NRECA Long-Term Disability Plan

SUMMARY PLAN DESCRIPTION
(BENEFITS BOOKLET)

SEMO ELECTRIC COOPERATIVE

01-26031-002

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) Long-term Disability Plan (the Plan).

Your Responsibilities

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

While reading this material be aware that:

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

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

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Plan Information

Plan Name

The NRECA Long-term Disability Plan which is a component Plan of the NRECA Group Benefits Program.

Plan Number:	501
Plan Type:	Long-term Disability 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 for benefits** • **Documentation to support Proof of Loss**	**Claims Administrator** Cooperative Benefit Administrators, Inc. (CBA) P.O. Box 6249 Lincoln, NE 68506
General benefit questions • **Eligibility** • **Enrollment** • **When coverage begins or ends** • **Cost of coverage** • **Changing your beneficiary**	**Benefits Administrator** SEMO ELECTRIC COOPERATIVE P.O. BOX 520 SIKESTON, MO 63801

Chapter 2: Long-Term Disability Plan Highlights

Benefit period begins	After 13 weeks of Disability (see the chapter titled *Your Benefits During Leave of Absence*)
Disability monthly benefit	66 2/3% of your monthly Earnings up to a maximum monthly benefit of $15,000.
Maximum Benefit Period	Disability benefits will be paid monthly for as long as you qualify for benefits under this Plan, but not for longer than the Maximum Benefit Period. The Maximum Benefit Period is based on your age on the date your Disability occurs and ends at age 65. Disabilities due to Mental/Nervous Conditions or Substance Abuse may be subject to a 24-month limitation on benefits. See the *Definition of Disability* section in the *Long-term Disability Benefits* chapter for details about this feature.

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

Active Employees are eligible to participate in the Plan unless they are excluded by their job classification. The following job classifications (or job titles) 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

Eligibility Waiting Period

To be eligible to participate in the Plan, you must have satisfied your Employer's Eligibility Waiting Period. The Eligibility Waiting Period is the length of time that you must have worked for your Employer before you can participate in the Plan.

Your Plan has the following Eligibility Waiting Period: An active employee is eligible to participate in the Plan after: 1 Month.

To be eligible, you must also complete and return the form titled *NRECA Employee Worksheet* to your benefits administrator within **31 days** of satisfying your Employer's Eligibility Waiting Period.

Additional Eligibility Requirements

In addition to meeting the Eligibility Waiting Period requirements, **full-time** Employees must also:

- Be expected to work at least 1,000 hours for your Employer as an active Employee during your first 12 months of employment;
- Have worked at least 1,000 hours for your Employer each subsequent calendar year; or
- Have worked at another co-op within the past six months and met the hours of service criteria noted in the bullets above. A **co-op** means:
    - Your Employer;
    - Any member co-op of NRECA (even if the co-op does not participate in NRECA plans);
    - An Employer that is an affiliate of a member co-op;
    - An Employer that has since become a member co-op of NRECA; or
    - An Employer that has since merged with, been consolidated with or been liquidated into a current member co-op of NRECA.

Full-time Employees must also satisfy the "Active Work Requirement," also called the "Actively at Work" requirement. This 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., Family and Medical Leave Act (FMLA) absence, jury duty, bereavement leave or vacation). **This does not include time off as a result of Injury, Sickness or disciplinary suspension.**

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

If an Employee is confined for medical care or treatment in a Hospital, in any institution or at home on the date coverage would otherwise become effective, then the effective date of the Employee's 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.

When Coverage Begins (Participation Date)

You are covered under this Plan effective on the later of:

- The effective date of the Plan, or
- The date you meet the eligibility criteria described in the *Eligibility to Participate* and *Eligibility Waiting Period* sections in this chapter.

Cost of Coverage

The cost of your coverage is subject to your Employer's policies and can change at any time. You and your Employer share the cost of your coverage as follows:

You pay the entire cost of your coverage.

Special Enrollment Opportunity

If you decline coverage during your initial enrollment period, you may qualify for an additional opportunity to enroll as a late enrollee (subject to an evidence of insurability requirement, described below) if you experience one of the following events:

- Marriage, birth, adoption, placement for adoption, or court-appointed legal guardianship of your dependent child, if you enroll prior to and within **31 days** after the event date;
- Divorce, annulment or death of spouse or dependent child, if you enroll within 31 days after the event date; 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 form 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.

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

Late enrollees must satisfy the Evidence of Insurability requirement. Your benefits administrator will provide you with instructions for satisfying this requirement. You can provide evidence of insurability by completing a Statement of Health (SOH) application **within 60 days** of the effective date of election. Coverage will be approved or denied based on the evidence of insurability that you provide.

When Coverage Ends

Your Disability coverage ends on the earliest of the following dates:

- Your employment terminates or date you transfer to a job classification (or title) that your Employer does not cover;
- You cease to be eligible for participation under the Plan;
- You cease to pay premiums required under the Plan;
- You retire from your Employer;
- The Plan is terminated, changed, or no longer covers your job classification (or title); or
- You take a leave of absence that is not an Employer-approved leave of absence, in which case coverage would terminate on your last day worked.

If your group Disability coverage under this Plan terminates for any reason, it cannot be converted to an individual Disability policy.

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 Injury, Sickness or 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. **An approved leave of absence does not include a disciplinary suspension.**

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);
- 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, your eligibility to participate in this Plan terminates on the date your uncompensated leave begins.

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 *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 your last day worked.

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.

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

Coverage under this Plan is not subject to USERRA. Coverage ends on your last day of work.

Military Leave Longer Than 31 Days

Coverage under this Plan is not subject to USERRA. Coverage ends on your last day of work.

Chapter 5: Long-term Disability Benefits

Definition of Disability

To be considered Disabled during the Benefit Waiting Period (see *Appendix A: Key Terms* for definitions) and for the **first 24 months of your Disability benefits**:

- You must be prevented from performing any or all of the Material and Substantial Duties of your Own Occupation due to any Injury, Sickness, Mental/Nervous Condition or episode of Substance Abuse. Note that disabilities due to Mental/Nervous Condition or Substance Abuse may be subject to a 24-month limitation on benefits. See the section of this chapter titled *Maximum Benefit Period for Disability Benefits due to Mental/Nervous Conditions or Substance Abuse* for details;
- You have lost at least 20% of your Pre-disability Earnings (defined in *Appendix A: Key Terms*); and
- You have met all other Plan requirements.

