NRECA Dental Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

Enhanced Plus Dental Plan

SEMO ELECTRIC COOPERATIVE

01-26031-003

EFFECTIVE DATE: January 1, 2019

NRECA

America's Electric Cooperatives

Introduction

Summary Plan Description

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

Your Responsibilities

You are responsible for reading the SPD and related materials completely and complying with the rules and Plan provisions described herein. The provisions applicable to the specific benefit options under this benefit Plan determine what services and supplies are eligible for benefits; however, you and your provider have the ultimate responsibility for determining what services you will receive.

While reading this material be aware that:

- The Plan is provided as a benefit to persons who are eligible to participate, as defined in the chapter titled *Eligibility and Participation Information*. Plan participation is not a guarantee or contract of employment with NRECA or with member cooperatives. Plan benefits depend on continued eligibility; and

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

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Plan Information

Plan Name

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

Plan Number:	501
Plan Type:	Enhanced Plus Dental Plan
Year End:	December 31
Plan Effective Date:	January 1, 2019

Plan Funding

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

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

Plan Administration

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

Named Fiduciary

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

Plan Sponsor

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

Plan Sponsor's Employer Identification Number: 53-0116145

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

Plan Administrator

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

Telephone number: 703.907.5500

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

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

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

Plan Trustee

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

Agent for Service of Legal Process

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

Claims Administrator

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

Chapter 1: Contact Information

For Information About	Contact
• **Claims** • **Preferred dental providers**	**United Medical Resources (UMR)** P.O. Box 30515 Salt Lake City, Utah 84130-0515 **PPO USA/Connection Dental** 877.277.6872 ppousa.com
Authorization of dental services	**Participants** Cooperative Benefit Administrators, Inc. (CBA) 866.673.2299, option 1 contactcenter@nreca.coop Cooperative.com **Providers** UMR 877.233.1800
General benefit questions • Eligibility • Enrollment • When coverage begins or ends • Cost of coverage • Family Medical Leave Act (FMLA)	**Benefits Administrator** SEMO ELECTRIC COOPERATIVE P.O. BOX 520 SIKESTON, MO 63801
COBRA Administrator	**UMR** **COBRA Administration** PO BOX 1246 Wausau WI 54402
Designating an Authorized Representative	**NRECA Privacy Officer** 4301 Wilson Boulevard Arlington, VA 22203-1860 Telephone: 703.907.6601 Fax: 703.907.6602 Email: privacyofficer@nreca.coop

Chapter 2: Enhanced Plus Dental Plan Highlights

Dental Service	Plan Pays[1]	Deductible Applies?	Benefit Maximum[3]
Preventive and diagnostic services	100%	No	$2,000
Basic services[2]	100%	Yes, $50 per person.	$2,000
Major services[2]	80%	Yes, $50 per person.	$2,000

[1] *Eligible charges are subject to reasonable & customary (R&C) rates for a covered service. You will be responsible for 100% of any other costs or charges, including eligible charges above R&C rates. See the chapter titled* How The Plan Works *for the definition of R&C rates. Please review the remainder of this SPD for full details.*

[2] *The Deductible is a combined amount for basic and major services.*

[3] *For all pediatric dental services, other than orthodontia, annual benefit maximums do not apply.*

Dental Service	Plan Pays	Deductible Applies?	Benefit Maximum	Who is Eligible
Orthodontia	50%	No	$2,000 lifetime benefits per eligible person.	All those enrolled in the Plan

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

To be eligible to participate in this Plan:

- You must be in a benefits-eligible classification;
- If your status is “active Employee,” you must also satisfy one of the hours of service requirements for active Employees; and
- Have satisfied the Eligibility Waiting Period, if applicable.

Benefits-eligible Classifications

The following participant classifications are eligible for benefits:

- Active Employees;
- Dependents of Employees;
- Disabled Employees receiving Employer-sponsored long-term disability (LTD) benefits;
- Dependents of disabled Employees receiving Employer-sponsored LTD benefit;
- Under age 65 retired Employees (if covered by the Plan at the time of retirement);
- Under age 65 dependents of retired Employees (if covered by the Plan at the time of retirement);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) beneficiaries; and
- Employees on approved leave of absence (see the chapter titled *Your Benefits During a Leave of Absence* for details).

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

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

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

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

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

See your benefits administrator if you have questions about eligibility.

Hours of Service Requirement for Active Employees

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

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

- At the time of annual enrollment, you have worked at least 1,000 hours for your Employer in the preceding calendar year.

Coverage for Your Dependents

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

Eligible dependent(s) must be:

- Your spouse. Spouse means the person to whom a participant is legally married under applicable state law, provided that such marriage is recognized as a legal marriage by the state in which the participant's Employer has its principal place of business;
- Your child* (married or unmarried), up to age 26 who is:
    - Your biological child;
    - Your stepchild by marriage;
    - Adopted by you (or placed for adoption with you); or
    - A child for whom you have legal guardianship;
- Your child* who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under your group health plan (if the child is eligible as stated above); or
- Your incapacitated adult child*.

*****Your dependent child's coverage will end at 11:59 pm on the last day of the month in which he or she reaches age 26.

Eligibility Requirements for Incapacitated Adult Children

If your child:

- Is at least 26 years of age;
- Is unmarried;
- Qualifies as your tax dependent on an annual basis because he or she is permanently and totally disabled (as defined by the Internal Revenue Service (IRS) in Publication 501); **and**
- Has been continually covered as your eligible dependent under the NRECA Dental Plan or other insurer since becoming an incapacitated adult child.

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

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

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

You and Your Spouse or Child Work for Participating Employers

One person cannot be simultaneously covered under the Plan as an Employee, Director or retiree and as a spouse or child. Also, an individual may not be covered under more than one NRECA-sponsored Dental Plan at one time.

Current Spouse

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

- You enroll in individual coverage while your spouse and dependent children enroll in family coverage;
- Your spouse enroll in individual coverage while you and your dependent children enroll in family coverage;
- You enroll in family coverage (including your spouse and eligible-dependent children) and your spouse has no coverage under his or her own employment record; or
- Your spouse enroll in family coverage (including you and your eligible dependent children) and you have no coverage under your own employment record.

Former Spouse

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

- **Your** enrollment election includes your jointly eligible dependent children. Therefore, your former spouse's enrollment election must **exclude** your jointly eligible dependent children; or
- Your **former spouse's** enrollment election includes your jointly eligible dependent children. Therefore, your enrollment election must **exclude** your jointly eligible dependent children.

If You Are Both a Retiree and an Employee

If you are a retiree **and** an Employee of a participating Employer and are eligible for coverage separately (as an Employee, retiree, Director or Retained Attorney), you are not permitted to be covered under more than one NRECA-sponsored Dental Plan at the same time. Rather, you must choose to be covered as either an Employee, retiree, Director or Retained Attorney.

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

- **Your** enrollment election includes your jointly eligible dependent children. Therefore, your former spouse's enrollment election must **exclude** your jointly eligible dependent children; or
- Your **former spouse's** enrollment election includes your jointly eligible dependent children. Therefore, your enrollment election must **exclude** your jointly eligible dependent children.

If Your Dependent Child Is Also an Employee

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

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

Eligibility Waiting Period

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

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

Your Plan's Eligibility Waiting Period

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

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

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

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

Rehired Former Employees and Rehired Retirees

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

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

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

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

Note: If part-time employment is a benefits-eligible status at your Employer and you are rehired into a part-time position, then you must also satisfy the 1,000 hours of part-time service requirement.

