NRECA Retired Life Insurance Plan

SUMMARY PLAN DESCRIPTION

ASSOCIATED ELECTRIC CO-OP
01-26073-001

EFFECTIVE DATE: January 1, 2021

NRECA
America's Electric Cooperatives

Introduction

Summary Plan Description

This summary plan description (SPD), also known as the *Benefits Booklet,* describes the benefits provided to Participants by the National Rural Electric Cooperative Association (NRECA) Retired Life Insurance (the Plan).

Your Responsibilities

You are responsible for reading the SPD and related Plan materials distributed by NRECA or by your Employer such as, premium contribution notices, summary of material modifications, and employer benefits eligibility rules, completely and complying with the rules and Plan provisions described herein. The provisions applicable to the specific benefit options under this benefit Plan determine what services and supplies are eligible for benefits; however, you and your provider are ultimately responsible for determining what services you will receive.

While reading this SPD be aware that:

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

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

Fraud Warning Statement

For California Residents: Review this summary plan description carefully. If you are age 65 or older on your effective date, under California law (Cal. Ins. Code §786 effective July 1, 2015) you may return this summary plan description to your cooperative's benefits administrator within 30 days of the date you receive it and he or she will refund any premium you paid. In this case, the summary plan description will be considered to never have been issued. If you are age 60 or older and paid more than one month’s premium at enrollment, you will receive a prorated premium refund if you cancel within 30 days.

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Plan Information

Plan Name

The NRECA Retired Life Insurance Plan, which is a component Plan of the NRECA Group Benefits Program.

Plan Number:	501
Plan Type:	Retired Life Insurance
Year End:	December 31
Plan Effective Date:	January 1, 2021

Underwritten By

Metropolitan Life Insurance Company
501 U.S. Highway 22
P.O. Box 6891
Bridgewater, NJ 08807

Plan Administration

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

Named Fiduciary

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

Plan Sponsor

National Rural Electric Cooperative Association
4301 Wilson Boulevard, Mailstop IFS7-355
Arlington, VA 22203-1860

Plan Sponsor Employer Identification Number: 53-0116145

Plan Administrator

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

703.907.5500

The Insurance and Financial Services department of the National Rural Electric Cooperative Association (NRECA) performs the general administrative duties. The names of persons who have the decision-making responsibilities are on file at the NRECA Insurance and Financial Services department.

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

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

Agent for Service of Legal Process

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

The agent for service of process receives all legal notices on behalf of the Plan Sponsor regarding claims or suits filed with respect to the Plans.

In addition to the agent for service of legal process, service may also be made upon the Plan Trustee.

Plan Trustee

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

Claim Adjudicator

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

Chapter 1: Contact Information

For Information About	Contact
Claims for benefits	**MetLife** Group Life Claims P.O. Box 6100 Scranton, PA 18505 800.638.6420
• **Eligibility** • **Enrollment** • **When coverage begins or ends** • **Cost of coverage** • **General questions** • **Changing your Beneficiary**	**Benefits Administrator** ASSOCIATED ELECTRIC CO-OP 2814 S Golden Ave PO BOX 754 SPRINGFIELD, MO 65801
Eligibility appeals	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203
Voluntary final appeals	**NRECA Appeals Committee** Attn: Senior Vice-President, Insurance and Financial Services 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203

Chapter 2: Retired Life Plan Highlights

This chapter is a summary of the benefits provided under the Plan's Retired Life Insurance provisions. For a full description of all Plan benefits and exclusions, see the *Term Life Benefits* chapter.

You will be insured only for the benefits:

- For which you become and remain eligible;
- That you elect, if subject to election; and
- Which are in effect.

Retired Life Insurance Benefit Highlights

Benefit Level	Who Pays
$5,000	Retiree
$10,000	Retiree
$15,000	Retiree
$20,000	Retiree

Benefit Level	Coverage	Who Pays
Retired Life Insurance benefit prior to 2008	If you retired before your Employer's renewal date in 2008, your Retired Life Insurance benefit is the same as it was prior to the 2008 renewal date. You will continue coverage under the pre-2008 benefit as long as you are eligible.	Ask your benefits administrator

Minimum Retired Life Insurance Benefit	$5,000
Maximum Retired Life Insurance Benefit	$20,000

If your Employer pays for an amount of Retired Life Insurance, you may elect an additional amount of Retired Life Insurance to reach a combined maximum of $20,000. If your Employer

does not pay for part of your Retired Life Insurance, you may elect one of the four benefit levels of Retired Life Insurance noted in the chart above up to a maximum of $20,000.

Once you select a Retired Life Insurance benefit amount, it cannot be increased. However, you may choose a lower benefit amount during your Employer's annual enrollment or when a qualifying event occurs such as marriage or divorce. Once the coverage is reduced it cannot be reinstated or increased.

You may elect an Accelerated Benefit Option (ABO) of up to 80% of your Retired Life Insurance amount, not to exceed $16,000. Note, however, that ABO is not available if the value of your life insurance coverage is under $10,000.