After 24 months of Disability benefits (measured from the end of the Benefit Waiting Period), you will continue to be considered Disabled if:

- You are unable to perform any or all of the Material and Substantial Duties of any Gainful Occupation for which you are qualified based on education, training and experience due to any Injury, Sickness, Mental/Nervous Condition or episode of Substance Abuse;
- You have lost at least 40% of your Pre-disability Earnings; and
- You continue to meet all other Plan requirements.

Note: the definition of Disability also includes an **Earnings-based component** called “Earnings While Disabled” that allows you to earn some income and still be considered Disabled under the terms of the Plan.

You must also meet these other conditions before you will receive any benefits under the Plan:

- The period of Disability benefits must begin while you are covered under the Plan; and
- You must be receiving care from a Physician that is appropriate to the disabling condition, and such care must be administered as often as necessary to achieve maximum medical improvement.

When Benefits Begin

Your Long-term Disability (LTD) benefits begin once you have met the Plan’s eligibility requirements and you are found to be Disabled pursuant to the terms of the Plan. You may begin receiving Disability benefits after the Benefit Waiting Period, which is 13 weeks of consecutive Disability.

A return to Active Work for **30 or fewer days** (whether or not they are consecutive), with your Physician’s approval, is permitted during the Benefit Waiting Period.

Recovery guidelines allow **30 days** of temporary recovery during the Benefit Waiting Period when you can return to work. Any time worked on a single day will be treated as one full day of work for this purpose.

This temporary recovery provision encourages Employees to attempt to return to work without penalty during the Benefit Waiting Period. The number of days worked does not count toward satisfying the Benefit Waiting Period and will extend the benefit waiting period by the number of days worked. If you work more than 30 days during the Benefit Waiting Period, you will be required to satisfy a new Benefit Waiting Period.

Long-term Disability Approval and Other NRECA Benefits

Approval for LTD benefits can have an impact on other NRECA sponsored benefits, including but not limited to medical, prescription drug, dental, vision, life, Retirement Security, 401(k) and account-based plans (e.g., health flexible spending account, dependent care, health reimbursement account). Your age at the time of Disability approval also has an impact on LTD benefits, particularly if you are at or above your coop's normal retirement age. Please refer to other SPDs or consult with your benefits administrator to determine the impact of an award of LTD benefits on your other benefits.

Disability Benefit Amount

Your monthly benefit is 66 2/3% of your basic monthly Earnings, subject to the compensation limit imposed by the Internal Revenue Code (IRC) (discussed below).

If your Earnings change while receiving a benefit under this Plan, your monthly benefit amount will not be adjusted until you return to work and become eligible for LTD Plan coverage (excluding a recurrence for the same Disability).

Benefits are based on a **30-day month** and will be prorated accordingly for a partial month.

Maximum Benefit

Due to the compensation limit imposed by the IRC, effective January 1, 1994, no more than $280,000 (in 2019 and adjusted periodically for inflation) of annual Earnings may be considered when the Plan calculates your benefit. However, a supplemental insurance policy outside the NRECA Group Benefits Trust has been established to provide benefits to the extent an Employee's salary exceeds the compensation limit. This supplemental insurance policy is provided under the NRECA Excess Long-Term Disability Plan.

The combined monthly benefit maximum from this Plan and the supplemental insurance policy (under the NRECA Excess Long-Term Disability Plan) is $15,000.

Minimum Benefit

The minimum monthly benefit under this Plan is $65.

Income and FICA Tax Withholding

If you pay 100% of the LTD premium on an after-tax basis, income tax and FICA tax withholding does not apply to you. If you pay any portion of the LTD premium on a before tax basis, or if your co-op pays a portion of the premium, income tax and FICA tax withholding applies to you.

Federal Income taxes will be withheld on any taxable Disability benefits. The default withholding will be 22% of the taxable benefit, unless you submit IRS Form W-4 to CBA, in which case federal income taxes will be withheld according to the instructions on your IRS Form W-4.

State income taxes will be withheld at the rate of single with zero allowances from all taxable Disability benefits if the state you reside in has state income tax and you do not submit withholding instructions. If you submit IRS Form W-4 with federal withholding instructions, the same instructions will be applied to state income taxes. If you want a different amount withheld for state taxes, you must provide a state specific withholding form.

Federal Insurance Contributions Act (FICA) taxes will be withheld from taxable Disability benefit payments as applicable.

Length of Disability Benefits

Disability benefits will be paid monthly as long as you qualify for benefits under this Plan, but not for longer than the Maximum Benefit Period.

The Maximum Benefit Period is determined by your age when your Disability begins. The standard Maximum Benefit Period ends at age 65 for anyone who becomes Disabled before age 60.

Benefits will be paid while you remain Disabled up to the Maximum Benefit Period shown below **except** for disabilities due to Mental/Nervous Conditions or Substance Abuse. See the section in this chapter titled *Maximum Benefit Period for Disability Benefits due to Mental/Nervous Conditions or Substance Abuse* for details.

Age on the Date your Disability Begins	Maximum Benefit Period
Under 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 through 74	12 months
75 and older	6 months

Once you reach the Maximum Benefit Period, Disability benefits are no longer payable even if you remain Disabled.

Maximum Benefit Period for Disability Benefits due to Mental/Nervous Conditions or Substance Abuse

When a Disability is contributed by (i.e., the claimant's physical conditions alone do not result in Disability), caused by or due to a Mental/Nervous Condition or Substance Abuse, an employee’s Maximum Benefit Period for all such periods of Disability is limited to 24 months. This is not a separate maximum for each such condition or for each period of Disability due to a

Mental/Nervous Condition or Substance Abuse, but rather a combined lifetime maximum for all periods of Disability due to all these conditions, either separate or combined. If at the end of the 24 months the employee is confined in a Hospital or other facility qualified to provide necessary care and treatment for Mental/Nervous Conditions or Substance Abuse, CBA may, in its discretion, extend the Maximum Benefit Period to include the time during which the employee remains confined.

