the right to request an external review. All other adverse benefit determinations (including a denial, reduction or nonpayment of benefits because you do not meet the plan's eligibility requirements) are not eligible for this plan's external review process.

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

For more information about adverse benefit determinations that involve rescission of coverage (regardless of whether the rescission has any effect on benefits previously paid or pending or on any future claims at the time the rescission occurs), see the section of this chapter titled *Appealing an Adverse Benefit Determination: Rescission of Coverage*.

External Review Types

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

You may request an **expedited** external review if:

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

External Review Timeline	
Filing deadline	Within **four months** of the date you receive the written adverse benefit determination for your internal appeal
Preliminary review by CBA	• Within **five calendar days** after receipt of your external review request (standard review) • **Immediately** (expedited review)
Preliminary review notification	• In writing, within **one calendar day** after completion of the preliminary review (standard review) • Immediately (expedited review)
If **incomplete**	Re-file with complete information within the original **four-month filing period** or **48 hours** after receiving the request for additional information
If **eligible** for review	CBA–Appeals Administrator will assign your appeal to an independent review organization (IRO) and provide a full external review file to the IRO within **five calendar days**
If **ineligible** for review	No further reviews are available

External Review Timeline	
Deadline to supply additional information	Within **10 calendar days** after you receive notice that the IRO has accepted your claim
IRO notifies you of a determination	• In writing, within **45 calendar days** after the IRO receives the request (standard reviews) • Within **72 hours** (expedited reviews)

Preliminary Review of Your External Review Request

The Plan has **five calendar days** to complete a preliminary review of your external review request. This review confirms that:

- You are (or were) covered under the plan at the time the service (or supply) was requested or provided;
- The adverse benefit determination did not occur because you failed to meet the plan's eligibility requirements;
- The adverse benefit determination was based on medical judgment;
- You have exhausted the plan's internal appeal process (unless you were not otherwise required to exhaust the process before requesting external review); and
- You have provided all the information and forms required to process the external review.

Preliminary Review Results Notification

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

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

Appeal Assignment to an Independent Review Organization (IRO)

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

- The IRO will notify you that it has been assigned to review your external appeal and may offer you the opportunity to present additional information; and
- The IRO will review the following items (if they are received by the applicable deadline) without regard to any previous decisions or conclusions:
  - Your medical records;
  - Your attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents submitted by the plan, claimant or provider;
  - The terms of the plan under which you have coverage;

- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards and associations;
- The IRO's clinical reviewer's opinion; and
- The plan's applicable clinical review criteria, unless the criteria are inconsistent with the terms of the plan or with applicable law.

External Review Determination Notification

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

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

If the determination is **favorable**:

- For pre-service appeals, the claims administrator will immediately issue the necessary authorization for the service;
- For post-service appeals, the claims administrator will promptly process the claim for benefits;
- For services rendered by a network provider, any benefit payment due will be made to the network provider directly; and
- You remain responsible for any applicable copayment, deductible and coinsurance under the plan.

If the determination is **unfavorable**:

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

Legal Action

You must complete the procedures described in both the *Claims* and the *Appealing an Adverse Benefit Determination* sections of this chapter before you can take legal action regarding benefits under this Plan. Any suit for benefits must be brought within **12 months** from the date of the internal appeal denial.

Appealing an Adverse Benefit Determination: Rescission of Coverage

Your (or your dependents') coverage under a medical 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/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* section*, Chapter 3, When Coverage Ends.*

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. For purposes of these rescission appeal procedures, NRECA shall be the named fiduciary and shall have discretionary authority to resolve factual issues and make final determinations with regard to appeals related to rescissions.

Chapter 8: Prescription Drug Claims and Appeals

General Information

This chapter describes the steps you must take to file a claim for reimbursement for plan benefits and seek an appeal when you receive an adverse benefit determination.

When you receive prescription drugs or supplies from a participating network pharmacy, the pharmacy verifies your eligibility and coverage and, if required, may contact your provider to initiate a preauthorization from CVS/caremark or CBA. It is the participant's responsibility to make sure that preauthorization is obtained from CVS/caremark or CBA. CVS/caremark will directly reimburse the network provider for covered prescription drugs or supplies if your pre-authorization is approved. If you obtain prescription drugs or supplies from a non-network retail pharmacy or from a non-CVS/caremark mail-order pharmacy, you must pay the provider in full when you fill your prescription or purchase your supply and then submit a claim for reimbursement. See the section titled *Filling Prescriptions* in the *Prescription Drug Benefits* chapter.

A claim for reimbursement means a request for plan benefits that is made in accordance with the procedures outlined in this chapter. After you submit a claim for reimbursement, CVS/caremark processes the claim against your plan provisions to determine reimbursement. If your claim is approved, you will receive a reimbursement check in the mail from CVS/caremark. If your claim is denied, you have the right to request a benefit exception or preauthorization for medical necessity from CVS/caremark or CBA. See the section titled *Prior Authorization* later in this chapter.

If your claim for reimbursement or request for benefit exception or preauthorization for medical necessity is denied, it is known as an adverse benefit determination. You have the right to ask for a review of that decision through what is called an internal appeal (first level and second level). If both your first- and second-level internal appeals are denied, in whole or in part, you may then request an external review.

The steps in this chapter are intended to comply with applicable regulations by providing reasonable procedures for filing claims, notifying participants of benefit decisions and appealing adverse benefit determinations. Be sure to follow these procedures for all claims and appeals for benefits under this Plan.

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

Contacts[1]		
Type	**CVS/caremark**	**CBA**
Authorizing a representative	**CVS/caremark** **Research Department** P.O. Box 832407 Richardson, TX 75083 888.796.7322	**NRECA Privacy Officer** 4301 Wilson Boulevard Arlington, VA 22203-1860 703.907.6601 or 703.907.6602 privacyofficer@nreca.coop
Prior authorization (when required)	**CVS/caremark** P.O. Box 686005 San Antonio, TX 78268-6005 888.796.7322	**CBA** P.O. Box 6249 Lincoln, NE 68506 402.483.9200

Contacts[1]		
Type	**CVS/caremark**	**CBA**
Filing a claim for reimbursement	**CVS/caremark** P.O. Box 52136 Phoenix, AZ 85072 888.796.7322	All claims must be filed with CVS/caremark.
Filing a first-level internal appeal	**CVS/caremark Prescription Claim Appeals (MC 109**) P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866.689.3092	**CBA–Appeals Administrator** P.O. Box 6249 Lincoln, NE 68506
Filing a second-level internal appeal	**CVS/caremark Prescription Claim Appeals (MC 109)** P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866.689.3092	Not applicable
Filing a request for external review	**CVS/caremark** External Review Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866.443.1172	**CBA–Appeals Committee** (External 9222) P.O. Box 6249 Lincoln, NE 68506

[1] *Before choosing where to send your appeal, please review the requirements in the section of this chapter titled* Prior Authorization*.*

Authorizing a Representative

An authorized representative is an individual who you designate in writing to represent you in the claims or appeals process. You have the right to have someone (including your physician) file a claim for reimbursement or appeal on your behalf or represent you in the appeal process. For urgent care claims, a health care professional with knowledge of your medical condition is permitted to act as your authorized representative. Within this chapter, references to “you” include your authorized representative or your provider if your provider is submitting a claim for reimbursement on your behalf.