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

Eligible Class(es)

You are eligible for insurance under this Plan if you were:

- Participating in the NRECA Group Term Life and AD&D Insurance Plan;
- Covered by life insurance under such plan on the day immediately preceding the date of your retirement; and
- Have retired in accordance with your Employer's retirement plan, or reached the Normal Retirement Age of your Employer's retirement plan.

For purposes of coverage under this Plan, your Employer defines "retiree" as a former employee who has met the following criteria:

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

Ineligible Class(es)

The following classifications of retired employees are not eligible for coverage:

This Plan does not have any excluded job classifications, positions, or titles.

Date You Are Eligible For Insurance

You will be eligible for the insurance described in this SPD on the day you retire.

If you contribute any portion of the premium for coverage, to be eligible to participate in the Plan, you must also enroll in benefits with your Employer using their enrollment process or complete and return the *NRECA Employee Worksheet* form to your benefits administrator within **31 calendar days** of your retirement.

If You Become a Director

If you enroll in the NRECA Directors Life and AD&D Insurance Plan, you will no longer be eligible for insurance benefits as a retired employee under this Plan (see the *Porting or Converting Coverage* chapter for details). **Note** that if you enroll in the NRECA Directors Life and AD&D Insurance Plan, you will not be eligible for coverage under this Plan after your Directorship ends.

If you choose to enroll in the NRECA's Directors AD&D Only Insurance Plan, you are eligible for Life Insurance benefits as a retired employee under this Plan.

If You Return to Work

If you return to active, full-time employment, your Retired life coverage will end, and you will become eligible for basic life coverage if you are eligible. Upon subsequently separating, you will be eligible to re-enroll in this plan, based on the age you are at the time of the latest separation. If you return to work as a part-time employee that works less than 1,000 hours each year, you can remain eligible for this plan. You cannot have both Retired life and Basic life coverage at the same time.

Enrollment Process

If you are eligible for insurance under this Plan, you may enroll by completing the required process. You must request enrollment no later than 31 calendar days from your initial eligibility for this Plan. If you enroll in Contributory Insurance, your Employer will notify you how much you will be required to contribute.

Date Your Insurance Ends

Your insurance will end on the earliest of:

- The date the Plan ends;
- The date insurance ends for your retiree classification; or
- The end of the period for which the last premium has been paid for you (or by you).

Refer to the *Porting or Converting Coverage* chapter for information about the options to continue to an individual life insurance policy if your Retired Life Insurance ends.

Chapter 4: Term Life Benefits

Your Term Retired Life Benefits

Your Retired Life Plan is strictly Term Life insurance coverage through the Employer's plan. As such, no cash values accumulate nor are there any loan provisions in this Plan.

Benefit Payment

If the benefit amount payable to your Beneficiary is $5,000 or more, the claim will be paid by MetLife's establishment of a Total Control Account (TCA). The TCA is a settlement method used to pay claims in full. MetLife establishes an interest-bearing account that provides your Beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your Beneficiary can access the TCA balance at any time without charge or penalty by Writing drafts from the TCA in amounts of $250 or more. In addition, your Beneficiary may withdraw the entire amount of the benefit payment immediately from the TCA if desired. Please note that the TCA is not a bank account and is not a checking, savings or money market account.

Exclusions

There are no exclusions under this Plan.

Additional Retired Life Insurance Coverage Features

MetLife Will Preparation Benefit

You are eligible to use your MetLife Will Preparation benefit (which is provided by participating MetLife Legal Plan attorneys) once your Retired Life Insurance benefit becomes effective. When you use the MetLife Legal Plan's network, the Will Preparation benefit fully covers the following legal fees:

- Telephone and office consultations to discuss the preparation or updating of your will or your Spouse's will;
- Preparation of the will(s);
- Updating of the will(s);
- Preparation of codicils; and
- Documents such as living wills, powers of attorney.

There is no limit to the number of wills or updates to your will(s) or your Spouse's will(s) that are covered under this benefit.

The following services are **not** covered under this Will Preparation benefit:

- Tax planning;
- Non-attorney fees; and
- A living trust, which is a trust that takes effect during a person's lifetime.

You may use an attorney outside of the MetLife Legal Plans' network and be reimbursed up to $150 (for an Employee) and $200 (for an Employee and Spouse) for attorneys' fees for preparation of your will(s). Further information is available through Hyatt Legal Plans.

Program details and contact information can be obtained from your benefits administrator or by visiting: cooperative.com > My Benefits > Education & Resources > Insurance Plan Documents.

Chapter 5: Accelerated Benefit Option (ABO)

For purposes of this chapter, the term “ABO-eligible life insurance” means your Retired Life Insurance benefits for which the ABO is available, as described in the *Retired Life Plan Highlights* chapter.

If you become Terminally Ill, you or your legal representative may request that MetLife pay ABO-eligible Life Insurance before your death. This is called an accelerated benefit. The request must be made while ABO-eligible Life Insurance is in effect.