When Benefits End

Benefit payments under this Plan will terminate on the earliest of these events:

- You no longer meet the definition of "Disabled," as determined by CBA;
- You fail to furnish written proof of your continued Disability to CBA when and as required by CBA;
- You reach the end of the Maximum Benefit Period;
- You refuse to participate in a Workplace Modification supported and implemented by your Employer and CBA;
- You refuse to participate in a Mandatory Rehabilitation program designated by CBA;
- You refuse to submit to independent medical examination(s), functional capacity evaluation(s) or personal interview(s) as required by CBA;
- You fail to provide Proof of Loss to CBA when and as required by CBA;
- You refuse to receive ongoing care from your Physician that is appropriate (in CBA's sole discretion) to your disabling condition, or such care is not administered as often as necessary to achieve maximum medical improvement during the period of Disability, or both;
- You become confined to jail, prison or other house of correction as a result of conviction for a criminal or other public offense; or
- You die.

Reduction of Monthly Benefit Due to Other Sources of Income

The Plan will reduce your monthly Disability benefits by other benefits or income you might receive after becoming Disabled. These are called **benefit offsets**. Examples of these benefit offsets are:

- Workers' compensation benefits or benefits from any similar government plan or program. To the extent such benefits are paid in a lump sum settlement, the settlement will be characterized as lost wages over the Maximum Benefit Period for purposes of determining the monthly benefit offset.
- Unemployment benefits or benefits from any similar government plan or program. To the extent such benefits are paid in a lump sum settlement, the settlement will be characterized as lost wages over the Maximum Benefit Period for purposes of determining the monthly benefit offset.
- Payments made pursuant to state, provincial or federal laws of the United States or Canada including but not limited to motor vehicle insurance statutes or similar legislation to the extent "no fault" loss of time coverage is required in policies or contracts to meet the requirement of such statute or legislation.

- Distributions made under any defined benefit pension plan, including but not limited to the NRECA Retirement Security Plan and the International Brotherhood of Electrical Workers (IBEW) pension plan.
- Other income received as a retirement benefit from a retirement plan that is wholly or partially funded by Employer contributions unless:
  - You began receiving regular periodic distributions prior to becoming Disabled; or
  - You immediately transfer or roll over the payment or benefit to another qualified retirement plan or to an individual retirement account (IRA) for the funding of future retirement, and the balance of the transferee account or IRA at the end of each year does not fall below the amount transferred as a result of any withdrawal by the Participant.
- Amounts withdrawn from a qualified retirement plan or IRA attributable to amounts transferred or rolled over from a retirement plan that is wholly or partially funded by Employer contributions.
- Disability benefits from the Veteran's Administration or any other foreign or domestic governmental agency unless:
  - The benefit began before you became Disabled; or
  - If you were receiving the benefit before becoming Disabled, only the amount of any increase in the benefit that is attributable to your Disability will be a benefit offset.
- Earnings while Disabled (defined in *Appendix A: Key Terms*).
- Disability benefits under any group life insurance policy.
- Disability payments from any Employee benefit plan.
- Certain amounts withdrawn from the NRECA 401(k) Pension Plan (or other qualified retirement plan or IRA) that are attributable to both quasi-retirement transfers from the NRECA Retirement Security Plan and rollovers from the NRECA-sponsored Retirement Security Plan (excluding any Employee contributions). If such a withdrawal causes the balance of such plan or IRA as of the end of each year to fall below the amount transferred, then your Disability benefits will be reduced by the amount that is the difference between your ending balance and the amount transferred or rolled over. No reduction in your Disability benefits will occur if, at the end of each year, there have not been any withdrawals, even if the ending balance is less than the amount transferred (e.g., due to investment losses).
- Payments from any deferred compensation plan, executive compensation plan, top hat plan or similar type of benefit arrangement.
- Social Security benefits for Disability (including dependent benefits) or retirement.

This list is not all-inclusive. If you are not sure about a particular type of payment, contact CBA. It is possible that certain types of income not specifically mentioned in the list above will reduce your Disability benefit payments.

Any **cost of living increases** you and your family receive from the above sources will not affect your benefits.

Any **single lump sum payment** you receive will be considered as a monthly series of payments for the purpose of this Plan. If you receive a single lump sum payment and the corresponding maximum monthly payment can be determined by CBA, then the benefit offset will be determined by prorating the single sum over the time period for which the sum is paid.

If the maximum monthly payment cannot be determined by CBA, then the monthly benefit offset will be determined by dividing the lump sum payment over the period for which payments would otherwise be made.

In the case of lump sum cash distribution(s) attributable to your accrued benefit from the NRECA Retirement Security Plan, the monthly benefit offset is determined using an actuarially determined monthly annuity payment based on a 50% joint and survivor annuity for married Employees and based on a life-only annuity for unmarried Employees.

Entitlement to other benefits may reduce your monthly benefit even if you do not apply for and receive such benefits. If you do not apply for other benefits to which you are entitled, CBA will reduce your monthly benefit by an estimate of what you would have received if you had applied for the benefits. If you subsequently receive such benefits, any necessary adjustments will be made to your monthly benefit.

Social Security Disability and Workers' Compensation Benefits

CBA may, in its sole discretion, advance the full monthly Disability benefit to you without reduction while you are waiting for payment of Social Security Disability benefits (including dependent benefits) or appealing a workers' compensation (or similar) claim denial or are seeking additional benefits due to the cessation of benefits under an accepted liability workers' compensation claim or both. However, if CBA advances such benefits, you will be required to promise in Writing that you will repay the advance as soon as you receive the other expected benefits. If you do not repay the advance within **30 days** after you receive the other benefits, CBA reserves the right to suspend your Disability benefit, take legal action to pursue repayment plus interest or both.