To authorize someone to represent you through the claim for reimbursement or appeals process, 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. 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: Neither the insurer, NRECA nor any participating employers are responsible for how your authorized representative discloses your protected information or for his or her failure to protect such information.

Prior Authorization

The plan has specific criteria that must be met for certain prescriptions to be covered. To ensure that these drugs meet the coverage criteria, prior authorization review is required. For additional information about prior authorization, refer to the section titled *Medications Requiring Prior Authorization* in the *Prescription Drug Benefits* chapter.

Note: All appeals must be filed with the same entity (CBA or CVS/caremark) that was originally responsible for preauthorizing the drug or supply.

- If no prior authorization was required or if CVS/caremark provided preauthorization, file your appeal with CVS/caremark; or
- If CBA was responsible for prior authorization, file your appeal with CBA. See the addresses listed in the *Contacts* table. See the sections titled *Appealing an Adverse Benefits Determination* and *External Review* for specific appeals procedures.

Claims

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

This Plan has four types of claims:

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

These claim types are defined in *Appendix A: Key Terms* at the end of this SPD.

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

If your claim for reimbursement does not include sufficient information for CVS/caremark 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 described in the table titled *Claims Review Timeline*, your claim for reimbursement may be denied, in whole or in part.

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

Filing a Claim for Reimbursement

When you receive prescriptions, you are responsible for filing the claim for reimbursement correctly. You are also responsible for obtaining prior authorization, if required, before you receive services or purchase supplies. Contact CVS/caremark or CBA if you have questions (see the table titled *Contacts* at the beginning of this chapter). **You have 12 months from the date you received a prescription drug or purchased a supply to file a claim for reimbursement for benefits for that drug or supply.** You will be notified within 30 calendar days of claim receipt of a benefit determination.

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

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

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

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

Claim Determinations, Extensions and Requests for Additional Information

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

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

Claim Determination Notice Content

Regardless of the type of claim, you will be notified of an adverse benefit determination in writing. The notice will include:

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

Further, the notice 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 final appeal.

Appealing an Adverse Benefit Determination

If you disagree with an adverse benefit determination on a claim, you have the right to have your adverse benefit determination reviewed on appeal. This plan has an **internal** appeal process (first level and second level) and an **external** review process for certain adverse

benefit determinations. Generally, you must exhaust the internal appeal process before seeking an external review or bringing a civil action under Section 502(a) of ERISA.

Regardless of any verbal discussions that you have had about your claim, you have **180 calendar days** from the date you receive an adverse benefit determination to file a written internal appeal with CVS/caremark or CBA, as applicable.

The information in this section applies to both internal and external appeals. Within this section, references to "you" may include your provider (if your provider is authorized to appeal on your behalf) or another authorized representative.

Within this explanation, "reviewer" means:

- CVS/caremark–Prescription Claim Appeals Administrator or the CBA–Appeals Administrator (for first-level internal appeals);
- CVS/caremark–Prescription Claim Appeals Administrator (for second-level internal appeals); and
- CVS/caremark External Review Appeals Department or CBA–Appeals Committee (for external reviews).

Documentation to Include With Your Appeal

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

- Your name;
- Name of the plan (that is, the Medical High Deductible PPO Plan);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

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

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

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

Note: It is very important to include all information that you want the reviewer to consider at the time you file your appeal. Remember that the date the appeal is filed is the date it is received by the reviewer. The reviewer must render a determination within the time frame described in this chapter regardless of whether you indicate that more information is forthcoming.

First-level Internal Appeal

If CVS/caremark denied your claim (an adverse benefit determination) based on administrative or clinical terms as defined in *Appendix A: Key Terms* at the end of this SPD, then you have the right to request a first-level internal appeal within **180 calendar days** of the date you receive the adverse benefit determination notice.

The reviewer has full and discretionary authority to administer and interpret the plan for all first-level internal appeals (as applicable).

Where to Send Your Internal Appeal

First-level internal appeals for urgent care claims may be filed verbally. All others must be filed in writing with the reviewer (by either U.S. mail or overnight delivery) to the address listed in the *Contacts* table in this chapter.

Submit your first-level and subsequent appeals **to** CBA if your claim is denied and the drug or supply required prior authorization by CBA**.**

Submit your first-level and subsequent appeals to CVS/caremark if your claim is denied and the drug or supply either required prior authorization by CVS/caremark or did not require prior authorization.

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

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

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

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

First-level Internal Appeal Review and Determination

The reviewer will notify you of the decision in writing. If your urgent care claim is approved or denied in whole or in part, you will receive a verbal notice, followed by a written notice within three days. Regardless of the type of claim, if your first-level internal appeal receives an adverse benefit determination, you will be notified in writing or electronically. The notice will include the following information:

- The specific reason(s) for the adverse determination;

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

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

Second-level Internal Appeal (CVS/caremark Appeals Only)

If the CVS/caremark–Prescription Claim Appeals Administrator issued an adverse benefit determination for your first-level internal appeal based on medical judgment as defined in *Appendix A: Key Terms* at the end of this SPD, then you have the right to request a second-level internal appeal within **180 calendar days** of the date you receive the adverse benefit determination notice. The reviewer has full and discretionary authority to administer and interpret the plan for all second-level internal appeals.

Second-level internal appeals for urgent care claims may be filed verbally. All others must be filed in writing with the reviewer by either U.S. mail or overnight delivery to the address listed in the *Contacts* table.

Second-level Internal Appeal Timeline		
Filing deadline		Within **180 calendar days** of the date you receive the written adverse benefit determination
When you will be notified of a determination	**Urgent care**	Within **72 hours** after the reviewer receives the appeal
	Pre-service	Within **30 calendar days** from the reviewer's receipt of the appeal
	Concurrent care	Within the appeal time frames for pre-service, urgent care, or post-service claims as appropriate to the request
	Post-service	Within **60 calendar days** after the reviewer receives the appeal
Determination extension period	None permitted	

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

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

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

Second-level Internal Appeal Review and Determination

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

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

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

External Review (Standard and Expedited)

The adverse benefit determination notice you receive from the previous reviewer will describe the plan's external review procedure. You have the right to request an external review of your adverse benefit determination if:

- CVS/caremark–Prescription Claim Appeals Administrator issued an adverse benefit determination for your second-level internal appeal and you have otherwise exhausted the internal appeals process for a claim involving medical judgment; or
- CBA–Appeals Administrator issued an internal adverse benefit determination in response to your internal appeal and that determination was based on medical judgment or if you have otherwise exhausted the internal appeals process for a claim involving medical judgment.

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

External Review Types

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

- Your denied claim (an adverse benefit determination) involves a medical condition for which the time frame to complete an urgent care internal appeal would seriously

jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an urgent care internal appeal;

- Your final internal adverse benefit determination involves a medical condition where the time frame to complete a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
- Your final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility.

The table below summarizes the external review timeline. Details about each step appear in the following sections.

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

Preliminary Review

The CVS/caremark–External Review Appeal team or the CBA–Appeals Committee has **five calendar days** to complete a preliminary review of your external review request. This review confirms that:

- You are (or were) covered under the plan when the prescription drug benefit was requested or provided;
- The adverse benefit determination did not occur because you failed to meet the plan's eligibility requirements;
- The adverse benefit determination was based on medical judgment;
- You have exhausted the plan's internal appeal process (unless you were not otherwise required to do so before requesting external review); and

- You have provided all the information and forms required to process the external review.