You or your legal representative should contact your former Employer to obtain a claim form and information regarding the accelerated benefit. **“Terminally Ill” or “Terminal Illness”** means that, due to injury or sickness, you are expected to die within 12 months. **For residents of Texas only**, **“**Terminally Ill” or “Terminal Illness” means that, due to injury or sickness, you are expected to die within 24 months.

Requirements for Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, MetLife will pay an accelerated benefit to you or your legal representative if MetLife has received Proof that you are Terminally Ill.

MetLife will pay an accelerated benefit for the ABO-eligible Life Insurance benefit **only once.**

Proof of Your Terminal Illness

MetLife requires the following Proof of your Terminal Illness:

- A completed accelerated benefit claim form;
- A Signed physician’s certification that you are Terminally Ill; and
- An examination by a Physician of MetLife’s choice, at MetLife’s expense and request.

Upon MetLife’s receipt of your request to accelerate benefits, MetLife will send you a letter with information about the accelerated benefit payment you requested. MetLife’s letter will describe the accelerated benefits payment amounts and the remaining amount of Retired Life Insurance after the accelerated benefit is paid. The remaining benefit will be paid to your Beneficiary upon your death.

Accelerated Benefit Amount

MetLife will pay an accelerated benefit up to the percentage shown in the *Retired Life Plan Highlights* chapter for the ABO-eligible Life Insurance benefit in effect for you, subject to the following:

- **Maximum Accelerated Benefit Amount**. The maximum amount MetLife will pay for each ABO-eligible Life Insurance benefit is show in the *Retired Life Plan Highlights* chapter.
- **Previous Conversion of an ABO-eligible Life Insurance Benefit.** MetLife will not pay an accelerated benefit for any ABO-eligible Life Insurance that you previously converted under the provisions described in the *Porting or Converting Coverage* chapter.

MetLife will pay the accelerated benefit in one sum unless you or your legal representative select another payment mode.

Effect of Payment of an Accelerated Benefit

On the premium for Your Life Insurance: After MetLife pays the accelerated benefit, any premium you are required to pay will be based upon the amount of your Retired Life Insurance remaining after the accelerated benefit is paid.

On Your Life Insurance at Your death: The amount of Retired Life Insurance that MetLife will pay at your death will be decreased by the amount of the accelerated benefit paid by MetLife.

On Your Life Insurance at conversion/port: The amount that you are entitled to convert/port under the chapter titled (see the *Porting or Converting Coverage* chapter) will be decreased by the amount of the accelerated benefit paid by MetLife.

Date Your Option to Accelerate Benefits Ends

The accelerated benefit option ends on the earliest of:

- The date the ABO-eligible Life Insurance ends;
- The date you or your legal representative have accelerated all ABO-eligible Life Insurance benefits; or
- Upon your death.

Chapter 6: Claims and Appeals

The claims and appeals procedures stated 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. You must follow these procedures for all claims for benefits arising from this Plan.

Your claim will be processed according to applicable Plan provisions and the guidelines used by MetLife. General contact information for MetLife is listed in the *Contact Information* chapter. Specific contacts for claims and appeals are listed in this chapter.

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 about eligibility, contact your benefits administrator.

For purposes of this chapter, “you” also includes your Authorized Representative.

Claims and Appeals Contacts

Type	Reviewer	Address
Authorizing a representative	NRECA Privacy Officer 703.907.6601 703.907.6602 privacyofficer@nreca.coop	**Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard Arlington, VA 22203-1860
Filing a claim	MetLife	**MetLife** Group Life Claims P.O. Box 6100 Scranton, PA 18505 **Overnight Address:** **MetLife** **Group Life Claims** 10 E. D. Preate Dr. Moosic, PA 18507
Filing an appeal of an adverse benefit determination	MetLife 800.638.6420	**MetLife** Group Insurance Claims Review *(Send to the address of the MetLife office that processed the claim)*
Filing an eligibility appeal	NRECA Appeals Administrator	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203

Claims and Appeals Contacts

Type	Reviewer	Address
Filing a voluntary final appeal (eligibility)	NRECA Appeals Committee	**NRECA Appeals Committee** Attn: Senior VP, I&FS 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203

Authorizing a Representative

Your Beneficiary may authorize another individual to speak with MetLife by giving verbal consent for MetLife to speak with that individual. Any forms would still need to be Signed by the Beneficiary. Contact the MetLife claims representative for more information.

Your Beneficiary may designate a power of attorney or guardian in Writing. Such documentation will be held on file with MetLife. Contact the MetLife claims representative for instructions.

Claims

A claim is any request for a plan benefit made in accordance with the procedures described in this chapter. You must submit a claim for Plan benefits in Writing to the benefits administrator. Ask your benefits administrator if you need help obtaining a claim form.

A claim is considered filed when it is received by MetLife in accordance with these procedures. MetLife's time frame to provide you with a determination notice starts when the claim is filed, regardless of whether MetLife has all of the information necessary to decide the claim when it is first filed. If your claim does not include enough information for MetLife to make an initial benefit determination, you may be asked to supply additional information. If you do not provide that information within the applicable time, your claim may be denied in whole or in part.