Interest on the principal amount of the advance that is not repaid within 30 days of your receipt of the other benefits will accrue at a rate equal to the prime rate plus 3%, compounded annually from the date that is **30 days** after your receipt of the other benefits. CBA may also recover from you reimbursement of CBA's costs and attorney's fees incurred to enforce this repayment provision.

Participants who are approved for Social Security Disability benefits often become entitled to Medicare Part A and Part B 24-months from their Disability approval. It is important that you notify your benefits administrator should this occur since it may have an impact to your medical and/or your prescription drug benefit.

Mandatory Rehabilitation Provision

To help you return to work, your coverage has a Mandatory Rehabilitation provision. For a particular Disability, CBA may determine that rehabilitation is within the ability of a Disabled Employee who is entitled to benefits under this Plan. This means that your Disability is not so severe that you are not able to learn new productive skills and become self-supporting.

We will review your Disability to see if certain services are likely to help you return to work. When this review is complete, CBA may require that you participate in a rehabilitation program. The rehabilitation program will start when a written rehabilitation agreement is signed by you, CBA and your vocational case manager.

Rehabilitation is mandatory. Your Disability benefits may be terminated if you refuse to participate in a rehabilitation program that CBA has determined is appropriate or for which CBA has agreed to pay expenses up to $10,000.

Trial Work Period

To help you get back to work, your coverage provides for a trial work period during which you can continue to receive Disability benefits and return to work for the Employer in some capacity, as your Disability allows, for **up to three months**. The trial work period gives you the opportunity to determine how much work you can handle with your medical condition(s) and to receive as much as 100% of your Pre-disability Earnings from your Employer and the Plan combined. If you are interested in the trial work period, you must submit a written request to CBA in advance. The trial work period must be approved by CBA, the Employer and your Physician.

During the trial work period, your monthly benefit will be calculated as your Pre-disability Earnings minus your Earnings during the trial work period and minus applicable offsets. The three month trial work period may be extended or renewed by CBA, in consultation with the Employer and your Physician, but not for more than three months at a time. In no event may the trial work period exceed 12 months. You may have only one trial work period during any single period of Disability due to the same or related causes.

If your Disability prevents you from completing a trial work period and you continue to satisfy this Plan's definition of Disability, you will continue to receive your Disability benefits and the full amount of your Disability benefit will be reinstated prospectively. You may be required to submit medical documentation to confirm your inability to complete the trial work period.

Workplace Modification Benefit

If you return to work as a result of a Workplace Modification made by the Employer, the Plan may reimburse your Employer for certain related expenses.

Your participation by returning to work is mandatory if CBA deems the Workplace Modification necessary to ensure your return to work and the Employer supports it. Failure to participate may result in the termination of Disability benefits.

Loss of Earnings Provision

As a way to provide opportunity for rehabilitation and productivity, Employees are allowed to work while Disabled and continue to receive a percentage of the Disability benefit in addition to their work Earnings While Disabled. The combination of the reduced Disability benefit and the Employee's work Earnings may not exceed the standard Disability benefit. Your Earnings While Disabled may come from your Employer or from another Employer. Your Disability benefit is calculated as the Disability benefit percentage multiplied by your Pre-disability Earnings minus your Earnings while Disabled and any benefit offsets.

For the first 24 months of Disability you may earn no more than 80% of your Pre-disability Earnings. After 24 months of Disability you can earn no more than 60% of your Pre-disability Earnings.

Recurrent and New Disabilities

For purposes of satisfying the Benefit Waiting Period, if you have been Actively at Work for fewer than 180 days, a recurring Disability resulting from the same or similar cause or condition will be regarded as a continuation of the prior Disability, and a new Benefit Waiting Period is not required. If you have been Actively at Work for at least 180 days, a recurring Disability resulting

from the same or similar cause or condition will be regarded as a new unrelated Disability, and a new Benefit Waiting Period must be satisfied before benefits can begin.

If you become Disabled from a condition unrelated to your prior Disability after being Actively at Work for your Employer for at least one day, that successive Disability will be considered a new Disability and a new Benefit Waiting Period must be satisfied before benefits can begin.

In all cases, recurrent and new disabilities require this Plan to be in force at the time of your Disability.

Multiple Disabilities

If you suffer from two or more disabilities at the same time, whether related or unrelated, benefits will be paid as if the disabilities were caused by one Injury or one Sickness. In no event will you be considered to have more than one continuous period of Disability at the same time.

Exclusions

General Exclusions

No Disability benefit will be paid by this Plan for disabilities:

- For which you are not being treated or for which you are not under the care of a Physician appropriate (in CBA's sole discretion) to the disabling condition and not receiving care that is administered as often as necessary to reach maximum medical improvement;
- When you are not Actively at Work or have not met the Active Work Requirement;
- Caused or contributed to by service in the armed forces, National Guard or military reserves of any country or international authority (including active duty, active duty for training purposes, undeclared war and resistance to armed aggression) except a non-service connected Injury or Sickness while on a temporary tour of duty of 31 or fewer days;
- Caused or contributed to by an act of war, declared or undeclared, including resistance to armed aggression;
- Resulting from attempted suicide or intentionally self-inflicted Injury, while sane or insane;
- Caused by (or contributed to or resulting from) participation in the commission of an assault, felony, strike, civil disorder or riot;
- When you are confined to jail, prison or other house of correction as a result of conviction for a criminal or other public offense;
- Caused by, contributed to or resulting from intoxication.
- When you fail to provide acceptable Proof of Loss to CBA; or
- When you do not cooperate with CBA in accordance with the terms of the Plan, including but not limited to the Mandatory Rehabilitation provision, independent medical examinations, functional capacity evaluations, personal interviews or requests for verification of your financial status.

Pre-existing Condition Exclusion

No benefits will be payable under the Plan for any Disability that is due to or results from, in whole or in part, a Pre-existing Condition, unless such Disability begins after the last day of 365

consecutive days during which you have been continuously covered under this Plan. In the event that your Disability is excluded as a Pre-existing Condition, a recurring Disability resulting from the same or similar cause or condition shall be excluded unless the Active Work Requirement of 180 consecutive days is met before the onset of the subsequent Disability can be treated as a new Disability.