Preliminary Review Results Notification

The CVS/caremark–External Review Appeal team or the CBA–Appeals Committee will send an acknowledgment notice to you within **one calendar day** of the preliminary review.

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

Assignment to an Independent Review Organization (IRO)

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

External Review Determination Notification

The IRO will notify both you and the CVS/caremark–External Review Appeal team or the CBA–Appeals Committee of the external review decision within the time frame described in the *External Review Timeline* table. The determination will contain:

- A general description of the reason for the request;
- Information sufficient to identify the claim at issue;
- The date the IRO received the assignment to conduct the review;
- The date of the IRO's decision;

- The principal reason(s) for the decision, including references to the evidence, documentation, specific plan provisions and evidence-based standards used to reach the decision;
- A statement that the determination is binding on all parties except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including the phone number for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service (PHS) Act section 2793.

If the Determination Is Favorable

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

If the Determination Is Unfavorable

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

Legal Action

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

Appealing an Adverse Benefit Determination: Rescission of Coverage

Your (or your dependents') coverage under a medical plan benefit option may be retroactively terminated if you:

- Performs an act, practice or omission that constitutes fraud; or
- Makes 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/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* section*, Chapter 3, When Coverage Ends.*

- 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. For purposes of these rescission appeal procedures, NRECA shall be the named fiduciary and shall have discretionary authority to resolve factual issues and make final determinations with regard to appeals related to rescissions.

Chapter 9: Wellness Benefits and Resources

POWER Wellness Program

As part of your medical plan, you have access to the POWER Wellness Program. The Plan's approach to wellness is about more than just physical fitness or losing weight. It's about taking a comprehensive approach toward well-being by incorporating physical, mental and financial wellness to achieve a long, fulfilled and prosperous life. The POWER Wellness Program provides several resources to you and your family designed to encourage health and well-being.

SMART Programs

Through the NRECA Employee Benefits website, you have access to resources, videos, activities and more that focus on improving nutrition, physical activity and other areas of your health. For more information, visit cooperative.com > My Benefits > My Insurance > SMART® Programs.

Discounts

As part of the POWER Wellness Program, you have access to discounts for a variety of nationally known health and wellness programs and services. To learn more about the discount opportunities available, visit cooperative.com > My Benefits > My Insurance > Wellness Discounts.

MyHealth Manager Powered by WebMD

MyHealth Manager is an interactive, online portal that provides you with access to the information you need to make better choices about your health. The site includes a variety of resources and easy-to-use tools developed by one of the most trusted sources of health and medical information: **WebMD**. However, medical decisions are ultimately made by you and your physician and do not involve the Plan. Key features of MyHealth Manager are:

- **MyHealth Survey:** a brief, confidential questionnaire that helps you understand your health risks based on your screening results and lifestyle habits;
- **MyHealth Assistants:** online health coaching modules where you can select activities to meet your short- and long-term health and wellness goals; and
- **Symptom Checker:** a tool that helps you determine if and when you should seek medical treatment.

To access MyHealth Manager, visit cooperative.com > My Benefits > My Insurance > WebMD MyHealth Manager.

In addition to the wellness benefits offered as part of the POWER Wellness Program, your employer may also offer a wellness program. Check with your benefits administrator to learn more about your employer's wellness offerings.

Life Strategy Counseling Program

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

Life Strategy Counseling Services

The program offers telephonic counseling for:

- Family or relationship problems;
- Parenting difficulties;

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

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

- Childcare
  - Parenting and childcare resources;
  - Local children's programs;
  - Tutoring resources; and
  - Selecting a college;
- Adult Care
  - Locating an elder care facility;
  - Aging issues;
  - Medicare and Medicaid information; and
  - Long-term care evaluation;
- Convenience
  - Real estate and relocation services;
  - Home or appliance repairs; and
  - Pet services.

LSC will put you in touch with a dedicated Masters-level counselor from APS Healthcare/KEPRO who will work with you. You will have access to telephonic counseling and support 24 hours a day, seven days a week, 365 days a year. These calls are confidential.

At your request, the Life Strategy Counselor can also refer you to further professional assistance in your area as appropriate.

Access to online resources like webinars, articles, and skill builders is also available through cooperative.com >My Benefits > My Insurance > Life Strategy Counseling to watch a helpful video about the program or visit www.apshelplink.com. Use the company code "nreca".

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

Life Strategy Counseling Exclusions

The following services are specifically **excluded** from LSC:

- Biofeedback and hypnotherapy;
- Services required by court order or as a condition of parole or probation, not, however, to the exclusion of services to which you would otherwise be entitled;
- Services for children regarding remedial education including evaluation or medical treatment of learning disabilities or minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. LSC shall, however, provide services for parents coping with children who are dealing with any of the issues listed in this bullet point;
- Medical treatment or diagnostic testing related to learning disabilities, developmental delays or educational testing or training;
- Services provided outside of LSC;

- Psychological testing;
- Sleep therapy;
- Medical treatment of congenital or organic disorders associated with permanent brain dysfunction, including without limitation, organic brain disease, Alzheimer's disease and autism. Services that enhance the coping skills of eligible family members are covered services;
- IQ testing;
- Medical treatment for chronic pain. Services that enhance participant and eligible family members coping skills are covered services;
- Services involving medication management or medication consultation with a psychiatrist;
- Fitness for Duty Evaluations (FFDEs);
- Any form of therapy or counseling considered experimental, investigational or unproven; and
- Medical treatment of any kind.

MyHealth Coaches®

Health Dialog provides telephonic coaching through NRECA's MyHealth Coaches® program and online medical information via the NRECA Employee Benefits website. MyHealth Coaches are health professionals such as nurses, dieticians and respiratory therapists who are available to answer questions and address concerns about your health. Contact MyHealth Coaches 24 hours a day, seven days a week, at 866.696.7322.

MyHealth Coaches specialize in working with people who live with chronic conditions, including asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and congestive heart failure. Coaches also assist with medical decisions like whether to have back surgery, and with other areas such as quitting tobacco and losing weight. All conversations with MyHealth Coaches are confidential and private. Medical plan participants and dependents ages 18 and older have access to Health Dialog's Health Information Center portal through the NRECA Employee Benefits website as well. There, you can find information on various health topics and conditions, decision aids, and tools and resources to help make informed decisions about what treatment and care is right for you.

Tobacco Cessation Program

Studies show that tobacco users have a better chance of successfully quitting when they participate in a counseling program. Your Plan makes tobacco cessation help available to you and your covered dependents ages 18 and older through the MyHealth Coaches® program. The program is designed to help individuals stop using tobacco products, including cigarettes and smokeless tobacco. The program provides telephonic counseling support and mailed materials.

Program participants who are smokers may be eligible to receive either nicotine replacement therapy (NRT) (e.g., patch, gum, lozenge) mailed directly to them (if medically appropriate) or coverage for tobacco cessation prescription medications (e.g., Chantix, Zyban). Program participants who are chewers are not eligible for prescription medications because tobacco cessation prescription drugs are not approved by the FDA for use with chewing tobacco. The Tobacco Cessation Program can be reached by calling MyHealth Coaches® at 866.696.7322.

Weight Management Program

MyHealth Coaches also offer members support in managing their weight. The program addresses BMI and disease risk, helps participants set 12-week weight-loss goals and track

their health behaviors, and teaches tips for managing portion sizes. Coaches assist individuals with starting an exercise program as well.