Within this chapter, "Claimant" may mean you, your Beneficiaries, the executor of your estate, or an Authorized Representative. See *Authorizing a Representative* above for specifics about how to authorize a representative.

Filing a Claim

A Claimant must complete and return the appropriate claim forms to the benefits administrator, who will verify eligibility and the benefits to be claimed, certify the forms, and forward all documents to NRECA. NRECA will then forward the forms to MetLife for processing.

In addition to claim forms, the Claimant may be required to provide additional evidence (e.g., a death certificate or accident report) that establishes the nature and extent of the loss or condition, MetLife's obligation to pay the claim and the Claimant's right to receive payment. Such additional evidence must be provided at the Claimant's expense. MetLife will request this evidence directly from the Claimant and, in its sole discretion, will determine if the submitted documentation is sufficient.

Upon receipt of all requested documentation, MetLife will determine what benefits are payable. If the claim is approved, the benefit is paid. The normal form of payment is one sum, but other

alternative payments are available. For additional information about payment options, contact MetLife.

You may also ask your state's consumer assistance program or ombudsman for help filing an appeal, if applicable. To determine if your state has such resources:

- See the U.S. Department of Labor website at dol.gov/ebsa/;
- Call the DOL's Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272); or
- Write to the EBSA at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Claim Submission Timeframe	
Life Insurance Benefits	Send the claim form and Proof (as defined in *Appendix A: Key Terms*) to MetLife as soon as reasonably possible after the death of the insured Effective from March 1, 2020 until the extended due date defined below. Notwithstanding the foregoing, the deadline for when a participant may file or perfect a benefit claim shall be extended without regard to the COVID-19 Outbreak Period. The "Outbreak Period" runs from March 1, 2020 until sixty (60) days after the COVID-19 National Emergency ends.

Claim Determinations, Determination Extensions, and Requests for Additional Information

Claim Review Timeline	
When you will be notified of a determination	Within a reasonable period, but not later than **90 calendar days** after claim receipt, unless MetLife requests an extension or additional information
Determination extension period	MetLife will notify you of any extension up to **90 additional calendar days** and will explain the reason for the extension and when it will render its decision

Contents of the Claim Determination Notice

For all claims, Written notice of any adverse benefit determination. The notice will include:

- The specific reason(s) your claim was denied;
- The specific Plan provisions on which the denial is based;
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.

The notice will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appeals

If MetLife denies your claim for Plan benefits, if you believe you should be entitled to a different Benefit Amount, or if you disagree with any determination that has been made regarding your Plan benefits, you or your Authorized Representative may appeal the decision.

Documentation to Include with Your Appeal Request

The following information applies to all appeal levels. For purposes of this explanation, the "reviewer" means:

- MetLife Group Insurance Claims Review (for an **adverse benefit determination** appeal);
- NRECA Appeals Administrator (for **eligibility** appeals); and
- NRECA Appeals Committee (for **voluntary final eligibility** appeals).

Appeals must be submitted in Writing by the filing deadline and must include:

- Your name;
- Plan name (i.e., the Retired Life Insurance);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

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

The reviewer will conduct a full and fair review of your appeal if you have submitted it by the proper deadline.

Appealing an Adverse Benefit Determination

Your adverse benefit determination appeal must be filed in Writing with MetLife by the filing deadline. The review period begins when the appeal is received, regardless of whether the reviewer has all 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 contacting the reviewer.

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

When you will be notified of a determination	Within **60 calendar days** of the date MetLife receives the appeal unless you are notified by MetLife that an extension or more time is needed to evaluate your appeal before the initial 60 calendar day period is over
Determination extension period (if needed)	One extension period of **up to 60 calendar days**

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. However, a request for documentation does not extend the time allowed for you to file an appeal.

Adverse Benefit Determination Appeal Review and Determination

If your appeal is denied, the determination notice will include:

- The specific reason(s) your appeal was denied;
- The specific plan provision(s) on which the denial is based;
- If applicable, describe any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- Explain your rights under ERISA's claim and appeal rules; and
- Explain your right to file a civil action under ERISA within 12 months.

Upon Written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim.

If your Written benefit appeal is denied, you may voluntarily take part in one more review process called the **Voluntary Final Appeal Process for Benefits**. If you do not choose to use the voluntary final appeal process, you may seek legal action.

Legal Action for Benefit Claims

A legal action on a claim may be brought against MetLife only during a certain period. This period begins 60 calendar days after the date Proof is filed and ends three years after the date such Proof is required.

Eligibility Appeals

If NRECA denies benefits because you were not eligible to participate in the Plan, you have the right to file a Written eligibility appeal with the NRECA – Appeals Administrator (the reviewer). The reviewer has full and discretionary authority to administer and interpret the Plan for all eligibility appeals.

Your eligibility appeal must be filed with the reviewer by the filing deadline (see *Eligibility Appeal Timeline* below). The review period begins when the appeal is received, regardless of whether the reviewer has all information necessary to decide the appeal. If the reviewer requires more than the stated time to decide your appeal, he or she will send a letter stating an extension time.