Initial Proof of Disability

You must notify CBA of your Disability within **90 days** of the onset of the Disability. Contact your benefits administrator for a Long-term Disability Claim Form packet and instructions on how to complete the forms. You, your Employer and your treating Physician each have sections of the forms to complete.

Once CBA has been notified of the Disability, you will be required to provide Proof of Loss by sending CBA the completed claim forms, which include:

- Employee application;
- Employer's information;
- Attending Physician's *Statement of Disability*;
- Authorization to obtain information; and
- *Essential Job Functions* Statement.

Proof of Loss must be furnished in writing to CBA not more than **90 days** after the last day of your Benefit Waiting Period. If it is not reasonably possible to give initial notice or Proof of Loss within the time limits, benefits may not be invalidated or reduced as long as CBA receives it as soon as reasonably possible.

No claim for Disability shall in any event be approved by CBA if notification of Disability and application are not provided to CBA within 12 months of the onset of the Disability.

Completed claim forms and documentation supporting Proof of Loss should be sent to the CBA Claims Administrator at the address shown in the *Contact Information* chapter.

If you disagree with CBA's determination in whole or in part, you may file an appeal (see the chapter titled *Claims and Appeals*).

Continuing Proof of Disability

Proof of continuing Disability indicating that you are under the regular care of a Physician, that you remain Disabled and that you are meeting all other Plan provisions, may be required and must be provided, at your expense, upon request. In some cases, you may be required to give CBA authorization to obtain additional medical information and to provide non-medical information as part of the continuing Proof of Disability. CBA may also require you to be examined by CBA's Physician or personally interviewed by CBA or its agents at such times and such frequency as CBA, in its sole discretion, deems necessary to establish Proof of Loss. The claim may be denied or benefits may end if the requested information is not submitted.

Chapter 6: Claims and Appeals

General Information

A **claim** is any request for a Plan benefit made in accordance with the procedures described in this chapter. If your claim is denied (also called an adverse benefit determination), you or your authorized representative have the right to appeal the decision.

This chapter describes the steps you must take to file a claim or request an appeal. These steps are intended to comply with applicable regulations by providing reasonable procedures for filing claims, notifying participants of benefit decisions and appealing adverse benefit determinations. You must follow these procedures for all claims for benefits under this Plan.

An issue or dispute solely regarding your eligibility for coverage or participation in the 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.

For Claims Initially Filed On or After April 1, 2018

Coverage Rescissions

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.

If the Plan retroactively cancels coverage (e.g., due to a misstatement on an application), the coverage rescission is treated as a benefit denial, requiring the Plan to give the participant the opportunity to appeal the decision. The exception is when the cancellation of coverage stems from a failure to timely pay required premiums or contributions toward the cost of coverage.

The Plan will rescind your 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 eligibility for coverage under the Plan when you in fact were or are not eligible for coverage under the Plan. An intentional misrepresentation of fact includes, but is not limited to, your failure to report a change in eligibility status in accordance with the terms of the Plan. Your enrollment as an ineligible individual or your failure otherwise to comply with the Plan's requirements for eligibility will constitute fraud or an intentional misrepresentation of material fact.

The following coverage terminations are not rescissions of coverage. They do not require the Plan to give you 30 days' advance written notice of coverage termination.

- The Plan terminates your coverage retroactive to your employment termination date when
  - 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
  - You paid no Plan premiums or contributions after your employment termination date.
- You failed to pay required Plan premiums or contributions for coverage under the Plan on a timely basis, and the Plan terminates your coverage retroactive to the last date of coverage for which you did pay required Plan premiums or contributions on a timely basis.

For unintentional mistakes or errors which result in your coverage under the Plan that should not have occurred, the Plan will terminate your coverage prospectively (going forward), once the mistake or error is identified. Because such termination is not a rescission of coverage, the Plan will not give you 30 days' advance written notice.

If you experience a coverage rescission and have questions, contact the Member Contact Center at 866.673.2299.

Culturally and Linguistically Appropriate Benefit Denial Notices

Benefit denial notices will be available in a culturally and linguistically appropriate manner if 10% or more of the population in the county where you reside is literate only in the following same non-English language, as determined by the US Census Bureau: Chinese, Tagalog, Navajo and Spanish, and will include a prominent statement in the relevant non-English language detailing how you can access language services. You can contact the Member Contact Center at 866.673.2299 for oral customer service in that non-English language, and the Plan will provide written notices translated into that non-English language upon request.

Deemed Exhaustion of the Plan's Claims and Appeals Processes

If the Plan fails to comply with its claims processing rules, you may be treated as having exhausted the administrative remedies available to you under the Plan. This means that you can file a lawsuit immediately without regard to whether you have requested an appeal of your benefit denial. If you believe that the Plan has failed to comply with its claims processing rules, you may contact CBA (see the section titled *Claims and Appeals Contacts*) to request that CBA explain the violation(s). CBA must provide a written explanation of the violation to you within 10 days of your request, including why CBA believes that the violation should not cause the Plan's administrative remedies to be exhausted. The violation will not cause the Plan's administrative remedies to be exhausted if the violation is de minimis, non-prejudicial to you, attributable to good cause or matters beyond the Plan's control, happens in the course of an ongoing good-faith exchange of information between you and the Plan, and is not reflective of a pattern or practice of non-compliance. If a court rejects your request for immediate review on the basis that the Plan met the standards for the exception described in the previous sentence, your claim will be considered refiled on appeal once the Plan receives the court's decision and provides you with notice of such refiling on appeal.

New or Additional Evidence and Rationale Considered by the Plan on Appeal

For benefit denials on appeal whether at the first-level appeal or the voluntary final appeal before the appeal decision-maker can issue a benefit denial decision on appeal, it must give you the following free of charge, as soon as possible and sufficiently in advance of the date on which the benefit denial decision is required to be provided to you:

- Any new or additional evidence that the appeal decision-maker (or other person at its direction) considered, relied upon or generated in connection with your appeal; and
- Any new or additional rationale on which the benefit denial decision on appeal would be based.