The program involves an intake assessment for those at high BMI risk, a review of goals and healthy eating plans, and regular phone calls with a health coach. Participants receive a weight management toolkit upon joining the program. Members can call 866.696.7322 to speak with a coach about weight management 24 hours a day, seven days a week.

Important: Release of Liability for the NRECA POWER Wellness Program

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

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

Chapter 10: Continuing Coverage Under COBRA

General Information

Federal law requires the Medical High Deductible PPO 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 www.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, directors, retained attorney);
- 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 employer, a pre-65 retired employee, the 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.

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

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 have been notified 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** contact 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. **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 in which the child reaches age 26 regardless of any separate notification requirements for which you are responsible.

When 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: A notice to your spouse is treated as notice to any dependent children who reside with your spouse.

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.

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
Your employment termination[1]	18 months

Initial Qualifying Event	Coverage Period
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 dependent children)	36 months
Your death (coverage extends to eligible spouse, and dependent children)	36 months *See Special Rule for Surviving Spouse and Dependents*

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

Special Rule for Surviving Spouse and Dependents

If you die, your surviving spouse and dependent children are eligible to continue coverage beyond the required 36-month COBRA period. Such surviving spouse and dependent coverage will end independently for each participant 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 will coordinate this coverage continuation.

Second Qualifying Events

An 18-month extension of coverage may be available to your spouse and dependent children who elect 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[1]	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)
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)

Second Qualifying Event[1]	Maximum Duration for Covered Spouse, or Dependents

[1] 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 (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 the initial COBRA notice or SPD that describes the notice procedures (or is deemed to receive the initial COBRA notice or SPD).

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, 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

Newly eligible dependents may be added to coverage after the initial COBRA qualifying event, if they meet the eligibility requirements and are enrolled **within 60 days** of becoming eligible. However, except for newborn or newly adopted children, dependents added after the qualifying event may be covered only by a qualified beneficiary. They may not extend coverage individually. Newly born or adopted children who become dependents after the qualifying event do have these continuation rights individually.

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

Discontinuing Your Coverage or Removing a Dependent From Coverage

If you would like 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 *Medical Plan Benefits* chapter. If you have other coverage, you must notify the claims administrator for each plan in which you are enrolled.

End of COBRA Continuation Coverage

If you or your dependents elect COBRA continuation coverage, it may be continued for the period of time 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 of the change 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 under another group plan that does not impose any pre-existing condition exclusions for you or your dependents pre-existing conditions, after your COBRA qualifying event. 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 that would justify the Plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud). 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 the information 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.

Transitioning to Medicare Using COBRA

COBRA continuation coverage may be used to bridge the gap in health coverage as you transition to Medicare. This is important to note because if you experience a gap in health coverage in excess of 63 days, you will lose the guaranteed right to purchase an individual Medicare supplemental insurance policy that does not impose pre-existing condition exclusions. For more information, visit www.medicare.gov.

Chapter 11: Important Notifications and Disclosures

Not a Contract of Employment

This Plan must not be construed as a contract of employment and does not give any employee a right of continued employment. Nor may the Plan be construed as a guarantee of other benefits from your employer.

Non-assignment of Benefits

You cannot assign, pledge, borrow against or otherwise promise any benefit payable under the Plan before you receive it.

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 medical expenses. The Plan will seek recovery for payment of benefits through subrogation or reimbursement, and the Plan's right of full recovery may be from any source of payment, including, but not limited to: 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.

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 medical expenses. You must notify the Plan within 45 days of the date when notice is given to any third party of your intention to recover damages due to your injury or sickness. If you enter into litigation for payment of your injury or sickness, you must not prejudice, in any way, the 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 your 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 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 $147 per day 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.

Women's Health and Cancer Rights Act (WHCRA)

Covered individuals who had or are going to have a mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). If you receive mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of a mastectomy, including swelling associated with the removal of lymph nodes (lymphedemas).

These benefits will be provided subject to the same coinsurance applicable to other medical and surgical benefits provided under this Plan. See the *Plan Highlights* chapter for specific coinsurance applicable to these benefits.

Contact your benefits administrator for more information on WHCRA.

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.

Appendix A: Key Terms

Accident

A non-occupational injury caused by a sudden and unforeseen event that occurred at an exact time and place.

Administrative Denial

A prescription drug claim that has been denied as a result of plan terms; for example, an ineligible claimant, the prescribed days' supply exceeds plan limits or failure to request prior authorization when it is required.

Adverse Benefit Determination

A denial, reduction or termination of (or a failure to make full or partial payment for) a benefit, including any such denial, reduction or failure to provide or make payment that is based on a determination of your eligibility to participate in a benefit option under the Medical High Deductible PPO Plan.

Failure to 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, in connection with the rescission, there is 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 *Medical Claims and Appeals* chapter.

Ambulatory Surgical Center

Any public or private institution that:

- Is licensed as an ambulatory surgical center by the state in which the center is located or
- Is established, equipped and operated primarily as a facility for performing surgical procedures and meets the following requirements:
    - Is operated under the supervision of a staff of physicians, maintains adequate medical records for each patient and provides for periodic review of the facility and its operation by a utilization or tissue committee composed of physicians other than those who own or supervise the facility;
    - Permits a surgical procedure to be performed only by a physician privileged to perform such procedure in a hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used;
    - Provides no overnight accommodations for patients and has at least two operating rooms, one post-anesthesia recovery room and full-time services of registered nurses for patient care in all operating and post-anesthesia recovery rooms;
    - Is equipped to perform diagnostic x-ray and laboratory examinations required in connection with the surgery to be performed and has the necessary equipment and trained personnel to handle foreseeable emergencies including, but not limited to, a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction and a blood bank or other supply for hemorrhaging; and
    - Maintains written agreements with one or more hospitals in its area for immediate acceptance of patients who develop complications or require postoperative confinement.

The surgical suite or facility must be accredited by either the Accreditation for Ambulatory Health Care or the American Association of Accreditation Plastic Surgery Facilities.

Approved Clinical Trial

A phase I, phase II, phase III or phase IV clinical trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.

Authorized Representative

A person who you have authorized in writing to represent you in the claims process, the appeals process or both.

Birthing Center

A facility that can be used instead of a hospital setting for the birth of a child. A birthing center must meet several requirements. It must:

- Be certified or approved by a state department of health or other legally constituted regulatory state authority;
- Be equipped and operated primarily for the purpose of providing an alternative method of childbirth (this does not include an abortion center or clinic);
- Operate under the direction of a physician;
- Permit a surgical procedure to be performed only by a physician;
- Require an examination by an obstetrician at least once prior to delivery (to identify high-risk pregnancies);
- Offer prenatal and postpartum care;
- Provide at least two birthing rooms;
- Have available the necessary equipment—including a fetal monitor, incubator and resuscitator—and trained personnel to handle foreseeable emergencies;
- Provide the services of registered graduate nurses for patient care;
- Not provide beds or other accommodations for patients to stay more than 48 hours;
- Maintain written agreements with one or more hospitals in the area for immediate acceptance of patients who develop complications or who require post-delivery confinement;
- Provide for periodic review by an outside agency; and
- Maintain adequate medical records for each patient.

Chemotherapy

Outpatient treatment of disease using chemical agents.

Claimant

A participant who is making a claim for Plan benefits.

Clinical Denial

For purposes of the *Prescription Drug Claims and Appeals* chapter, a “clinical denial” is a claim that has been denied for clinical reasons (e.g., failure to meet CVS/caremark drug utilization guidelines, when your request for prior authorization is denied based on medical judgment).