Health ID Card

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

When Coverage Begins (Participation Date)

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

Cost of Coverage

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

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

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

Making Changes During the Year and Special Enrollment

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

Also, if you decline coverage during your initial enrollment period and later experience one of the events listed here, you may qualify to add coverage for yourself and your eligible dependents. If you have a qualifying event, you will have 31 days from the date of the event to make a request for enrollment or disenrollment. New dependents may be enrolled, as indicated, if they satisfy the requirements for eligibility under the Plan.

Events include:

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

Such coverage, if elected on a timely basis, will be effective retroactively to the date of the divorce, marriage, birth, adoption, placement for adoption or legal guardianship. If you, as an Employee, or your spouse is not currently enrolled, you may enroll yourself and your spouse when you enroll a new dependent child.

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

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

Losing Other Coverage

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

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

- You, as an active Employee, or your dependents were covered under another group or individual dental plan or another group or individual dental insurance policy (through or outside of a Marketplace) at the time you were eligible for dental coverage from your Employer, and you or your dependents lose such coverage through no fault of your/their own; or
- You, as an active Employee, or your dependents lost the other group dental coverage because you exhausted COBRA continuation coverage, and you were either no longer eligible under that plan or an Employer's contributions under that plan stopped.

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

Special Rules for Retirees and Their Covered Dependents

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

If you are the covered dependent of a retiree who is currently enrolled in the Plan and you are under age 65, you are eligible for special enrollment upon marriage or acquisition of a new dependent by marriage, adoption, birth, placement for adoption or legal guardianship.

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

Special Enrollment Rights Under CHIP

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

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

- If you or your dependents become eligible for coverage under your state's CHIP or Medicaid program, you and your dependents have the right to withdraw from this Plan the first day of the month after you give notice to your Employer.

Qualified Medical Child Support Order (QMCSO)

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

When Coverage Ends

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

Your coverage (and your dependents' coverage) for Plan benefits ends if:

- You fail to pay your share of the premium;
- Your hours worked drop below the required eligibility threshold;
- You are no longer in a status that is eligible to participate in the Plan;
- You or your dependents submit false claims or misuse health ID cards;
- You or your dependents intentionally misrepresent a material fact concerning eligibility for coverage or benefits under the Plan, or you or your dependents commit fraud to obtain coverage or benefits under the Plan. In either case, termination of coverage will be retroactive to the date of ineligibility, and you (or your dependents) will receive 30 days' advance written notice of coverage termination. See the *Rescission of Coverage* section below. An intentional misrepresentation of fact includes, but is not limited to your failure to report a divorce, a change in your dependent's eligibility status or any other change in eligibility status in accordance with the terms of the Plan;
- Your uncompensated leave of absence exceeds the thresholds outlined in the chapter titled *Your Benefits During a Leave of Absence*.
- **If you retire after age 65**, your coverage ends on the later of either your last day of employment or the last day of the month, if you elect retiree coverage.
- **If you retired prior to age 65**, coverage ends on the last day of the month prior to when you turn 65 unless your birthday falls on the first day of the month. In that case, your coverage ends on the last day of the second month prior to your 65th birthday.
- **If you are the dependent spouse of a retiree**, your coverage ends the last day of the month prior to when you turn 65 unless your 65th birthday falls on the first day of the month. In that case, your coverage ends on the last day of the second month prior to your 65th birthday.
- **If you are the dependent child of a retiree**, your coverage ends when you no longer meet the Plan's dependent child eligibility requirements.

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

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

In these cases, coverage for your spouse and children ends when your coverage ends. Dependent coverage also ends:

- For a spouse, upon divorce;
- For any dependent, when he or she no longer meets dependent eligibility requirements;
- When you voluntarily make a permitted election to drop coverage of a covered dependent; or
- When your covered dependent dies.

Rescission of Coverage

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

The following coverage terminations are **not** rescissions of coverage, and do not require the Plan to give you 30 days' advance written notice of coverage terminations if:

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

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

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

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

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

Misuse of Plan Health ID Card

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

Continuation of Coverage

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

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

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

The Plan's Right to Audit

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

Chapter 4: Your Benefits During a Leave of Absence

General Information

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

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

Your leave of absence may be protected under either the **Family Medical Leave Act** (FMLA) or the **Uniformed Services Employment and Reemployment Rights Act of 1994** (USERRA). Please refer to the specific sections describing each of these leave types for applicable information.

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

Compensated and Uncompensated Leave of Absence

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

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

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

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

Eligibility to Participate During Your Leave of Absence

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

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

Note: If you participate in your Employer's long-term disability (LTD) plan and you either have a claim pending with that plan (whether an initial claim, a claim for which an appeal is

pending or a claim for which the appeals filing deadline has not expired) or you are waiting for the LTD plan's Benefit Waiting Period to end, then your eligibility to participate in this Plan continues as long as the required premium is paid. If your LTD claim is approved, continued eligibility to participate in this Plan depends on your Employer's policy. If your LTD claim is denied, then your eligibility to participate in this Plan ends on either the date your initial claim is denied or the date your claim is denied on appeal.

Annual Benefits Enrollment

When you are on a leave of absence and are eligible to continue to participate in this Plan, you may generally make benefit elections (subject to all enrollment provisions of the Plan) during the annual benefits enrollment period for the upcoming Plan year. Benefits elected during the annual benefits enrollment period and corresponding costs for coverage become effective January 1 of the following year. However, if during the annual benefits enrollment period you elect a benefit option with an Actively at Work requirement and then, on the following January 1, you are on a leave of absence, your coverage effective date will be delayed until you return to work in a benefits-eligible position.

Paying for Benefits During Your Leave of Absence

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

Returning From a Leave of Absence

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

If your benefits coverage was terminated due to nonpayment of premiums while you were on an approved leave of absence and you return to work immediately following your approved leave, then you may re-enroll in this Plan within **31 days** of the date you return work.

When you re-enroll within the 31-day period, most changes in coverage and corresponding costs will be effective on the date of your qualifying event. If you do not re-enroll within 31 days of the date you return to work, you cannot re-enroll until you experience a subsequent qualifying event or during the next annual benefits enrollment period. For details, see the section titled *When You Can Enroll (or Make Changes)* in the *Eligibility and Participation* chapter.

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

If You Terminate Employment While on a Leave of Absence

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

Workers' Compensation

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

Family Medical Leave Act (FMLA)

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

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

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Military Leave of 31 or Fewer Days

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

Military Leave Longer Than 31 Days

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

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

If you drop your coverage when you start military leave, or if your coverage lapses or terminates due to nonpayment, and you later return to work in a benefits-eligible position within the applicable job reinstatement period, then your coverage and contributions can be reinstated to the extent required by USERRA. Coverage is effective upon your reemployment. If you do not reinstate your coverage within 31 days of your reemployment, then you must wait until the next annual benefits enrollment period to reenroll, unless you have an applicable special enrollment right, life event or employment event. For more information, see the sections titled *Special Enrollment Rights Under CHIP* and *Life and Employment Events* in the *Eligibility and Participation Information* chapter.

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

Chapter 5: Enhanced Plus Dental Plan Benefits

How the Plan Works

This Plan covers preventive and diagnostic services to encourage you and your covered dependents to maintain healthy teeth. It also covers basic and major restorative services to repair teeth. Orthodontic services to help straighten teeth are also included. The section in this chapter titled *What the Plan Covers* provides a detailed list of the services covered under each of these major categories.