Eligibility Appeal Timeline

Filing deadline	Within **60 calendar days** of the date you receive the denial notice due to eligibility
When you will be notified of a determination	Within **60 calendar days** after receipt of the appeal request unless NRECA requests an extension
Determination extension period (if needed)	One period of up to **60 calendar days**

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. However, requesting documentation does not extend the time allowed for you to file an appeal.

Eligibility Appeal Review and Determination

If your eligibility appeal is denied in whole or in part, your decision notice will:

- Contain the specific reason(s) your appeal was denied;
- List the specific Plan provision(s) on which the denial was based;
- Explain your rights under ERISA's claim and appeal rules;
- Explain your right to file a civil action under ERISA within 12 months; and
- Contain the procedures you must follow to take part in the voluntary final appeal process and the time limits for such procedures.

Voluntary Final Appeal Process for Eligibility

If you wish to have the NRECA Appeals Committee review your denied appeal, you may follow the voluntary final appeal process for eligibility. Using this process has no effect on your right to other benefits under this Plan or on your right to take legal action. Before you submit your voluntary final appeal, you may request additional information about the process by calling NRECA's Cooperative Benefit Administrators, Inc. (CBA), at 866.673.2299.

You must file a voluntary final appeal with the NRECA Appeals Committee, in Writing, by the filing deadline described in the timeline table below. The review period begins when the appeal is received, regardless of whether the reviewer has all information necessary to decide the appeal. The reviewer may need additional time to complete his or her review and, if so, will notify you of an extension.

Voluntary Final Appeal Process Timeline for Eligibility	
Filing deadline	Within **60 calendar days** of the date you receive NRECA's Written denial of your eligibility appeal
When you will be notified of a determination	Within **60 calendar days** of the date MetLife receives the appeal unless you are notified by MetLife that an extension or more time is needed to evaluate your appeal before the initial 60-day period is over
Determination extension period (if needed)	One extension period of **up to 60 calendar days**

If your voluntary final appeal is denied in whole or in part, your decision notice will contain:

- The reason(s) why the final appeal was denied;
- The specific Plan provision(s) on which the denial was based;
- An explanation of your rights under ERISA's claim and appeal rules; and
- A statement of the Claimant's right, within 12 months, to bring a civil action under ERISA.

Chapter 7: Porting or Converting Coverage

If your coverage ends, you may continue all or a part of your Plan benefits through either Conversion or Portability.

Conversion

If all or part of your life insurance ends for one of the reasons below, you have the option to buy an individual whole life insurance policy (a new policy) from MetLife during the application period in accordance with the conditions and requirements of this section. Whole life coverage has a set premium that does not increase. This option is only available for life insurance coverage and does not include AD&D coverage. This is called the "option to convert." Evidence of insurability will **not** be required; however, you have the option to complete a Statement of Health (SOH) form. If you complete a SOH, your premiums may be lower.

When You Have the Option to Convert

You have the option to convert when:

- Your Retired Life Insurance ends because:
  - You cease to be in an eligible class of retiree;
  - The Plan ends, provided you have been insured for life insurance for at least five years; or
  - The Plan is amended to end life insurance for an eligible class of which you are a member, provided you have been insured for life insurance for at least five years; or
- Your life insurance is reduced:
  - Because you change from one eligible class to another; or
  - Due to a Plan amendment.

If you choose not to convert a reduction in the amount of your life insurance that occurred for reasons described above, you will not have the option to convert that amount later. A reduction in the amount of your life insurance resulting from an accelerated benefit payment will not give rise to a right to convert under this section.

Conversion Application Period

If you choose to convert your life insurance for any of the reasons stated above, MetLife must receive a completed Conversion application form within the application period described below.

If you are given Written notice of the option to convert **within 15 calendar days before or after** the date your life insurance ends, the application period begins on the date that such life insurance ends and expires **31 calendar days** after such date.

If you are given Written notice of the option to convert **more than 15 calendar days after** the date your life insurance ends, the application period begins on the date such life insurance ends and expires 15 calendar days from the date of such notice. In no event will the application period exceed 91 calendar days from the date your life insurance ends.

Conversion Conditions

The option to convert is subject to these conditions:

- MetLife's receipt within the application period of:
  - Your Written application for the new policy; and
  - The premium due for such new policy;
- The premium rates for the new policy will be based on:
  - MetLife's rates then in use;
  - The form and amount of insurance;
  - Your class of risk; and
  - Your attained age when your life insurance ends;
- The new policy may be on any form then customarily offered by MetLife excluding term insurance; and
- The new policy will take effect on the 32nd day after the date your life insurance ends, regardless of the length of the application period.

Maximum Amount of the New Policy

If your life insurance ends because the Plan ended or was amended to end life insurance for an eligible class of which you are a member, then the maximum amount of insurance that you may elect for the new policy is the lesser of $2,000 or the amount of your life insurance that ends under this Plan minus the amount of life insurance under any Plan for which you become eligible within 31 calendar days after the date this Plan's insurance ends.

If your life insurance ends for any reason other than Plan termination or amendment, as described above, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance that ends under the Plan.