Concurrent Care Claim

A claim for which the claims administrator has approved an ongoing course of treatment to be provided over a period of time or for a certain number of treatments where one of the following is also true:

- The claims administrator determines that the approved course of treatment should be reduced or terminated before the end of such period of time or number of treatments has been completed. **Note**: This does not apply where the reduction or termination is due to plan amendment or plan termination; or
- You must request an extension of the course of treatment or number of treatments beyond what the claims administrator has approved (when pre-service approval is required and the continuing services have not yet been provided).

Convalescent Nursing Home

A legally operated institution that:

- For a fee, provides room, board and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care;
- Is under full-time supervision of a physician or registered nurse;
- Keeps adequate medical records;
- If not operated by a physician, has the services of one available under an established agreement;
- Is not an institution, or part of one, used mainly as a rest facility or a facility for the aged; and
- Is licensed for skilled nursing care.

Copayment

A fixed amount (for example, $15) that you pay for a covered health care service, usually at the time when you receive the service. The copayment amount may be different depending on the type of covered health care service.

Coinsurance

Your share of the costs for a covered health care service, calculated as a percent of the allowed amount. For example, if the plan's allowed amount for an office visit is $100 and you have met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Cosmetic Procedures

A treatment or surgery that is intended to improve the patient's physical appearance, that is **not** medically necessary and from which no significant improvement in physiologic function can be expected (regardless of emotional or psychological factors).

Custodial Care

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

Deductible

The annual deductible is the amount that you must pay toward covered expenses for covered health services or supplies before the medical plan begins to pay any portion of the cost of covered expenses for those covered services or supplies. In-network and out-of-

network annual deductibles and annual out-of-pocket maximums accumulate jointly. For example, if you use an in-network provider, the amount applied to your in-network annual deductible also counts toward your out-of-network annual deductible, and vice versa.

Durable Medical Equipment

Equipment and supplies ordered by a physician for everyday or extended use. Examples include wheelchairs, hospital beds and respirators. Air conditioners, humidifiers, air purifiers and other similar convenience items are **not** considered durable medical equipment.

Durable medical equipment is equipment that is recognized as such by Medicare Part B and meets all of the following criteria:

- It can stand repeated use;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to a person in the absence of sickness or injury;
- It is appropriate for home use;
- It is related to the patient's physical disorder;
- It is for temporary use only;
- It is certified, in writing by a physician, as being medically necessary;
- It is the standard, basic model rather than a deluxe, luxury model;
- It is not more costly than alternative services that would be effective for diagnosis and treatment of the condition; and
- It enables a patient to make reasonable progress in treatment.

Emergency Medical Condition

A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- A serious threat to the individual's health;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

External Review

An appeal option available for certain medical claims after the internal claims and appeals review process has been exhausted and the adverse benefit determination has been upheld. The external review is conducted by an independent review organization (IRO).

Formulary

A formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. A committee of physicians, nurse practitioners, and pharmacists maintain the formulary.

Habilitation Services

Health care services delivered by a licensed or certified provider to help a person learn, improve or maintain skills that were never previously learned or acquired and are necessary for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-

language therapy, and other services for people with disabilities in a variety of inpatient and outpatient settings.

Habilitation services and *re*habilitation services can be similar but are performed for different purposes. While rehabilitation services help a patient *regain* function that they have lost, *habilitation* services help someone maintain, learn or improve skills they need for daily living functions but did not learn or acquire (often in childhood) due to a developmental, cognitive, or other condition.

Home Health Care Agency

A Home Health Care Agency is considered to be one of the following:

- A hospital that provides a program of home health care;
- A home health agency as defined by Medicare; or
- An organization that is certified by the patient's physician as an appropriate provider of home health services, is licensed or certified as a Home Health Care Agency if the state or local jurisdiction in which it is located requires such licensing or certification, has a full-time administrator, keeps written records of services provided to the patient and has at least one registered nurse (RN) or the care of an RN available.

Benefits for services provided by Home Health Care Agencies are subject to the following conditions:

- The services and supplies must be ordered by a physician as a part of the home health care plan.
- The patient must be under the care of a physician who submits the home health care plan. This plan is a written program for the care and treatment of a sickness or injury in the patient's home. It must certify that inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required if the home care weren't provided; and
- The home health care benefit will not exceed the amount that would have been paid had the services and supplies been furnished by a hospital during an inpatient confinement. For this purpose, a hospital confinement is considered a continuous period during which inpatient care in a hospital, convalescent nursing home or skilled nursing facility would be required were it not for the home care.

Hospice Care Program

A program directed by a physician to help care for a terminally ill person through either:

- A centrally administered, medically directed and nurse-coordinated program that provides a coherent system of primarily home care, uses a hospice team and is available 24 hours a day, seven days a week; or
- Confinement in a hospice. A hospice is a facility that provides short periods of stay for a terminally ill person in a homelike setting for either direct care or respite. This facility may be either freestanding or affiliated with a hospital. It must operate as an integral part of the hospice care program. If such a facility is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a hospice.

A Hospice Care Program must meet standards set by the National Hospice Organization and be approved by the Plan. If such a program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice Care Program.

Hospital

An institution that is:

- Accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals, or
- Operated in accordance with the law under the supervision of a staff of physicians and with 24-hour-a-day nursing service, and which is primarily engaged in providing:
    - general inpatient medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or
    - specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control or through a written agreement with a hospital or with a specialized provider of those facilities.

An institution that does not meet the tests of the above items but is state licensed and accredited by the Joint Commission for Accreditation of Hospitals as a community mental health center and residential treatment facility for alcoholism and drug abuse or as an ambulatory surgical center.

In no case will the term hospital include a convalescent nursing home or include an institution that:

- Is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
- Is operated primarily as a school.

For institutions that care for alcoholism, mental illness and substance abuse, the term hospital also means an alcohol dependency treatment center, psychiatric day treatment facility and drug dependency treatment center, respectively.

Hospital Confinement

A covered person is considered confined when he or she is a registered patient in a hospital and a room and board charge is made. A hospital confinement for more than 24 hours is considered an inpatient expense regardless of whether a room and board charge is incurred; for example, observation charges for a period of more than 24 hours.

Immunization

An injection with a specific antigen to promote antibody formation. It is used to make a person immune to a disease or less susceptible to a contagious disease.

Internal Appeal Process

The review of an adverse benefit determination conducted by the claims administrator.

Life-threatening Disease or Condition

A disease or condition that is likely to result in death unless the disease or condition is interrupted.

Medical Emergency

A sudden and unexpected physical condition for which immediate services, diagnoses or treatment are required to avoid threat to life or limb.

Any medical treatments or services received must be medically necessary as determined under the Plan.

Medical Judgment

A coverage decision that is based on the medical plan's (or claims administrator's) requirements for the medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit. A determination that a treatment is experimental or investigational; or as otherwise defined by applicable law.

In connection with the external review process, whether an adverse benefit determination involves medical judgment is generally determined by the external reviewer.