The Dental PPO Network

Under this Plan, you may visit any licensed Dentist; however, NRECA has partnered with Connection Dental PPO network for discounted dental services. Connection Dental has a group of participating dental providers. A Connection Dental PPO network logo appears on your health ID card to let providers know you qualify for a discount. Your *Explanation of Benefits* notice will reflect the dental PPO network discount.

If you are eligible to participate in the Plan, you and your eligible dependents may go to any dental provider; however, if you use a provider who participates in the dental PPO network, you are eligible to receive a discount on covered services.

Remember these facts about the dental PPO network:

- Dental PPO network providers are not affiliated with, have not been selected by, and have no contract with your employer. The Plan pays network Dentists according to contracted rates and these rates apply only to dental network providers;
- Neither the Plan nor your Employer provide or guarantee the quality of the dental care that you or a covered dependent receive; and
- You always have the choice of what services you receive and who provides your care, regardless of what the Plan covers or pays.

To identify which providers participate in the Connection Dental PPO network:

- Refer to the dental logo on your health ID card;
- Review the most current list of preferred providers online at ppousa.com; or
- Call PPO USA at 877.277.6872 for assistance.

Reasonable and Customary (R&C) Rates

The R&C rate for any service or supply is the usual charge for the service or supply in the absence of insurance, but not more than the prevailing charge in the geographic area for a like service or supply.

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) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service or supply.

When setting R&C rates, CBA consults industry-wide databases, including but not limited to Fair Health. CBA also considers factors such as:

- The nature and duration of the service;
- The skill required to perform that service;
- The training and experience of the provider who performs the service; and

- The dental supplies necessary for the treatment or service.

Covered Services

This Plan is designed to cover charges for dental services that produce a professionally satisfactory result, not treatment that is more expensive than needed for good dental care.

The Plan covers all or a portion of eligible charges. An eligible charge is the amount charged by a Dentist for a covered service for you or for your covered dependent. In order to be an eligible charge, the expense must be for a service that is:

- On the list of dental services provided under the Plan;
- Part of a treatment plan; and
- Not excluded by the Plan (see the sections in this chapter titled *General Exclusions and Specific Exclusions*).

If you have questions about whether a dental service charge is an eligible charge, please contact CBA.

Evaluation of Services

When evaluating submitted or billed charges to determine which are eligible, the Plan also reviews 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.

Cost-sharing

In most cases, when you or a covered dependent obtain dental care, you and the Plan will share the cost of that care in one or more ways.

The Deductible

The Deductible for this Plan is $50.

The Deductible is the combined amount that you or a covered dependent must pay each calendar year for eligible basic and major dental services before the Plan will pay benefits (see the sections later in this chapter that describe basic and major services). Deductibles do not apply to preventive and diagnostic covered dental services.

Coinsurance

For some dental treatments and services, you and the Plan will share the cost of expenses once any required 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.

Below is a summary of how you and the Plan share the cost of certain services:

- The Plan will pay 100% of the cost of preventive and diagnostic services up to the R&C rate* or the negotiated fee agreed to by the dental PPO provider for dental services;

- The Plan will pay 100% up to the R&C rate* or the negotiated fee agreed to by the dental PPO provider for basic dental services after the $50 Deductible has been satisfied each calendar year; and

- The Plan will pay 80% up to the R&C rate* or the negotiated fee agreed to by the dental PPO provider for major dental services after the $50 Deductible has been satisfied each calendar year.

- The Plan will pay 50% of the costs of covered orthodontic treatment for an eligible person, up to the lifetime orthodontic benefit maximum of $2,000.

***** *If your provider's charges exceed R&C rates, you will be responsible for any amounts over those rates.*

Annual and Lifetime Benefit Maximums

The annual benefit maximum is the amount the Plan will pay in benefits for a covered person in a year for combined preventive and diagnostic, basic and major dental services. These are important maximum(s) to keep in mind. Please see the annual benefit maximums for your Plan benefits listed below:

- The Plan will pay a maximum of $2,000 per person per calendar year in dental benefits for combined dental services other than orthodontia.

- The Plan will pay a maximum of $2,000 in benefits for orthodontia in an eligible person's lifetime.

Note: Pediatric Dental Services are not subject to the annual benefit maximums (see *Pediatric Dental Services* in this chapter).

Dental Treatment Plans

If you and your Dentist expect a particular course of treatment to cost $300 or more, the Dentist should first submit a dental treatment plan to CBA to obtain a pre-treatment approval and estimate of Plan benefits. The purpose of the treatment plan is to avoid any misunderstanding about what the Plan will cover.

The treatment plan must be submitted to CBA and must include:

- Each of the Dentist's recommended services;
- The Dentist's charge for each service; and
- X-rays or any other documentation that CBA requests or requires.

CBA will review the dental treatment plan and consider alternate benefit services that may also be suitable for the treatment of a specific condition in accordance with customary dental practices. After reviewing the treatment plan, CBA will return it to the Dentist outlining the estimated benefits available from the Plan. This will help you and the Dentist to understand in advance what the Plan will pay and the charges for which you will be responsible.

Providers should submit an orthodontic treatment plan before providing orthodontic treatment for covered individuals. See the section titled *Orthodontia* in this chapter for more information.

An alternate benefit service will apply:

- If the Plan determines that a less expensive alternative procedure, service, or course of treatment can be performed in place of the proposed treatment to correct a dental condition; and
- If the alternative treatment will produce a professionally satisfactory result.

The maximum allowable amount will be the R&C rate for the less expensive treatment option.

Be sure to discuss treatment options with your Dentist and obtain a pre-treatment estimate of benefits from CBA before receiving services.

When a Charge is Incurred

The table below shows when the Plan considers a charge to have been incurred:

Service	The Charge is Incurred On
An appliance or modification of an appliance	The impression preparation date
A crown, bridge or gold restoration	The impression preparation date
Implants	The date the implant was placed
A root canal therapy	The date the pulp chamber is opened
All other services	The date the service is received
Orthodontia	**The date orthodontic appliances are first installed**

Medically Necessary Services and Supplies

This Plan covers only services and supplies that are considered Medically Necessary. To be considered Medically Necessary, dental services or supplies must be:

- Ordered by a Dentist;
- Commonly and customarily recognized as appropriate for proper dental care and treatment;
- Neither educational nor experimental in nature; and
- Not furnished mainly for the purpose of dental or other research.

What the Plan Covers

The Plan covers preventive and diagnostic services, basic and major restorative services, and orthodontia.

Preventive and Diagnostic Services

Preventive and diagnostic services include visits to a Dentist, dental examinations, x-rays, and pathology and sealants. For information about what the Plan pays, please see the chapter titled *Dental Plan Highlights*.

Visits and Examinations

- Professional visits during office hours for oral examination (but not more than two visits per person per calendar year);
- Professional visits after office hours (payment will be made on the basis of services rendered or the visit, whichever is greater);
- Consultation with a specialist for case presentation when diagnostic procedures have been performed by a general Dentist;
- Emergency palliative treatment;
- Teeth cleaning (prophylaxis):
  - For children under age 14 (limited to two cleanings per calendar year);
  - For individuals age 14 and older, including scaling and polishing (limited to two cleanings per calendar year); and
- Topical fluoride application, including prophylaxis (limited to children under age 19 and limited to one course of treatment per year).