Claims and Appeals Contacts

Purpose	Contact

Purpose	Contact
Authorizing a representative	**NRECA Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard Arlington, VA 22203-1860 703.907.6601 703.907.6602 privacyofficer@nreca.coop
Filing a claim	**Cooperative Benefit Administrators, Inc.** **Claims Administrator** P.O. Box 6249 Lincoln, NE 68506 866.673.2299 402.483.9355 402.483.9201 (fax)
Filing an appeal	**Cooperative Benefit Administrators, Inc.** **Appeals Administrator** P.O. Box 6249 Lincoln, NE 68506 866.673.2299
Filing a voluntary final appeal	**Appeals Committee** CBA 9284 P.O. Box 6249 Lincoln, NE 68506 866.673.2299

Using an Authorized Representative

Either you or your authorized representative may file claims for Plan benefits and appeal adverse claim decisions. An authorized representative is an individual who you have authorized in writing to act on your behalf. An authorized representative may not be a doctor or other health provider.

If you use an authorized representative, you must complete the form titled *Authorization to Use and Disclose Protected Health Information.* Ask your benefits administrator for the form. Before you submit the form to NRECA, you may contact the Plan's Privacy Officer to ask questions about the use and disclosure of your health information, using the contact information for the Privacy Officer in the *Claims and Appeals Contacts* section at the start of this chapter.

The Disability Claim Filing Process

Claim Filing Time Limits

- You must notify CBA of your Disability not later than **90 days** from the onset of your Disability.

- You must file Proof of Loss not later than **90 days** from the last day of your Benefit Waiting Period.
- No claim for Disability shall in any event be approved by CBA if notification of Disability and application are not provided to CBA within 12 months of the onset of the Disability.

Where to Send Your Claim

Send your claim to the Claims Administrator, CBA, at the address in the *Claims and Appeals Contacts* section of this chapter.

Your claim is considered filed on the date CBA receives your completed claim in writing.

CBA Evaluates Your Claim

CBA will notify you that your claim is either approved or denied not later than **45 days** after receipt of claim by the Plan.

If circumstances warrant, CBA may require **two extensions** of up to **30 days** each. CBA will notify you within the initial 45-day period if an extension is required. If CBA needs the initial 30-day extension because you did not provide all of the information needed to process your claim, CBA will tell you what information is missing. If an additional 30-day extension is needed, CBA will notify you before the end of the first 30-day extension.

If Your Claim is Incomplete

You must submit additional information requested by CBA within **45 days** from the date CBA sends you the notice to tell you that your claim is missing information.

Note: The time period to decide your claim is suspended from the date CBA notifies you that your claim is incomplete until the date you provide CBA with the requested information, not to exceed **45 days**. CBA may then use the remainder of the review period to complete its evaluation of the claim.

If Your Claim is Denied

CBA will provide you a notice that contains:

- Specific reason(s) for the benefit denial;
- Reference to specific Plan provisions on which denial is based;
- A description of any additional information needed to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's review procedures and time limits that apply to them;
- An explanation of your rights under ERISA's claim and appeals rules; and
- A copy of any internal rule, guideline, protocol or similar criterion used in the decision or a statement that the material is available upon request for free.

For claims initially filed on or after April 1, 2018, the denial notice provided to you by CBA will also contain the following:

- The basis for disagreeing with, or not following, any Disability determination, made by the Social Security Administration, that you presented;
- The basis for disagreeing with, or not following, the views of medical or vocational experts whose advice was obtained on behalf of the Plan—whether or not the advice was actually relied upon when making the benefit decision;

- The basis for disagreeing with, or not following, the views presented by health care professionals who treated you and vocational professionals who evaluated you;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim, or, alternatively, a statement that such guidelines, protocols, standards or other similar criteria do not exist.
- A statement that you have the right to receive, upon request and free of charge, copies of all documents, records and other information relevant to your claim for benefits. A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information:
    - Was relied upon in making the benefit decision;
    - Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether such document, record, or other information was relied upon in making the benefit decision;
    - Demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim decisions are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants;
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination; and
    - If the benefit denial was based on experimental or medical necessity criteria (or similar exclusion or limit), an explanation of the scientific or clinical judgment that the denial was based on, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The First-level Appeal Process

Time Period to Request an Appeal

You or your authorized representative must request an appeal not later than **180 days** from the date you receive the notice that your claim is denied.

You may request copies of all documents, records, and other information related to your denied claim from the Plan, free of charge. You also have the right to submit with your appeal written comments, records, documents and other information to support your appeal, whether or not you already submitted these items.

Where to Submit Your Appeal

Send your appeal request to the Appeals Administrator (CBA) at the address in the *Claims and Appeals Contacts* section at the start of this chapter.

The Appeals Administrator who reviews your appeal will not be the person who made the original decision to deny your claim nor will that reviewer be someone directly supervised by the original decision maker. The Appeals Administrator will conduct a full and fair review of all documents and evidence to support your claim for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts will be different from the ones previously consulted.

Appeal Review Time Period

Your appeal will be reviewed not later than **45 days** from the date the Appeals Administrator receives your appeal.

The Appeals Administrator may request **one 45-day extension** and will notify you during the initial 45-day period if the extension is required.

If Your Appeal is Denied

The Appeals Administrator will provide you with a notice that contains:

- Specific reason(s) for the benefit denial;
- Reference to specific Plan provisions on which denial is based;
- A description of any additional information needed to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's appeal procedures and time limits that apply to them;
- An explanation of your rights under ERISA's claims and appeals rules; and
- A copy of any internal rule, guideline, protocol or similar criterion used in the decision or a statement that such rule, guideline, protocol, or similar criterion is available upon request for free.