Medically Necessary, Medical Necessity or Medically Necessary Services and Supplies

To be considered medically necessary, medical services or supplies must meet all of the following criteria:

- Ordered by a physician;
- Consistent with the symptom or diagnosis and treatment of the sickness or injury;
- Appropriate within the standards of good medical practice;
- The most appropriate supply or level of service that can be safely provided to the patient in the appropriate setting;
- Not solely for the convenience of the patient, a physician, a hospital or another medical care facility;
- Not for educational, investigational or experimental services;
- Not for services that are mainly for the purpose of medical or other research; and
- Not for cosmetic procedures provided solely to improve appearance unless due to either a congenital defect that impairs function or an accident.

For hospital inpatient care to be considered medically necessary, the patient's symptoms or medical condition must be such that the services cannot be safely provided on an outpatient basis.

The length of a hospital confinement and hospital services and supplies will be considered medically necessary only to the extent that they are determined to be both:

- Related to the treatment of the sickness or injury, and
- Not provided for the scholastic education or vocational training of the patient.

The Plan considers charges for examinations that determine whether a patient needs a hearing aid or a hearing aid adjustment to be covered services.

Out-of-pocket (OOP) Coinsurance Maximum

The limit on the amount you pay for covered health services after you have paid your deductible and excluding any copayments. Plans generally pay all covered costs (except copayments) for the rest of the year after you reach this limit. This limit includes only amounts paid for covered services. For example, out-of-network reductions or claims for cosmetic treatment do not count toward the OOP Coinsurance Maximum. Amounts in excess of the non-network reimbursement amount also do not apply to the OOP Coinsurance Maximum.

Partial Hospitalization Program (PHP)

Either a full or partial day within a psychiatric hospital or behavioral health department of a hospital. The Plan treats both a full and a partial day of treatment as one inpatient day that is subject to the Plan's inpatient benefit provisions.

Performance Drug List

A performance drug list is a guide within select therapeutic categories for plan members and health care providers. Generics should be considered the first line of prescribing. If there is no generic available, there may be more than one brand-name medicine to treat a condition. These preferred brand-name medicines are listed to help identify products that are clinically appropriate and cost effective.

Physician

A legally qualified medical doctor or practitioner who is licensed in the governing jurisdiction and practicing within the scope of the license. The physician (or doctor) must not be related to the covered participant or patient by blood or marriage.

Post-service Claim

All claims that are not pre-service claims; for example, a claim for benefits that you make after receiving health care services.

Pre-service Claim

Any claim for a benefit where, to receive benefits, the Plan specifically requires approval or preauthorization from the claims administrator before obtaining medical services, such as in the case of preauthorization or prior authorization of health care items or services that the Plan requires.

If a Participant or provider calls the Plan for the sole purpose of learning whether or not a charge will be covered, that call is not considered a Pre-Service Claim, unless the Plan specifically requires the Participant to call for prior authorization. The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

If you receive services that require preauthorization or prior authorization before receiving the authorization or approval from the claims administrator, the claim will be reviewed as a post-service claim.

Preauthorization (Preauthorize or Prior Authorization)

A decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes this is also called prior authorization, prior approval or precertification. The Plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise that your Plan will cover the cost.

Qualified Medical Child Support Order (QMCSO)

Generally, a state court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is qualified. An order that is determined to be qualified is called a Qualified Medical Child Support Order (QMCSO). In addition, a state child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. For further information about QMCSOs, call the Member Contact Center.

Radiation Therapy

Outpatient treatment of disease through high-energy x-rays or radioactive substances.

Reasonable and Customary (R&C) Rates

The R&C rate for any service or supply is the usual charge of the provider for the service or supply in the absence of insurance, but not more than the prevailing charge in the geographic **area** for a **like service or supply.** CBA consults industry-wide databases, including but not limited to databases such as Fair Health.

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

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

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

In setting R&C rates, CBA considers factors such as:

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

Rehabilitation Services

Health care services that help a person maintain, restore or improve skills and functioning for daily living that have been lost or impaired because that person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.

Rescission of Coverage

A 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.

Restorative Speech Therapy

Therapy by a qualified speech therapist to restore speech loss or correct impairment due to:

- A congenital defect for which corrective surgery has been performed; or
- An injury or sickness.

Routine Patient Costs

Items and services typically provided under the Plan for a participant not enrolled in a clinical trial. Routine patient costs **do not** include:

- Investigational items, devices or related services;
- items and services that are not included in the patient's direct clinical management but instead are provided in conjunction with data collection and analysis; or
- A service clearly not consistent with widely accepted and established standards of care for a particular diagnosis.

Speech Therapist

A provider who meets all these conditions:

- Has a master's degree in speech pathology;
- Has completed an internship;
- Is licensed by the state in which he or she performs his or her services, if that state requires licensing; and
- Is not related to you or your dependent by blood or marriage.

Teladoc Consultation

Teladoc is a company that provides telehealth medical consultations. Teladoc is available 24 hours a day, 7 days a week, 365 days a year, and provides access to a national network of U.S. board-certified physicians who can resolve many acute non-emergency medical issues

and prescribe prescription drugs for a variety of acute care conditions via phone or online video consultations.

Terminal Illness

A condition that limits a person's life expectancy to six months or less.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994. Signed into law on October 13, 1994, USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. USERRA is intended to minimize the disadvantages to an individual that can occur when that person needs to be absent from his or her civilian employment in order to serve in the uniformed services.

Urgent Care Claim

Any pre-service claim for medical care or treatment for which the non-urgent care determination time periods could:

- Seriously jeopardize a patient's life, health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The attending provider who filed the claim decides whether a pre-service claim is an urgent care claim. The claims administrator defers to the attending provider's judgment. When the attending provider does not define the claim as an urgent care claim, an individual acting on behalf of the claims administrator will apply the judgment of a prudent layperson with average knowledge of health and medicine to decide whether the claim is an urgent care claim.

Note: If you need care for a condition that could seriously jeopardize your life, you should obtain such care without delay. Benefits will be determined when the claim is processed.

Urgent Care Clinic

Also known as urgent care, walk-in care, immediate care or convenient care; a category of clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent care clinics primarily treat injuries or illnesses that require immediate care but not serious enough to require an emergency room visit.

Appendix B: Preventive Drugs and Services

This Plan must cover a range of preventive services and may not impose cost-sharing (such as copayments, deductibles or coinsurance) on participants receiving these services, **if administered by an in-network provider**. These include:

Evidence-based Screenings and Counseling

The Plan must cover evidence-based services for adults that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), an independent panel of clinicians and scientists commissioned by the Agency for Healthcare Research and Quality. An "A" or "B" letter grade indicates that the panel finds there is high certainty that the services have a substantial or moderate net benefit. The services required to be covered without cost-sharing include screening for depression, diabetes, cholesterol, obesity, various cancers, human immunodeficiency virus and sexually transmitted infections, as well as counseling for drug and tobacco use, healthy eating and other common health concerns.

For additional information, visit the USPSTF website at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

Routine Immunizations

The Plan must provide coverage without cost-sharing for immunizations that are recommended and determined to be for routine use by the Advisory Committee on Immunization Practices (ACIP), a federal committee comprised of immunization experts that is convened by the CDC. These guidelines require coverage for adults and children and include immunizations such as influenza, meningitis, tetanus, Human Papillomavirus (HPV), hepatitis A and B, measles, mumps, rubella and varicella.