X-rays and Pathology

- Bitewing x-rays—two films or four films— (limited to one set of bitewing x-rays per calendar year);
- An entire denture series—14 or more films including bitewings, if necessary (limited to once every three years) or Panorex—one single film of the full mouth (limited to once every three years);
- Single films; additional films (up to 12 each);
- Intraoral, occlusal view, maxillary or mandibular, each;
- Upper or lower jaw, extraoral: one film or two films;
- Biopsy and examination of oral tissue;
- Microscopic examination; and
- Diagnostic casts.

Sealants

- Children under age 19;
- Permanent molar teeth; and
- One application per tooth every 24 months.

Space Maintenance

- Space Maintainers

Basic Services

Basic dental services include fillings, restorative repairs, oral surgery, general anesthesia, periodontics, and endodontics. For information about what the Plan pays, please see the chapter titled *Dental Plan Highlights*.

Restorations (fillings)

- Amalgam (primary permanent teeth) cavities involving one surface, two surfaces, or three or more surfaces;
- Silicate cement;
- Plastic;
- Composite—cavities involving one surface, two surfaces, or three or more surfaces; and
- Pins (retention) when part of the restoration used is another metal instead of gold for crown restoration.

Multiple restorations in one surface will be considered a single restoration.

Resin-based Composite Crowns

Other Restorative Procedures

- Denture repair:
  - Full and partial denture repairs;
  - Broken dentures (with no teeth involved);
  - Partial denture repairs (metal); and
  - Replacing missing or broken teeth (each tooth).
- Re-cementing of inlays, crowns, bridges.

Occlusal Guards

- Occlusal guards designed to treat and minimized the effects of bruxism (grinding). Occlusal guards are limited to one per 12 consecutive month period.

Oral Surgery

- Extractions:
  - Uncomplicated extractions;
  - Surgical extractions of erupted teeth;
  - Surgical extractions of impacted teeth—soft tissue, partially bony, completely bony; and
  - Post-operative visits (for sutures and complications) that are necessary after multiple extractions and impaction.
- Alveolar or gingival reconstructions:
  - Alveolectomy (edentulous) per quadrant;
  - Alveolectomy (in addition to the removal of teeth) per quadrant;
  - Alveoplasty with ridge extension, per arch;
  - Removal of exostosis;
  - Excision of hyperplastic tissue, per arch; and
  - Excision of pericoronal gingival.
- Cysts and neoplasms:
  - Incision and drainage of abscess; and
  - Removal of cysts or tumors.
- Other surgical procedures:
  - Closure of salivary fistula;
  - Removal of foreign body from bone (independent procedure);
  - Maxillary sinusotomy for removal of tooth fragment or foreign body;
  - Closure of oral fistula or maxillary sinus;
  - Sequestrectomy for osteomyelitis or bone abscess, superficial;
  - Crown exposure to aid eruption;
  - Removal of foreign body from soft tissue; and
  - Frenectomy (under lip only).

General Anesthesia

General anesthesia is covered as a basic dental service under the Plan:

- When provided in conjunction with a surgical procedure that is covered under the Plan;
- For children age six and under; and
- Under the following circumstances:
  - Intellectual disability;
  - Neuromuscular disease (spastic disease);
  - Allergy to local anesthesia; and
  - Infections at the site rendering local anesthesia ineffective for individuals aged seven and older.

Contact CBA for additional information.

Periodontics

- Emergency Treatment (periodontal abscess, acute periodontitis, etc.);

- Subgingival curettage or root planing and scaling, per quadrant (limited to four quadrants of each) per year;
- Correction of occlusion related to periodontal surgery, per quadrant;
- Gingivectomy (including post-surgical visits) per quadrant;
- Gingivectomy, osseous or muco-gingival surgery (including post-surgical visits) per quadrant; and
- Gingivectomy, treatment per tooth (fewer than six teeth).

Patients who have completed periodontal treatment (surgical or non-surgical periodontal therapies including scaling and polishing of the teeth, and a periodontal evaluation) are eligible for up to four periodontal maintenance visits per calendar year.

Anti-microbial Medications

Anti-microbial medication(s) (localized delivery, not the administration of antibiotics) are covered if certain periodontal procedures occurred during the prior twelve (12) months.

Endodontics

Endodontics is a branch of dentistry that is concerned with diseases of the pulp. The limits shown below are for one tooth, unless otherwise indicated:

- Pulp capping;
- Therapeutic pulpotomy, in addition to restoration;
- Vital pulpotomy;
- Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only; and
- Root canals (devitalized teeth only), including necessary x-rays and cultures, but excluding final restoration:
    - Single rooted canal therapy (traditional or Sargenti method);
    - Bi-rooted canal therapy (traditional or Sargenti method);
    - Tri-rooted canal therapy (traditional or Sargenti method);
    - Apicoectomy, including filling of the root canal; and
    - Apicoectomy (separate procedure).

Major Services

Major dental services include inlays, crowns, pontics (artificial teeth), restorative repairs, removable bridges, dentures, partial dentures, and implants. See the sections in the chapter titled *General Exclusions and Specific Exclusions* for limits on covered charges. For information about what the Plan pays, see the chapter titled *Dental Plan Highlights*.

Note: Gold restorations and crowns are covered only as treatment for decay or traumatic injury. They are covered only when teeth cannot be restored using filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

Inlays

- One, two, three or more surfaces; and
- Onlay, in addition to the inlay allowance.

Crowns

- Porcelain, porcelain with gold, or porcelain with non-precious metal;
- Non-precious metal (full cast);

- Gold (full cast, 3/4 cast or dowel pin); and
- Stainless steel.

Restorative Repairs

- Adding teeth or a partial denture to replace extracted natural teeth:
  - First tooth;
  - First tooth with clasp;
  - Each additional tooth and clasp; and
- Repairs of crowns and bridges.

Pontics (artificial teeth)

- Cast gold (sanitary);
- Cast non-precious metal;
- Slotted facing (Steele's);
- Slotted pontic (Tru-pontic type);
- Porcelain fused to gold or non-precious metal; and
- Plastic fused to gold or non-precious metal.

Removable Bridges

Benefits for removable bridges include coverage for all types of one piece casting, gold or chrome cobalt alloy clasp attachments per unit (including pontics).

Dentures and Partials

- Complete upper or lower dentures;
- Partial acrylic upper or lower dentures with chrome alloy cobalt clasps, base, all teeth and two clasps as well as each additional clasp;
- Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps as well as each additional clasp;
- Simple stress breakers, extra;
- Stayplate, base (each additional clasp);
- Office reline, cold cure, acrylic;
- Laboratory reline;
- Special tissue conditioning, per denture; and
- Denture duplication (jump case), per denture.

For dentures and partials, Plan benefits also include adjustments that are needed after installation.

Implants

- Implant supported prosthetics;
- Surgical placement of the implant body. This global procedure includes the second stage surgery, and the placement of the healing cap;
- Abutment procedures;
- Final prosthesis; and
- Repair, removal, and maintenance of implants once in a 12 month period.

Pediatric Dental Services

Pediatric dental services are services for individuals under age 19. These include preventive and diagnostic services, basic services and major services. Both Deductibles and

Coinsurance apply. Benefits for these services do not count toward the annual maximum benefit limit. Frequency limits, such as those for diagnostic and preventive care, still apply. Pediatric dental services exclude orthodontia.