For first-level appeal denials that are related to initial claims filed on or after April 1, 2018, the denial notice provided to you by the Appeals Administrator will also contain the following:

- The basis for disagreeing with, or not following, any Disability determination made by the Social Security Administration that you presented;
- The basis for disagreeing with, or not following, the views of medical or vocational experts whose advice was obtained on behalf of the Plan—whether or not the advice was actually relied upon when making the benefit decision;
- The basis for disagreeing with or not following the views presented by health care professionals who treated you and the vocational professionals who evaluated you;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim, or, alternatively, a statement that such guidelines, protocols, standards or other similar criteria do not exist;
- A statement that you have the right to receive, upon request and free of charge, and copies of, all documents, records and other information relevant to your claim for benefits. A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information:
    - Was relied upon in making the benefit decision;
    - Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether such document, record, or other information was relied upon in making the benefit decision;
    - Demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim decisions are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination; and

- A statement of your right to file a lawsuit under ERISA and the date by which that lawsuit must be filed.

If you complete the Plan's appeal process and your appeal is denied, you may voluntarily take part in one additional review of your denied appeal called the Voluntary Final Appeal Process. If you do not choose to use the Voluntary Final Appeal Process, you may seek legal action by filing suit under ERISA within one year from the date your appeal was denied.

The Voluntary Final Appeal Process

You may use this option if you wish to have the Plan's Appeals Committee review your denied appeal. Using this Voluntary Final Appeal Process has no effect on your rights to any other benefits under the Plan or your rights to legal action. Before you submit your written request, you may request additional information about the Voluntary Final Appeal Process by calling 866.673.2299.

Time Period to File a Voluntary Final Appeal

You must request a Voluntary Final Appeal not later than **60 days** from the date you receive the notice that your appeal is denied by the Appeals Administrator.

You may request copies of all documents, records, and other information related to your denied claim from the Plan, free of charge. You also have the right to submit with your appeal written comments, records, documents, and other information to support your appeal, whether or not you already submitted these items.

Where to Submit your Voluntary Final Appeal

Send your request to the Appeals Committee at the address listed in the *Claims and Appeals Contacts* section at the start of this chapter.

The Appeals Committee is selected by the plan administrator and was not involved in the original decision to deny your claim or to deny your appeal. The Appeals Committee will conduct a full and fair review of all documents and evidence to support your claim for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different persons than the ones who were previously consulted.

Review Time Period

Your appeal will be reviewed not later than **60 days** from the date the Appeals Committee receives it.

If circumstances warrant, the Appeals Committee may require an extension of up t**o 60 days**. CBA will notify you within the initial 60-day period if an extension is required.

The Appeals Committee will conduct a full and fair review of all documents and evidence submitted to support your claims for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different persons than the ones consulted previously.

If Your Voluntary Final Appeal is Denied

The Appeals Committee will provide to you with a notice containing:

- Specific reason(s) for the benefit denial;
- Reference to specific Plan provisions on which denial is based;

- A description of any additional information needed to perfect the claim and explanation of why such information is needed;
- An explanation of your rights under ERISA's claims and appeals rules; and
- A copy of any internal rule, guideline, protocol or similar criterion used in the decision or a statement that such rule, guideline, protocol, or similar criterion is available upon request for free.

For voluntary final appeal denials that are related to initial claims filed on or after April 1, 2018, the denial notice provided to you by the Appeals Committee will also contain:

- The basis for disagreeing with, or not following, any Disability determination made by the Social Security Administration that you presented;
- The basis for disagreeing with, or not following, the views of medical or vocational experts whose advice was obtained on behalf of the Plan—whether or not the advice was actually relied upon when making the benefit decision;
- The basis for disagreeing with, or not following, the views presented by health care professionals who treated you and vocational professionals who evaluated you;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim, or, alternatively, a statement that such guidelines, protocols, standards or other similar criteria do not exist;
- A statement that you have the right to receive, upon request and free of charge, and copies of, all documents, records and other information relevant to your claim for benefits. A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information:
    - Was relied upon in making the benefit decision;
    - Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether such document, record, or other information was relied upon in making the benefit decision;
    - Demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim decisions are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination; and
    - A statement of your right to file a lawsuit under ERISA and the date by which that lawsuit must be filed.

You may take legal action by filing suit under ERISA within **one year** from the date your voluntary final appeal was denied.

Chapter 7: Important Notifications and Disclosures

Not a Contract of Employment

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

Non-assignment of Benefits

You cannot assign, pledge, borrow against or otherwise promise any benefit payable under the Plan to a third party before you receive it. An authorized representative designation made by you 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 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 Disability expenses that you incur as a result of an Injury or Sickness caused by a third party (such as in an automobile Accident). This third party liability provision of the Plan allows you to receive Disability benefits, and, at the same time, places the expense of Disability coverage with the person or entity that is liable for, or caused, the Injury or Sickness.

If a covered individual receives any settlement or otherwise is compensated by a third party due to 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 received from the third party.

As a condition of receiving benefits under this Plan, you are expected to cooperate with CBA in its recovery of any amounts for which the Plan is entitled to be reimbursed. This includes completing any forms and repaying to the Plan any amounts you receive from a third party, as described above.

The Plan's right of full recovery may be from any source of payment, including, but not limited to: any judgement, 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 coverages that are paid or payable, and automobile medical payments or recovery from any identifiable fund.

Subrogation

Immediately upon paying any benefits to you, the Plan shall be subrogated (that is, substituted for) all rights or recovery that you have against any third party for loss of income due to your Injury or Sickness. This means that in the event you receive a settlement, judgment or compensation from a third party, the Plan has an independent right to seek reimbursement of the Disability benefits it paid on your behalf under this Plan. 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 Disability, 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 Disability 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 your loss of income, 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 loss of income due to the Injury or Sickness, the Plan reserves the right to bring legal action against you for amounts owed to the Plan, to suspend payment(s) for any future Disability benefits or both until it has recovered such amounts.**

Right of Recovery of Overpayment

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

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

If the overpayment is not refunded to the Plan, the Plan reserves the right to bring a legal action to recover the overpayment and/or to offset future benefit payments until the overpayment is recouped. 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.

Additional Procedures

The Plan Administrator may promulgate any roles, regulations or procedures not covered by this Plan that may be necessary for the proper administration of this Plan.

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.

Appendix A: Key Terms

Accident

An Injury that is:

- **Caused by a sudden and unforeseen event; and**
- **Exact as to time and place of occurrence.**

Accommodation

Any change or modification to a job, the work environment, or a work process that would allow an Employee to perform job functions with the Employer.