For additional information, visit the vaccine recommendation on the ACIP page of the CDC website at www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Preventive Services for Children and Youth

The Plan must cover without cost-sharing the preventive services recommended by the Health Resources and Services Administration's Bright Futures Project, which provides evidence-informed recommendations to improve the health and wellbeing of infants, children and adolescents. The preventive services to be covered for children and adolescents include some of the immunization and screening services described in the previous two categories, behavioral and developmental assessments, iron and fluoride supplements and screening for autism, vision impairment, lipid disorders, tuberculosis and certain genetic diseases. For additional information, view:

- Recommendations for Preventive Pediatric Health Care: www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
- Recommended Immunization Schedule for Persons Aged 0 Through 18 Years: www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf
- Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind: www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.pdf
- Recommended Adult Immunization Schedule: www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf

Preventive Services for Women

In addition to the screenings, immunizations and preventive services described above, the Affordable Care Act authorized the federal Health Resources and Services Administration to

make additional coverage requirements for women. Based on recommendations by the Institute of Medicine's Committee on Women's Clinical Preventive Services, federal regulations require the Plan to cover additional women's preventive services without cost-sharing, including well-woman visits, all U.S. Food and Drug Administration-approved contraceptives and related services, broader screening and counseling for sexually transmitted infections and HIV, breastfeeding support and supplies and domestic violence screening.

Other Diagnostic Testing or Services

Other services may be appropriate and may be covered by the Plan, subject to cost-sharing (such as copayments, deductibles or coinsurance). This list is not exhaustive and is subject to change based on evidence and recommendations of the appropriate recommending medical and scientific bodies. As a result, Plan benefits will change accordingly. Some preventive screenings are not covered due to the lack of clinical evidence for effectiveness (e.g., routine chest x-rays, full body x-rays).

If you have questions about coverage for a service that is not listed in this appendix or about any other recommended preventive service listed here, please call CBA.

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	**Adult (19+)**		**Child**
	Male	**Female**	**(0 to 18)**
Abdominal Aortic Aneurysm: Screening Clinicians should conduct a one-time screening for abdominal aortic aneurysm with ultrasonography in men ages 65 to 75 who have ever smoked.	X		
Alcohol and Drug Misuse: Screening and Behavioral Counseling Interventions Clinicians should screen adolescents and adults for alcohol or drug misuse (or both) and provide persons engaged in risky or hazardous behavior with brief behavioral counseling interventions to reduce misuse.	X	X	X
Aspirin for the Prevention of Cardiovascular Disease: Preventive Medication Clinicians should prescribe aspirin for men ages 45 to 79 when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. Clinicians should prescribe aspirin for women ages 55 to 79 when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. Clinicians should prescribe low-dose aspirin (81 mg/d) as a preventive medication after 12 weeks of gestation for women who are at high risk for preeclampsia.	X	X	

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Asymptomatic Bacteriuria in Adults: Screening Clinicians should screen for asymptomatic bacteriuria with urine culture for pregnant women at either 12 to 16 weeks' gestation or at their first prenatal visit, if later.		X	X
BRCA-related Cancer: Risk Assessment, Genetic Counseling and Genetic Testing Clinicians should screen women who have family members with breast, ovarian, tubal or peritoneal cancer using one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. **Note**: Prior authorization requirements apply to BRCA lab screening.		X	
Breast Cancer: Medications for Risk Reduction Clinicians should engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.		X	
Breast Cancer: Screening Clinicians should conduct one mammography screening (including 3-D mammography) per year for women ages 40 and older (or under 40 with a family history that may indicate increased risk for breast cancer), with or without clinical breast examination (CBE).		X	

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Breastfeeding: Support, Supplies and Counseling Comprehensive lactation support and counseling should be given by a trained provider during pregnancy or in the postpartum period. Costs for renting breastfeeding equipment should be covered for each birth. The “trained provider” must be an International Board Certified Lactation Consultant (IBCLC) designee. Covered services include counseling and lactation classes by an in-network IBCLC provider. The breast pump and related supplies must be purchased at an in-network durable medical equipment provider and are limited to one manual or electric breast pump per pregnancy. Other breastfeeding supplies such as maternity bras, nursing pads and additional bottles are excluded.		X	X
Cervical Cancer: Screening Clinicians should screen for cervical cancer in women ages 21 to 65 using cytology (pap smear) every three years. Women ages 30 to 65 who want a longer screening interval can be screened using a combination of pap smear and HPV testing every five years. High-risk HPV DNA testing in women ages 30 and older with normal pap smear results should be given every three years. Cervical dysplasia screening is covered for all sexually active females under age 18.		X	X
Colorectal Cancer: Screening Clinicians should screen for colorectal cancer in adults ages 50 to 75 using fecal occult blood testing, sigmoidoscopy or flexible sigmoidoscopy (once every five years), colonoscopy (once every 10 years) or double-contrast barium enema (once every five years). The risks and benefits of these screening methods vary.	X	X	

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Contraceptive Methods and Counseling The Plan covers FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity. Birth control pills, patches and rings for women are covered under the prescription drug benefit. Birth control methods administered by a doctor (e.g., diaphragm, implants or injections) are covered under the medical benefit and may be subject to deductible, copayment or coinsurance. Surgical birth control methods for both men and women are covered under the medical benefit and may be subject to deductible, copayment or coinsurance. Over-the-counter contraceptive methods and supplies for both men and women are not covered unless prescribed by a physician and approved by the FDA.	X	X	X
Congenital Hypothyroidism: Screening Clinicians should screen for congenital hypothyroidism in newborns ages 0 to 90 days.			X
Dental Care in Children: Screening Clinicians should prescribe oral fluoride supplementation starting from ages 6 months through 5 years, for children whose water supply is fluoride deficient. Clinicians should apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.			X
Depression: Screening Clinicians should screen for depression in adults ages 18 and older when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment and follow-up. Clinicians should screen adolescents ages 12 to18 years for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up.	X	X	X
Diabetes Mellitus (Gestational): Screening Clinicians should screen for gestational diabetes mellitus (GDM) in asymptomatic pregnant women at 24 to 28 weeks of gestation and at the first prenatal visit for those who are at high risk of developing gestational diabetes.		X	X

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Diabetes Mellitus (Type 2) in Adults: Screening Clinicians should screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	X	X	
Falls Prevention in Older Adults: Counseling and Preventive Medication Clinicians should recommend exercise or physical therapy and prescribe vitamin D supplementation to prevent falls in community-dwelling adults ages 65 and older who are at increased risk for falls.	X	X	
Folic Acid to Prevent Neural Tube Defects: Preventive Medication Clinicians should prescribe all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.		X	X
Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Clinicians should offer or refer adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	X	X	
Hemoglobinopathies (Sickle Cell): Screening Clinicians should screen for sickle cell disease in all newborns ages 0 to 90 days.			X
Hearing Loss in Newborns: Screening Clinicians should screen for hearing loss in all newborns ages 0 to 90 days.			X
Hypertension (Blood Pressure): Screening Clinicians should screen for high blood pressure in all adults, adolescents and children.	X	X	X

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Immunization for Adults Doses, recommended ages and recommended populations vary for the following immunizations: • Influenza; • Tetanus, diphtheria, pertussis; • Varicella; • Human papillomavirus (ages 19 to 26; three doses total); • Herpes Zoster (ages 50 and older; limited to one per lifetime); • Measles, mumps, rubella; • Pneumococcal conjugate; • Pneumococcal polysaccharide; • Meningococcal; • Hepatitis A; • Hepatitis B; and • Haemophilus influenzae type b. **Note 1:** Travel immunizations are covered, if recommended and administered by your in-network provider and if such immunizations meet the requirements in Note 2. **Note 2**: Certain immunizations are covered, subject to (1) FDA approval; and (2) explicit ACIP recommendation published in the CDC's Morbidity and Mortality Weekly Report (MMWR). New recommendations will typically be implemented within 60 days of publication in the MMWR. **Note 3:** Certain vaccinations are available on-site at Exclusive Choice pharmacies. Contact CVS/caremark Customer Care for more information.	X	X	