If You Die Within 31 calendar Days After Your life insurance Ends

If you die within **31 calendar days** after your life insurance ends, Proof of your death must be sent to MetLife. When MetLife receives such Proof with the claim, MetLife will review the claim and, if MetLife approves it, MetLife will pay the Beneficiary the amount of life insurance you were entitled to convert.

Life Insurance Portability

The Portability option allows you to continue the term coverage you currently have for all or a part of your life insurance coverage. Term life insurance renews annually, and at that time premiums could increase. If your Portability-eligible Insurance ends for any of the reasons stated below, you have the option to continue that insurance under another policy, in accordance with the conditions and requirements of this section. This is referred to as Porting. Evidence of your insurability will **not** be required; however, you will have the option to complete a SOH form.

For purposes of this subsection, the term "Portability Eligible Insurance" refers to your life insurance benefits, as (shown in the *Retired Life Plan Highlights* chapter) for which the Portability Eligible Insurance is available.

When Porting is an Option

Porting may only be exercised by a Written request during the Request Period specified below.

If you choose not to Port, life insurance benefits may instead be converted in accordance with the section titled *Conversion of Life Insurance*. If you choose to neither convert nor port your Life and AD&D Insurance benefits, your coverage ends.

- You may choose to Port if Portability Eligible insurance ends because:
  - You cease to be in a class that is eligible for such insurance;
  - The Plan is amended to end the Portability Eligible Insurance, unless such insurance is replaced by similar insurance under another group insurance plan issued to the NRECA Group Benefits Program or its successor; or
  - This Policy has ended, unless such insurance is replaced by similar insurance under another group insurance policy issued to the NRECA Group Benefits Program or its successor.
- You may choose to Port the reduced amount of insurance if your Portability Eligible Insurance is reduced due to a Plan amendment that affects the amount of insurance for your Employee classification.

If a request is made under this subsection, the Plan will issue a new Individual Policy which will explain the new insurance benefits. The insurance benefits under the new Policy may not be the same as those that ended under this Plan.

A request under this subsection may be made, if, on the date the Portability Eligible Insurance ended, the following requirement is met:

- The Plan is in effect.

Porting Request Period

For you to port, MetLife must receive a completed request form within the Request Period as described below.

If Written notice of the option to Port is given **within 15 calendar days before or after** the date such insurance ends, the Request Period:

- Begins on the date the insurance ends; and
- Expires **31 calendar days** after the date.

If Written notice of the option to Port is given **more than 15 calendar days after but within 91 calendar days** of the date such insurance ends, the Request Period:

- Begins on the date the insurance ends, and
- Expires **45 calendar days** after the date of the notice.

If Written notice of the option to Port is **not given within 91 calendar days** of the date such insurance ends, the Request Period:

- Begins on the date the insurance ends, and
- Expires at the end of such **91 calendar day** period.

Chapter 8: General Information

Entire Contract

Your insurance is provided under a contract of group insurance with MetLife. The entire contract between MetLife and the NRECA Group Benefits Program is made up of the following:

- The Plan and its exhibits, which include the SPD(s);
- NRECA's Group Benefits Program application; and
- Any amendments and endorsements to the Plan.

Beneficiary

For your loss of life, MetLife will pay benefits to your Beneficiary.

You may designate a Beneficiary during the enrollment process. To change your Beneficiary at any time you must provide a Signed and dated Written request to your Employer using a form satisfactory to MetLife. Your Employer must receive your Written request to change your Beneficiary within 30 calendar days of the date you Sign such request.

You do not need your Beneficiary's consent to make a change. When NRECA receives the change, it will take effect on the date you Signed it. The change will not apply to any payment made in good faith by MetLife before the change request was recorded.

If you designate two or more Beneficiaries but do not specify their shares, your beneficiaries will share the insurance equally.

If no Beneficiary is designated or if no surviving designated Beneficiary is surviving at the time of your death, MetLife may determine the Beneficiary to be one or more of the following who survive you:

- Your spouse;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

Instead of making payment to any of the above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment.

If a Beneficiary is a minor or incompetent to receive payment, MetLife will pay that Beneficiary's court-appointed property and estate guardianship.

Physical Exams

If a claim is submitted for insurance benefits other than life insurance benefits, MetLife has the right to ask the insured to be examined by a physician(s) of MetLife's choice as often as is reasonably necessary to process the claim. MetLife will pay the cost of such exam.

Autopsy

MetLife has the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons MetLife is requesting the autopsy.

Fraud Warning Statements

All States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information about any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Some states have their own fraud warnings. See the state-specific warning that may apply to your state of residence.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York (only applies to accident and health benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State Notices

Important Notice:

Where this SPD is inconsistent with the state notices below, the state notices will govern.

Notice for Residents of All States:

Life Insurance Benefits Will be Reduced If An Accelerated Benefit Is Paid

Disclosure: The Life Insurance accelerated benefit offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from Your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive an accelerated benefit excludable from income under federal law.

Disclosure: Receipt of an accelerated benefit may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect Your, Your Spouse's and Your family's eligibility for public assistance.