Active Work Requirement or Actively at 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 or 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.

Benefit Waiting Period

A time of continuous Disability extending for 13 or 26 consecutive weeks (as selected by the Employer) between the first scheduled day of work missed due to Disability and the day on which benefits begin.

Cooperative Benefit Administrators, Inc. (CBA) is the claims adjudicator for the Plan.

Disability or Disabled is defined in the *Definition of Disability* section of the *Long-term Disability Benefits* chapter.

Earnings or Pre-disability Earnings

The Employee's Earnings for a normal work week that does not exceed 40 hours, not including bonuses, deferred compensation, overtime pay and other additional compensation that the Employee may be receiving at the time of Disability.

Earnings While Disabled

The monthly Earnings you receive from the Employer (excluding sick leave, vacation leave and paid time off) and any other employment while Disabled. However, if the other employment is a job you held in addition to active full-time employment with the Employer, then during the

Benefit Waiting Period and for the next 24 months, any Earnings from other employment will be Earnings While Disabled **only** to the extent that they exceed the average monthly Earnings received from this other employment during the six month period immediately prior to becoming Disabled.

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; and
- Receiving **Earnings** as defined in this Appendix.

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.

Gainful Occupation

Any activity for profit or compensation that replaces or can be expected to replace more than 60% of the Employee's Pre-disability Earnings.

Hospital

An institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution or part thereof that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility or training center.

Injury

Bodily harm that is the direct result of an Accident and not related to any other cause. This Accident must not be employment-related.

Mandatory Rehabilitation

A rehabilitation program that may include, when CBA considers it to be appropriate, any necessary and feasible:

- Vocational testing;
- Vocational training;
- Alternative treatment programs including but not limited to those such as:
  - Physical therapy;
  - Occupational therapy; and
  - Speech therapy.
- Workplace Modification to the extent not otherwise provided;
- Job placement; and
- Similar services.

Material and Substantial Duties

The essential tasks of an occupation that cannot reasonably be modified or omitted, not including overtime work.

Maximum Benefit Period

The maximum period for which Disability benefits may be paid.

Mental/Nervous Condition

Any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, including any biological or biochemical disorder or imbalance of the brain, regardless of the cause(s) or the presence of physical manifestations. Mental/Nervous Condition includes but is not limited to bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders. Mental/Nervous Condition excludes demonstrable, structural brain damage.

Own Occupation

Any similar job that involves Material and Substantial Duties of the same general nature as your regular job at the Employer when your Disability begins. Any work Accommodation provided to you by your Employer, for a period lasting more than 12 consecutive months preceding your last day worked (your date of Disability), will be considered your regular job for purposes of evaluating your claim for Disability benefits.

Physician

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

Plan or **The Plan**

The NRECA Long-term Disability Plan.

Practitioner of the Healing Arts

A provider who is licensed, certified or ordained in some manner within his or her community, and publicly commits to a code of behavior that offers dedicated service to clients. The United Stated government has defined the term “Licensed Practitioner of the Healing Arts” as a:

- Physician;
- Licensed Clinical Psychologist (LCP);
- Licensed Clinical Social Worker (LCSW);
- Licensed Clinical Professional Counselor (LCPC); or
- Licensed Marriage and Family Therapist (LMFT).

Pre-Existing Condition:

- Any accidental bodily Injury, Sickness, Mental/Nervous Condition or episode of Substance Abuse; or
- Any manifestations, symptoms, findings or aggravations related to or resulting from such accidental bodily Injury, Sickness, Mental/Nervous Condition or Substance Abuse for which you received (or a reasonable person would have sought) **medical care** during the 90-day period that ends immediately before your effective date of coverage under this Plan.

However, any such manifestations, symptoms, findings or aggravations constitute Pre-Existing Conditions regardless of whether a condition was formally diagnosed or strongly suspected. **Medical Care** for this purpose means:

- A Physician is consulted or medical advice is given; or
- **Treatment** that is recommended prescribed by or received from a Physician. **Treatment** for this purpose includes but is not limited to:
  - Medical examinations, tests, attendance or observation; or
  - Use of drugs, medicines, medical services, supplies or equipment.

Proof of Loss

Means (but is not limited to):

- Documentation of:
  - The date your Disability began;
  - The cause of your Disability;
  - The prognosis of your Disability;
  - Your Earnings or income, including, but not limited to, copies of your filed and signed federal and state tax returns; and
  - Evidence that you are under the care of a Physician that is appropriate to the disabling condition.
- Any and all medical information, including X-rays and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- The names and addresses of all:
  - Physicians and Practitioners of Healing Arts you have seen or consulted;
  - Hospitals or other medical facilities in which you have been seen or treated; and
  - Pharmacies which have filled your prescriptions within the past three years.
- Your signed authorization for us to obtain and release:
  - Medical, employment and financial information; and
  - Any other information we may reasonably require.

All Proof of Loss must be satisfactory to CBA. No benefits will be paid unless and until CBA has determined (in its sole discretion) that the Proof of Loss submitted satisfies the definition of Disability.

At any time during your Disability, CBA has the right to have a Physician or other licensed professional examine you or to have its agents and subcontractors conduct personal interviews with you. Claims are regularly reviewed by CBA to confirm continuing eligibility for benefits.

Sickness

Any disease or illness. Sickness must begin while the Employee is covered under the Plan. The term also includes:

- Pregnancy; or
- Any medical complications of pregnancy.

Statement of Health (SOH)

The form you must complete to determine if you can be insured by the Plan. In some cases you may be asked for additional information, such as a Physician's report.

Substance means alcohol, addictive drugs, and their derivatives.

Substance Abuse

The pattern of pathological use of a Substance, which is characterized by:

- Impairments in social or occupational functioning;
- Debilitating physical condition;
- Inability to abstain from or reduce consumption of the Substance; or
- The need for daily Substance use for adequate functioning.

Workplace Modification

Steps taken by the Employer to adapt the workplace in response to an Employee's needs without major change.