Orthodontia

Orthodontia benefits are available for all eligible Employees and enrolled dependents (see the section titled *Coverage for Your Dependents* in the *Eligibility and Participation* chapter).

The Plan will pay 50% of covered charges for orthodontia services, up to a lifetime orthodontic benefit maximum of $2,000.

Eligible Orthodontic Charges

Orthodontic charges are considered eligible charges (defined in the section titled *How The Plan Works*) only when treatment is required for an overbite of at least four millimeters, a cross bite, or a protrusive or retrusive relationship of at least one cusp.

Orthodontic Treatment Plans

Before treatment starts, your Dentist must submit an orthodontic treatment plan to CBA that:

- Describes the recommended treatment;
- Outlines the estimated charges for the treatment; and
- Includes cephalometric x-rays, study models and other supporting evidence that treatment is needed.

Payment Schedules for Orthodontic Benefits

Charges for orthodontic services are considered incurred on the date that the appliances are first installed. The initial banding fee will be paid when CBA is notified that bands have been placed. The initial reimbursement will be up to a maximum of 25% of the total cost of the treatment plan. The remaining program balance will be paid in equal monthly installments over the duration of the treatment program, not to exceed 24 months.

Orthodontic treatment is covered for an Employee or dependent who meets the Plan's eligibility requirements, regardless of age.

Coverage While Traveling Outside the United States

In order for a service obtained outside the United States to be covered under the Plan, these requirements must be met:

- The service must be a recognized service in the United States;
- All provider billings and records must be translated into English;
- Bills must clearly show the patient’s name, provider’s name, date of service, diagnosis and a description of the services rendered; and
- The current currency exchange rate needs to be provided with the bill showing the daily rate for the dates the services were rendered. If you pay for services using a credit card, the card service will automatically translate the expenses into United States currency at the prevailing rate.

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

General Exclusions

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

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

The Plan does not cover charges for the following specific items:

Cosmetic Dentistry

Cosmetic dentistry refers to dental treatments and services that are solely for the purpose of improving appearance. The Plan will not cover charges incurred for cosmetic purposes unless the service is necessary due to an Accident that occurred while the patient was covered under the Plan.

Crowns

The Plan will not cover charges incurred for a crown, inlay or onlay, gold restoration, denture or fixed bridge (or addition of teeth to one) if the work involves a replacement or modification of a crown, inlay or onlay, gold restoration, denture, or fixed bridge that was installed within the preceding seven years.

Dentures

The Plan will not cover charges incurred for a denture or fixed bridge that involves replacing teeth that were missing before the patient was covered. The only exception is to replace a tooth that was extracted while the patient was covered, if that tooth was not an abutment for a denture or fixed bridge installed within the preceding seven years.

Implants

The Plan will not cover charges for implant supported prosthetics more than once for the same tooth position in seven years. The Plan will not cover charges for an implant that will

replace a bridge, denture, or other prosthesis, when such bridge, denture, or other prosthesis was installed within the preceding seven (7) years.

Missing Teeth

The Plan will not provide benefits to replace or treat areas where there were congenitally missing teeth or teeth that were missing at the time you or your family members began coverage under the Plan.

Prior Services and Supplies

The Plan will not cover charges for the following services and supplies that were provided before the patient was covered:

- Any appliance, or appliance modification for which the impression was made before coverage began;
- Crowns, bridges or gold restorations for which the tooth was prepared before coverage began; or
- Root canal therapy if the pulp chamber was opened before coverage began.

Replacements

The Plan will not cover charges to replace lost or stolen appliances.

Splinting and Occlusion

The Plan will not cover any charge for appliances or restoration for the purpose of splinting, or to increase vertical dimension or restore occlusion due to erosion or attrition.

Transplantations

The Plan will not cover any charge for the transplantation of a tooth or tooth bud.

Orthodontia

The Plan will not cover charges for orthodontic procedures related to an active appliance that was installed before the patient became covered, except when eligible Plan participants were covered under the member cooperative's prior dental orthodontic plan. This orthodontic exception applies only to those patients who had orthodontic coverage with their cooperative’s prior dental plan and had no lapse of coverage between the member cooperative's prior dental plan and the NRECA Plan.

Under this exception, any amounts paid under the prior dental plan will be applied to the maximum orthodontia benefit allowable under the Plan, so that the total orthodontia benefit does not exceed the Plan’s lifetime benefit maximum. In order to determine what the prior dental plan has paid, this Plan will require (from the orthodontist) a copy of the orthodontic treatment plan along with up-to-date copies of all Explanation of Benefits (EOB) notices that reflect the charges and paid amounts.

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.

Occupational Injury, Sickness or Disease

In most cases, the Plan will not cover charges associated with:

- Injury, sickness or disease that arises out of, or in the course of, any employment for wage or profit; or

- Injury, sickness or disease that is covered by any workers' compensation law, occupational disease law or similar law.

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

- Payment has not been made by the party responsible for payment of occupational injury, sickness or disease charges;
- There is a dispute between you and the party responsible for the payment of occupational injury, sickness or disease charges as to whether the charges are payable by such party or regarding the amount that should be paid by such party;
- You have exhausted your administrative remedies under the applicable workers' compensation law, occupational disease law or similar law (*i.e.*, by requesting every available review or appeal of any claim denial); and
- you (or, if incapable, your legal representative) agree in writing on forms provided by CBA to repay the Plan any benefits advanced to you by the Plan within 30 days of your receipt of any future payments made by, or on behalf of, the party responsible for the payment of the occupational injury, sickness or disease benefits. If you do not repay the Plan within 30 days of your receipt of such benefits, the Plan may take legal action to pursue repayment plus interest 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 paid within 30 days of your receipt of the other benefits. The Plan may also seek to recover its costs and attorney's fees incurred to enforce this repayment provision.

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

Services Not Furnished by a Dentist

The Plan will not cover charges for any dental treatment or service not furnished by a Dentist. The only exceptions are for x-rays ordered by a Dentist or for services by a licensed dental hygienist under a Dentist's supervision.

Non-covered Services

The Plan will not cover any dental service or supply that is not included on the list of covered dental services mentioned in this document.

Temporomandibular Joint (TMJ)

The Plan will not cover any charges incurred for treatment of the temporomandibular joint. This includes diagnostic and splint therapy or any other treatment not involving the teeth.

Coordinating Benefits with Other Plans

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

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

Participants are required to notify the Plan if they are personally covered under any other dental plan by calling NRECA's Member Contact Center (MCC) at 866-673-2299 or by emailing them at ContactCenter@nreca.coop. Under the general coordination of benefits rule, the total benefits paid by all plans will not exceed 100% of allowable expenses. An allowable expense for coordination of benefits means any necessary expense covered at least in part by the NRECA Dental Plan.

Primary and Secondary Plans

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

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

- **Employee and dependent coverage:** The plan covering an individual, other than as a dependent, is primary to the plan covering an individual as a dependent;
- **Dependent child coverage when parents are not separated or divorced:** The plan of the parent whose birthday falls earlier in the calendar year will be primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary;
- **Dependent child coverage when parents are separated or divorced:** The parents' plans pay in this order:
    1. The responsible parent's plan, if a court decree has established financial responsibility for the child's health care expenses;
    2. The custodial parent's plan;
    3. The stepparent's (i.e., the custodial parent's spouse's) plan; or
    4. The non-custodial parent's plan;
- **Active and inactive employment:** The plan covering an individual through active employment is primary to the plan covering the individual through retirement or layoff status; or
- **Longer or shorter length of coverage:** If none of the above applies, then the plan covering the individual for the longest period is primary.