Notice for Residents of Arkansas:

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll-free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

Notice for Residents of California:

Important Notice

To obtain additional information, or to make a compliant, contact the policyholder or MetLife at:

Metropolitan Life Insurance Company
Attn: Consumer Relations Department
500 Schoolhouse Road
Johnstown, PA 15904

800-438-6388

If, after contacting the policyholder and/or MetLife, you feel that a satisfactory solution has not been reached, you may file a complaint with the California Department of Insurance at:

Department of Insurance
Consumer Services
300 South Spring Street
Los Angeles, CA 90013

Website: http://www.insurance.ca.gov/

800-927-4357 (within California)
213-897-8921 (outside California)

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

Notice for Residents of Georgia:

Important Notice

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Notice for Residents of Idaho:

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

Notice for Residents of Illinois:

Important Notice

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue

New York, New York 10166
The address of the Illinois Department of Insurance is:
Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

Notice for Residents of Indiana:

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
800-438-6388

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: 800-622-4461; 317-232-2395

Complaints can be filed electronically at www.in.gov/idoi

Notice for Residents of Louisiana:

The Definition Of Child Is Modified For The Coverages Listed Below:

Accidental Death and Dismemberment Insurance:

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 26, regardless of the child's or grandchild's marital status, student status or full-time employment status. Your natural child, adopted child, stepchild or grandchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. In addition, marital status will not prevent or cease the continuation of insurance for a mentally or physically handicapped child or grandchild past the age limit.

Notice for Residents of Maine

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You or any person authorized to act on Your behalf may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

Notice for Massachusetts Residents:

Continuation of Accidental Death and Dismemberment (AD&D) Insurance

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your AD&D Insurance ends because:
    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your AD&D Insurance under the Continuation of Insurance with Premium Payment subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

Notice for Residents of Minnesota:

The Definition Of Child Is Modified For The **Coverages Listed Below:**

Accidental Death and Dismemberment Insurance:

The term also includes Your grandchildren who are financially dependent upon You and reside with You continuously from birth. The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance.

This is a life insurance policy which pays accelerated death benefits at your option under conditions specified in the policy. This policy is not a long-term care policy meeting the requirements of sections M.S.62A.46 to 62A.56 or chapter 62S.

Continuation of Basic or Supplemental or Dependent Life Insurance with Premium Payment

If Your Life Insurance ends due to termination of Your employment for any reason other than gross misconduct, You may continue such insurance for You or Your Dependents.

If You are eligible for continuation of Life insurance, Your employer will notify You of:

- Your right to elect to continue Life Insurance for You or Your Dependents;
- The amount You must pay each month to Your employer to keep such insurance in force;
- Instructions for payment; and
- The time that payments are due.

The amount of the premium You will be required to pay for continuation of Life Insurance will not exceed 102 percent of the amount of premium required to be paid for active employees in Your class for such insurance (this includes any premium amounts paid by the employer as well as the employee).

You will have 60 days within which to elect to continue Life Insurance under this section. The 60-day period begin on the date Life Insurance would otherwise end or on the date upon which notice of the right to continue Life Insurance is received, whichever is later. If You or Your Dependents die during the 60-day election period, we will consider You to have elected to continue Life Insurance under this section.

If Your employer fails to notify You of Your right to continue insurance under this section, or fails to forward a required premium to Us that You have paid, causing insurance for You or Your Dependents to end, then Your employer will become liable for these benefits to the same extent as, and in place of, us.

If You continue Life Insurance under this section, any reductions in Life Insurance that would have applied if

You were actively at work applies to the continued insurance.

Continuation of Life Insurance under this section will end on the earliest of:

- The date the group policy ends for all employees or for the class of employees to which you belonged when Your active work ceased;
- The date you fail to make a required premium payment when due;
- The date you become covered for life insurance under this or any other group term life insurance plan;
- With respect to Your Spouse or Civil Union partner, the date Your marriage ends in divorce or annulment;
- With respect to a Child, the date the Child no longer qualifies as a Child for purposes of Life Insurance;
- With respect to You or Your Dependents, the date You or Your Dependents reach any applicable age limits; or
- The end of 18 months following the date Your active work ended.

When a continuation under this section ends, You or Your Dependents may buy an individual policy of life insurance from Us. The details of this option are described in the sections titled *Life Insurance: Conversion Options for You* and *Life Insurance: Conversion Options for your Dependents.* For the purpose of that section, the end of this continuation will be considered the end of your employment.

Effect of Previous Conversion

If You or Your Dependents converted Life Insurance to an individual policy, We will only pay Life Insurance under this section if such individual policy is returned to Us. If it is returned to Us, We will refund to You, Your estate, or Your Dependents estate, as applicable, the premiums paid for such policy without interest, less any debt incurred under such policy.

If such individual policy is not returned to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.

Notice for Residents of Missouri:

Accidental Death and Dismemberment Insurance Exclusions

If You reside in Missouri the exclusion for “suicide or attempted suicide” is as follows: “suicide or attempted suicide while sane”.