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Immunization for Children Doses, recommended ages and recommended populations vary for: • Influenza; • Tetanus, diphtheria and acellular pertussis; • Varicella; • Human papillomavirus (ages 9 to18; three doses total); • Measles, mumps and rubella; • Pneumococcal conjugate; • Pneumococcal polysaccharide; • Meningococcal; • Hepatitis A; • Hepatitis B; • Rotavirus; • Haemophilus influenzae type b; and • Inactivated poliovirus. **Note 1:** Travel immunizations are covered, if recommended and administered by your in-network provider and if such immunizations meet the requirements in Note 2. **Note 2:** Certain immunizations are covered, subject to: (1) FDA approval; and (2) explicit ACIP recommendation published in the Morbidity and Mortality Weekly Report (MMWR) of the CDC. New recommendations will typically be implemented within 60 days of publication in the MMWR. **Note 3**: Certain vaccinations are available onsite at Exclusive Choice pharmacies. Contact CVS/caremark Customer Care for more information.			X
Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening Clinicians should screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and should provide or refer women who screen positive to intervention services.		X	X

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Iron Deficiency Anemia: Screening and Preventive Medication (ages 6 to 12 months) Clinicians should routinely screen for iron deficiency anemia in asymptomatic pregnant women. Hematocrit or hemoglobin screening is covered for children under age 18. Clinicians should routinely screen for iron supplementation in asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia. Iron supplements should be recommended for children ages 6 to 12 months who are at increased risk for iron deficiency anemia.		X	X
Lead Levels in Childhood: Screening Clinicians should routinely screen for elevated blood lead levels in asymptomatic children ages 1 to 5 years who are at increased risk. Clinicians should routinely screen for elevated blood lead levels in asymptomatic children ages 1 to 5 years who are at average risk.			X
Lipid Disorders (Cholesterol, Dyslipidemia): Screening Clinicians should screen all men ages 35 and older for lipid disorders and recommend screening for men ages 20 to 35 who are at increased risk for coronary heart disease. Clinicians should screen all women ages 20 and older for lipid disorders if they are at increased risk for coronary heart disease. Clinicians should routinely screen all children at higher risk for lipid disorders.	X	X	X
Lung Cancer: Screening Clinicians should screen annually for lung cancer with low-dose computed tomography in adults ages 55 to 80 who have a 30-pack-per-year smoking history and who currently smoke or have quit within the past 15 years. Discontinue screening once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	X	X	

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Obesity: Screening and Management Clinicians should screen all adults for obesity and offer or refer patients with BMI of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions. Clinicians should screen all children (ages 6 and older) for obesity and offer or refer them to comprehensive, intensive behavioral intervention to promote improvement in weight status.	X	X	X
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication Clinicians should prescribe prophylactic ocular topical medication for all newborns (ages 0 to 90 days) to prevent gonococcal ophthalmia neonatorum.			X
Oral Health Assessment in Children: Screening Clinicians should complete an oral health risk assessment for all young children (birth to age 10).			
Osteoporosis: Screening Clinicians should screen for osteoporosis in women ages 60 and older and for women under 60 whose fracture risk is equal to or greater than that of a 60-year-old white woman with no additional risk factors. Limited to one screening per year.		X	
Palivizumab prophylaxis to prevent Respiratory Syncytial Virus (RSV): Vaccine This vaccine is limited to infants born before 29 weeks gestation and to infants with certain chronic illnesses like congenital heart disease or chronic lung disease. **Note:** To be covered under the prescription drug benefit, prior authorization requirements apply. To be covered under the medical benefit, it must be billed by the provider during the initial inpatient confinement for a premature infant.			X
Phenylketonuria in Newborns: Screening Clinicians should routinely screen for Phenylketonuria (PKU), a genetic disorder, in newborns (ages 0 to 90 days).			X

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Prostate Cancer: Screening This screening is limited to one Prostate-Specific Antigen (PSA) blood test per year, for men, on or after age 50. **Note**: While not recommended by the USPSTF, the American Urological Association recommends PSA screening, together with digital rectal examination, only after explanation of the possible advantages and harms of such screening.	X		
Rh (D) Incompatibility: Screening Clinicians should conduct Rh (D) blood typing and antibody testing for all pregnant women during their first prenatal care visit and repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.		X	X
Sexually Transmitted Infections (STIs): Behavioral Counseling Clinicians should routinely screen (and provide intensive behavioral counseling) to all sexually active women, men and adolescents who are at increased risk for STIs.	X	X	X
STIs (Chlamydia and Gonorrhea): Screening Clinicians should screen for infection for all sexually active non-pregnant women ages 24 and younger and for older non-pregnant women who are at increased risk. Clinicians should screen for infection for all pregnant women ages 24 and younger and for older pregnant women who are at increased risk.		X	X
STI (Hepatitis B): Screening Clinicians should screen for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit. Clinicians should screen for HBV infection in persons at high risk for infection.	X	X	X
STI (Hepatitis C): Screening Clinicians should screen for hepatitis C virus (HCV) infection in persons at high risk for infection. Clinicians should offer one-time screening for HCV infection to adults born between 1945 and 1965.	X	X	

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
STI (HIV): Screening Clinicians should screen for HIV infection in adolescents and adults ages 15 to 65. Younger adolescents and older adults who are at increased risk should also be screened. Clinicians should screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	X	X	X
STI (Syphilis): Screening Clinicians should screen all pregnant women and persons at increased risk for syphilis infection.	X	X	X
Skin Cancer: Counseling Clinicians should routinely counsel fair-skinned children, adolescents and young adults ages 10 to 24 about minimizing their ultraviolet radiation exposure to reduce skin cancer risk.	X	X	X
Tobacco Use: Screening and Behavioral Counseling Interventions Clinicians should ask all adults (including pregnant women) about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Clinicians should provide interventions, including education or brief counseling, to prevent tobacco use among school-aged children and adolescents.	X	X	X
Tuberculin: Screening Clinicians should conduct tuberculin testing for children ages 0 to 17 who are at higher risk for tuberculosis.			X
Visual Impairment in Children: Screening Clinicians should screen all children at least once between ages 1 and 5 years to detect amblyopia or its risk factors.			X

Preventive Service *(100% covered if administered by an in-network provider. If an out-of-network provider is used, then services are subject to the deductible and coinsurance.)*	Adult (19+)		Child
	Male	Female	(0 to 18)
Wellness Examinations (well-adult, well-woman, well-child or -baby) Examinations are subject to age, gender and frequency appropriate limitations. Well-adult preventive services include annual screenings and assessment for overall health and well-being. One well-adult physical examination is covered at no cost per year. Well-woman preventive services include preconception care and many prenatal care services. One well-woman examination is covered at no cost per year. Well-child (or -baby) examinations include, but are not limited to the establishment and maintenance of a medical history; height, weight and body mass index measurements; developmental screenings (including autism); behavioral assessments; and immunizations. Executive- and employment-related physical examinations are excluded.	X	X	X