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

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

Coordination With Medicare

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

Here's how to determine if this Plan is primary or secondary:

- This Plan is the primary plan (and Medicare is secondary) if you are:
    - Actively at Work (for example, if you have not yet retired);
    - Disabled and have not yet qualified for Medicare coverage; or
    - Within the first 30 months of your Medicare coverage for kidney dialysis treatment or a kidney transplant;
- This Plan is the primary plan (and Medicare is secondary) if you are an active Employee who has a Medicare-eligible dependent enrolled in the Plan, unless your dependent is

qualified for Medicare coverage after the first 30 months of his or her Medicare coverage for kidney dialysis treatment or a kidney transplant; and

- Medicare is the primary plan (and this Plan is secondary) after the first 30 months of your Medicare coverage for kidney dialysis treatment or a kidney transplant..

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

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

Chapter 6: Claims and Appeals

General Information

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

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. Follow these procedures for all claims for benefits under the Enhanced Plus Dental 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
Filing a claim	**UMR** PO Box 30515; Salt Lake City, UT 84130-0515 877.233.1800
Filing an internal appeal	**CBA – Appeals Administrator** P.O. Box 6249 Lincoln, NE 68506 866.673.2299 (phone) 402.483.9201 (fax)

Claims and Appeals Contacts	
Type	**Name and Address**
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 who you designate in writing to represent you in the claims or appeals process. Once designated, an Authorized Representative (including your physician) may then file a claim or an appeal on your behalf or represent you in the process. For purposes of this chapter, references to "you" may include your Authorized Representative or provider if your provider is submitting a claim or appeal on your behalf.

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

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.

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 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* notice from your primary payer.

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

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

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

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

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

Claim Determinations, Extensions and Requests for Additional Information

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

If your claim cannot be processed because you did not provide sufficient information, the claims administrator will notify you 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 both an Internal Appeal Process and an External Review process that applies to certain Adverse Benefit Determinations. Generally, you must exhaust the Internal Appeal Process before seeking an External Review or bringing a civil action under Section 502(a) of ERISA.

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

Documenting Your Appeal

The information in this section applies to both internal and external appeals. For purposes of this explanation, 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 (i.e., the Enhanced Plus Dental Plan);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

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

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

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

Note: Include all information that you want the reviewer to consider at the time you file your appeal. Remember that the date the appeal is filed is the date it is received by either the CBA Appeals Administrator 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
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 dol.gov/ebsa/ or call the DOL Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272).

Internal Appeal Review and Determination

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

Regardless of the 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
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 dental 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 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 of Chapter 3.

If your (or your dependents') coverage is retroactively terminated, then you may appeal the decision in accordance with the rescission appeal procedures described in the advance written notice of coverage termination sent to you by the Plan.

Chapter 7: Continuing Coverage Under COBRA

General Information

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage is the same coverage that the Plan offers to other similarly situated participants and beneficiaries who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other participants, including annual enrollment and special enrollment rights.

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

Qualified Beneficiary

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

- Eligible individuals (Employees, retirees,);
- The spouse of an eligible individual;
- Dependent children of eligible individuals; and
- Children of eligible individuals who are receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO).
- In certain cases involving the bankruptcy of the cooperative, a pre-65 retired Employee, the pre-65 retired Employee's spouse (or former spouse) and his or her dependent children.

Qualifying Events

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

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

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

Initial Qualifying Events

The following events may allow a qualified beneficiary to continue coverage when it would otherwise end. **Eligible individuals who have terminated coverage under the Plan**

because they have other coverage are not considered qualified beneficiaries for purposes of COBRA continuation coverage.

You (Eligible Individual)	Your Spouse	Your Dependent Children
• Reduction in hours that results in ineligibility • Employment ends for any reason other than gross misconduct	• Eligible individual's reduction in hours that results in ineligibility • Eligible individual's employment ends for any reason other than gross misconduct • Divorce • Eligible individual's death	• Eligible individual's reduction in hours that results in ineligibility • Eligible individual's employment ends for any reason other than gross misconduct • Divorce • Eligible individual's death • Loss of dependent status

Your Notification Responsibilities for Initial Qualifying Events

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

- A divorce. Notify the COBRA administrator within **60 days** of the divorce. Notify the COBRA administrator of a divorce separately from any qualified domestic relations order that you may submit for retirement plans; and
- A dependent child loses dependent status. Notify the COBRA administrator within **60 days** of the date the dependent child no longer meets the Plan's dependent child eligibility requirements as described in Chapter 3 in the *Coverage for your Dependents* section. The COBRA administrator will know when a dependent child reaches age 26 and becomes ineligible for coverage for this reason; however, you must notify them of all other dependent status changes. Coverage ends at the end of the month in which the child reaches age 26 regardless of any separate notification requirements for which you are responsible.

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

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

Note that notice to your spouse is treated as notice to any dependent children who reside with your spouse.

Length of COBRA Continuation Coverage

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

Initial Qualifying Event	Coverage Period
Your reduction in hours, resulting in loss of benefits eligibility[1]	18 months
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 to dependent children)	36 months
Your death (coverage extends to eligible spouse, and to dependent children)	36 months *See Special Rule for Surviving Spouse and Dependents*

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

Special Rule for Surviving Spouse and Dependents

If you die, your surviving spouse and dependent children are eligible to continue coverage beyond the required 36-month COBRA period. Such surviving spouse and dependent coverage will end independently on the earliest of:

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

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

Second Qualifying Events

An 18-month extension of COBRA coverage may be available to your spouse and dependent children who elected COBRA continuation coverage if a second qualifying event occurs during their first 18 months of COBRA continuation coverage. The maximum length of COBRA continuation coverage when a second qualifying event occurs is 36 months. These second qualifying events include:

Second Qualifying Event[2]	Maximum Duration for Covered Spouse, or Dependents
Your divorce after the initial qualifying event	Additional 18 months (for a total of 36 months)
Your Medicare entitlement	Additional 18 months (for a total of 36 months)
Your death	Additional 18 months (for a total of 36 months)
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[2]	Maximum Duration for Covered Spouse, or Dependents

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

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

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

Social Security Disability Extension

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

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

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

Electing COBRA Continuation Coverage

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

Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, your spouse may elect COBRA continuation coverage even if you do not.

You or your spouse can elect COBRA continuation coverage on behalf of all the qualified beneficiaries. A designated representative acting on behalf of you, your spouse or your

dependent children may also make the election(s). You can elect COBRA continuation coverage for one, several or all dependent children who are qualified beneficiaries.

COBRA Election Period

You and your covered dependents have until the later of the following time periods to elect COBRA continuation coverage:

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

Your specific COBRA enrollment deadline will appear in your COBRA enrollment notice. If mailed, election forms must be postmarked no later than the deadline listed on the COBRA enrollment notice. If hand delivered, the COBRA administrator must receive the election forms no later than the deadline as indicated on the COBRA enrollment notice.

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

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

Cost of COBRA Continuation Coverage

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

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

During an 11-month disability extension described in the *Social Security Disability Extension* section of this chapter, the qualified beneficiary's cost may not exceed

150% of the cost to the group health plan (Employer plus eligible individual contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Making Payments for COBRA Continuation Coverage

You do not have to send your first payment along with your COBRA continuation coverage election form. However, benefits will not be available and claims will not be paid until the first premium payment is received.

The due date for your payments will be listed on your first COBRA billing notice. You must make your first payment for COBRA continuation coverage no later than **45 days** after the date you elect COBRA continuation coverage. All subsequent payments will have a 30-day grace period. **Note**: Your first payment will be for the time period between your coverage termination date and the end of the current month. COBRA continuation coverage is effective (retroactive to the date active coverage ended) only when you enroll by the COBRA enrollment deadline and make your first payment within **45 days** of your COBRA election date.

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

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

Changing COBRA Continuation Coverage

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

Adding a New Dependent

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

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

Discontinuing Your Coverage or Removing a Dependent From Coverage

To discontinue your COBRA continuation coverage election, you must notify the COBRA administrator. Coverage will be terminated as of either the event date or the date you call your COBRA administrator, whichever is later.

Premiums will continue to be billed and claims will be processed until you notify the COBRA administrator and provide any required documentation. Claims that you or your dependents incur after your coverage ends will be denied. If you do not supply the required documentation, you will receive a notice from the COBRA administrator, after which coverage will terminate as of the date of loss of eligibility.

Coordination of COBRA Continuation Coverage

If you already have other group insurance (or Medicare) and elect COBRA continuation coverage under an NRECA Plan, your coverage must be **coordinated**. This means that one plan will be considered primary and the other plan will be secondary. To determine which plan is primary, refer to the provisions described in the *Coordinating Benefits with Other Plans* section of the *Dental Plan Benefits* chapter. If you have other coverage, you must notify the COBRA administrator for each plan in which you are enrolled.

End of COBRA Continuation Coverage

If you or your dependents elect COBRA continuation coverage, that coverage can continue for the time period indicated in the section of this chapter titled *Length of COBRA Continuation Coverage*. Whenever your status or that of a dependent changes, you must notify the COBRA administrator within **60 days**. For details, see the sections in this chapter titled *Changing COBRA Continuation Coverage* and *Second Qualifying Events*.

Coverage will end when a qualified beneficiary exhausts the maximum period of COBRA continuation coverage; however, coverage may end **before** the maximum extension date if:

- Any required premium or contribution is not paid in full. Coverage will be terminated retroactively as of the end of the month for which the last full payment was made;

- Your Employer no longer provides coverage to any eligible individuals. Coverage terminates on the date the coverage is no longer offered;
- A qualified beneficiary obtains coverage after their COBRA qualifying event under another group plan that does not impose any exclusions for pre-existing conditions that you or your dependents may have. Coverage terminates on the date the qualified beneficiary obtains coverage under the other group plan or the date you contact the COBRA administrator, whichever is later;
- A qualified beneficiary engages in conduct (such as fraud) that would justify the Plan's termination of coverage for a similarly situated participant or beneficiary not receiving continuation coverage. Coverage will terminate on the date of the event;
- A qualified beneficiary is determined by the Social Security Administration to no longer be disabled. A qualified beneficiary (or Authorized Representative) must notify the COBRA administrator within 60 days of the Social Security Administration's determination. For details, see the section titled *Social Security Disability Extension* earlier in this chapter; or
- A qualified beneficiary becomes entitled to Medicare Part A, Part B or both. The qualified beneficiary must notify the COBRA administrator in writing within 60 days of Medicare entitlement. Coverage will terminate on the effective date of the entitlement. All other family members who are qualified beneficiaries remain eligible to participate in COBRA.

The COBRA administrator will continue to bill you for coverage and process claims until you notify them that you want to terminate coverage and provide any required documentation. Claims that you or your dependents incur after the coverage ends will be denied. If you do not provide documentation when required, the COBRA administrator will notify you, after which coverage will terminate as of the date of loss of eligibility.

For More Information

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

Changing Your Address

To protect your and your family's rights, keep the COBRA administrator informed of any changes in your and your family members' addresses. Keep copies of all correspondence with the COBRA administrator for your records.

Chapter 8: Important Notifications and Disclosures

Not a Contract of Employment

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

Non-assignment of Benefits

You and your covered dependents, if any, cannot assign, pledge, borrow against or otherwise promise any benefit payable under the Plan to a third party before you receive it. A benefit payment made by the Plan to a provider of health care services or supplies does not make such provider an assignee of benefits or otherwise confer on such provider any rights under the Plan or ERISA. An Authorized Representative designation made by you or a covered dependent in accordance with the Plan's procedures is not a prohibited assignment of benefits with respect to the Plan. An attorney-in-fact designation made by you or a covered dependent pursuant to a power of attorney document is not a prohibited assignment of benefits with respect to the Plan.

Third Party Liability

The Plan does not cover expenses that you incur as a result of an injury or sickness caused by a third party (such as in an automobile Accident). The third party liability provision of the Plan allows you to receive benefits and, at the same time, places the expense of coverage with the person or entity that may be liable for the injury or sickness. If a covered individual receives any settlement or otherwise is compensated by a third party as a result of an injury or sickness, the Plan has the right to recover from, and be reimbursed by, the covered individual for all amounts this Plan has paid and will pay as a result of that injury or sickness, up to and including the full amount the covered person receives from third parties. As a condition of receiving benefits under this Plan, you are expected to cooperate with CBA with its recovery of any amounts for which the Plan is entitled to be reimbursed, including the completion of any forms, and to repay the Plan any amounts you receive for benefits paid by the Plan. The right to reimbursement of the Plan comes first, even if the covered individual is not paid for all the claims for damages or if the payment received is for damages other than dental expenses. The Plan will seek recovery for payment of benefits through subrogation or reimbursement, and the Plan's right of full recovery may be from any source of payment, including, but not limited to: any judgment, settlement, or other payment made or to be made by or on behalf of a third party; any liability or other insurance coverage, worker's compensation, you or your covered dependent's own uninsured or underinsured motorist coverage, any medical payments, any "no-fault" or school insurance coverage paid or payable, and automobile medical payments or recovery from any identifiable fund. For purposes of this provision, "you" includes participants, their covered dependents, COBRA beneficiaries, and any other person who may recover under this Plan on your behalf (e.g., your estate).

Subrogation

Immediately upon paying any benefits to you, the Plan shall be subrogated (that is, substituted for) all rights or recovery that you have against any third party for benefits paid under the Plan. This means that in the event you receive a settlement, judgment, or compensation from a third party as a result of an injury or sickness, the Plan has the independent right to recover from, and be reimbursed by, the covered individual for all amounts this Plan has paid and will pay as a result of that injury or sickness, up to and

including the full amount the covered person receives from third parties. The right to reimbursement of the Plan comes first, even if the covered individual is not paid for all the claims for damages or if the payment received is for damages other than dental expenses. You must notify the Plan within 45 days of the date when notice is given to any third party of your intention to recover damages due to your Injury or Sickness. If you enter into litigation for payment of your injury or sickness, you must not prejudice, in any way, the subrogation rights of the Plan. Any costs incurred by the Plan in matters related to subrogation will be paid for by the Plan. The costs of legal representation you incur will be your responsibility.

Reimbursement

In most cases, the Plan will not be reimbursed directly by the third party. Normally, your claim against the third party will be settled with the third party. Therefore, if your benefits are paid by the Plan and then you receive settlement from the third party or the third party's insurer to compensate you for benefits paid under this Plan, you must reimburse the Plan for the benefits it paid to you up to the amount of such compensation. This Plan's right of reimbursement is a first priority right of reimbursement, to be satisfied before payment of any other claims, including attorney's fees and costs, and regardless of any state's make-whole doctrine.

If you fail to repay the Plan any amounts you receive for benefits paid under this Plan, the Plan reserves the right to bring legal action against you for amounts owed to the Plan and/or to suspend payment(s) for any future Plan benefits until it has recovered such amounts.

If you do not repay the Plan within 30 days of your receipt of these benefits, the Plan may take legal action to pursue repayment plus interest at the rate equal to the prime rate plus 3% (compounded annually from the date that is 30 days after your receipt of the other benefits) on the principal amount of the advance that is not repaid within 30 days of your receipt of the other benefits. The Plan may also recover from you reimbursement of the Plan's costs and attorney's fees incurred to enforce this repayment provision.

Mistakes in Payment

Although every effort is made to pay your benefits from the Plan accurately, mistakes can occur. If a mistake is discovered, the Plan Administrator will make corrections that are deemed appropriate. You will be notified if a mistake is found.

Right of Recovery of Overpayment

If it is later determined that the Plan made an overpayment or a payment was made in error, either to you or on your behalf, the Plan has a right at any time to recover that overpayment from the person to whom or on whose behalf the overpayment or erroneous payment was made. The Plan has the right to recover overpayments as a result of, but not limited to:

- Fraud;
- Any error the Plan makes in processing a claim; or
- Benefits paid after the death of the Employee.

If the overpayment is not refunded to the Plan, the Plan reserves the right to bring a legal action to recover the overpayment, to offset future benefit payments until the overpayment is recovered, or both. You will be notified if a mistake is found.

Changing or Terminating the Plan

This Plan may be amended or terminated at any time, for any reason, by action of the Plan Administrator or your Employer. This includes the right to change the cost of coverage. These changes may be made with or without advance notice to Plan participants. However, your rights to claim benefits for the period prior to the termination or amendment will not be affected if such benefit is payable under the Plan as in effect before the Plan is terminated or amended.

Severability

If any provision of this Plan is held invalid, the invalid provision does not affect the remaining parts of this Plan. The Plan is construed and enforced as if the invalid provision had never been included.

Statement of ERISA Rights

Your Rights

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

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require NRECA, as Plan Administrator, to provide the materials and pay you up to $149 a day, not to exceed $1,496 (2018 limit, indexed annually) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan

Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

HIPAA Privacy Rights

Availability of HIPAA Notice of Privacy Practices

The privacy rules under HIPAA govern how health information about you may be used and disclosed by the Plan and provide you with certain rights with respect to your health information. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan and describes the Plan's legal duties and privacy practices relative to such information.

If you would like a copy of the Plan's Notice of Privacy Practices, please contact NRECA's Privacy Officer as indicated in the *Contact Information* chapter. The Plan's Notice of Privacy Practices is also available on the NRECA Employee Benefits website at cooperative.com > My Benefits > Education & Resources > Insurance Plan Documents.

Appendix A: Key Terms

Accident

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

Actively at Work or Active Work

Means that an Employee must be present at work at the business establishment of the Employer or at other locations to which the Employer's business requires the Employee to travel on a day that is one of the Employer's scheduled work days, and must be performing, in the usual way, all of the regular duties of the Employee's job on a full-time basis on that day.

An Employee will be deemed to be Actively at Work on a day that is not one of the Employer's regularly scheduled work days only if the Employee was Actively at Work on the preceding scheduled work day. An Employee will be deemed to satisfy the Active Work Requirement if he or she is on an Employer-approved leave of absence (e.g., FMLA absence, jury duty, bereavement leave, vacation), but does not include time off as a result of Injury or Sickness.

In no event will an Employee be deemed to be on an Employer approved leave of absence for any absence that continues longer than 12 weeks, except for an FMLA leave of absence to care for family members who are injured while on active duty in the armed forces, including the National Guard or Reserves, which provides the Employee with a leave up to 26 weeks.

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

Adverse Benefit Determination

An Adverse Benefit Determination means any of the following:

- A denial, reduction or termination of a benefit, or a failure to provide or make payment for a benefit, including any such denial, reduction or failure to provide or make payment based on a determination of your eligibility to participate in a benefit option under this Plan.
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, unproven, investigational or not Medically Necessary or appropriate.

Note: A Rescission of Coverage as defined under applicable law is an Adverse Benefit Determination, whether or not there is, in connection with the rescission, an adverse effect on any particular benefit at that time. For additional details, see the section entitled *Appealing an Adverse Benefit Determination: Rescission of Cove*rage in the *Claims and Appeals* chapter.

Authorized Representative

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

Claimant

A participant who is making a claim for Plan benefits.

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).

Coinsurance

Your share of the costs for a covered dental care service, calculated as a percent of the allowed amount. The dental Plan pays the rest of the allowed amount, after your share of the Coinsurance has been calculated.

Cosmetic Procedure

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

Deductible

The annual amount that you must pay toward covered expenses for covered dental services or supplies before the dental Plan begins to pay any portion of the cost of covered expenses for those covered services or supplies.

Dentist

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

Director

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

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

Your Employer may, or may not, elect to provide coverage for the above-listed classes (see the *Eligibility and Participation Information* chapter for details).

Emergency Treatment; Emergency Services

A health 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.

Eligibility Waiting Period

- The period, if any, chosen by the Employer, of continuous employment with the Employer required before participation in the Plan is available to an Employee.

Employee

A person who is actively working for the Employer.

Employer

The organization, cooperative, association, system or entity from which you receive a salary for performing your job responsibilities and through which you receive benefits under the Plan.

ERISA

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

External Review

An appeal option available for certain dental 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).

Internal Appeal Process

A review of an Adverse Benefit Determination conducted by the applicable claims administrator upon request by the Plan participant.

Medical Judgment

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

In connection with the External Review process, the external reviewer is generally responsible for determining whether or not an Adverse Benefit Determination involves Medical Judgment.

Medically Necessary, Medical Necessity or Medically Necessary Services and Supplies

To be considered Medically Necessary, dental 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.

Post-service Claim

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

Pre-service Claim

Any claim for which the Plan specifically requires approval or authorization from the claims administrator before dental services are obtained.

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 Prior Authorization before receiving the authorization or approval from the claims administrator, the claim will be reviewed as a post-service claim.

Prior Authorization

A decision by the Plan that a dental care service or a treatment plan is Medically Necessary. Sometimes this is also called Prior Authorization, prior approval or precertification. The Plan may require Prior Authorization for certain services before you receive them, except in an emergency. Prior Authorization is not a promise that your Plan will cover the cost.

Qualified Medical Child Support Order (QMCSO)

Generally, a state court or agency may issue a medical child support order requiring an ERISA-covered health plan to provide health benefits coverage to a child or children. The group health plan must determine whether such medical child support order is qualified. An order that is determined to be qualified is called a Qualified Medical Child Support Order (QMCSO). A state child support enforcement agency may also obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified. For further information about QMCSOs, call the Member Contact Center at 866.673.2299.

Reasonable and Customary (R&C) Rates

The R&C rate for any service or supply is the usual charge for the service or supply in the absence of insurance, but not more than the prevailing charge in the geographic area for a like service or supply.

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.

CBA consults industry-wide databases, including but not limited to Fair Health. CBA also 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.

Rescission of Coverage

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

Retained Attorney

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

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 dental 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 Dentist with knowledge of your dental 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.