Notice for Residents of Montana:

The Definition of Child Is Modified for the Coverages Listed Below:

Accidental Death and Dismemberment Insurance:

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child’s student status or full-time employment status. Your natural child, adopted child, or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

Notice for Residents of New Mexico:

The Definition Of Child Is Modified For The Coverages Listed Below:

Accidental Death and Dismemberment Insurance:

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied accidental death and dismemberment insurance coverage under this certificate because:

- That child was born out of wedlock;
- That child is not claimed as Your dependent on Your federal income tax return; or
- That child does not reside with You.

If a Child is insured for Accidental Death and Dismemberment Insurance under this certificate and You are not the custodial parent, notify Us that such is the case and provide Us with the name and address of the custodial parent. After receipt of such notice We will:

1. Provide such information to the custodial parent as may be necessary for the Child to obtain benefits through that insurance;
2. Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the non-custodial parent; and
3. Make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state Medicaid agency.

If You are required by a court or administrative order to provide Accidental Death and Dismemberment Insurance for a Child, and You are eligible to provide such insurance for that child, We will:

1. Permit You to enroll a Child who is otherwise eligible for such insurance without regard to any enrollment season restrictions;
2. If You are enrolled but fail to make application to obtain insurance for such Child, We will enroll the Child for insurance upon application of the Child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and
3. We will not disenroll or eliminate insurance for such Child unless the insurer is provided satisfactory written evidence that:
   a) The court or administrative order is no longer in effect; or
   b) The Child is or will be enrolled in comparable health insurance through another insurer that will take effect not later than the effective date of disenrollment.

We will not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the Medicaid program and insured for Accidental Death and Dismemberment Insurance with Us that are different from requirements applicable to an agent or assignee of any other individual so insured.

Notice for Residents of North Carolina:

Read your Certificate Carefully.

Important Cancellation Information

Please Read the Provisions Titled *Date Your Insurance Ends* and *Date Your Insurance For Your Dependents Ends*

Under North Carolina general statute section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall:

1. Cause the cancellation or non-renewal of group health or life insurance, hospital, medical or dental service corporation plan multiple employer welfare arrangement, or group health

plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and

2. Willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under Article 53 of chapter 58 of the general statutes and their rights to purchase individual policies under the federal Health Insurance Portability and Accountability Act and under Article 68 of Chapter 58 of the general statues.

Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

Notice for Residents of Pennsylvania:

Accidental Death and Dismemberment Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- Re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- Re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- Continues to qualify as a Child, except for the age limit; and
- Submits the required proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the *Date Insurance For Your Dependents Ends* subsection of the section titled *Eligibility Provisions: Insurance for your Dependents*, this continuation will continue until the earliest of the date:

- The insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- The child is no longer a full-time student.

Notice for Residents of Texas:

Important Notice

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at 1-800-638-6420

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 800-252-3439.

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax # 512-475-1771

Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

Premium or Claim Disputes: Should You have a dispute concerning Your premium or about a claim, You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

Attach this notice to your certificate: This notice is for information only and does not become a part or condition of the attached document.

Life Insurance: Accelerated Benefit Option (ABO)

The laws of the state of Texas mandate that the terms “Terminally Ill” and “Terminal Illness” when used in the Life Insurance: Accelerated Benefit Option (ABO) for You and the Life Insurance Accelerated Benefit Option (ABO) for Your Dependents provisions mean that due to injury or sickness, You or Your Dependent is expected to die within 24 months of the date You request payment of an Accelerated Benefit.

The Definition Of Child Is Modified For The Coverage Listed Below:

Life Insurance: The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child’s or grandchild’s student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

Accidental Death and Dismemberment Insurance:

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child’s or grandchild’s student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS’ COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER’S COMPENSATION SYSTEM.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company

700 Quaker Lane

2nd Floor

Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Para Residentes de Texas:

Aviso Importante

Para obtener información o para someter una queja: Usted puede llamar al numero de teléfono gratis de MetLife para información o para someter una queja al 800-638-6420

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al 800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # 512-475-1771
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

Disputas Sobre Primas O Reclamos: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

Una este aviso a su certificado: Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal:

Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Notice for Residents of Utah:

The Definition Of Child Is Modified For The Coverage Listed Below:

Accidental Death and Dismemberment Insurance:

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

Notice of Protection Provided by

Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ulhiga.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

For Utah Residents (Dependent Life or Voluntary Accidental Death and Dismemberment Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under an Accidental Death and Dismemberment plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- The date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision. The Additional Requirement will not apply to a mentally or physically handicapped Child who has been continuously handicapped since a date before the Child reached the limiting age under this certificate and for whom satisfactory Proof of such handicap has been provided.

Notice for Residents of Vermont:

Vermont law provides that the following apply to Your certificate:

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

Notice for Residents of Virginia:

Important Information Regarding Your Insurance

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at: 800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
toll-free: 877-310-6560
fax: 804-371-9944
Web address: www.scc.virginia.gov
Email: ombudsman@scc.virginia.gov

Notice for Residents of Washington:

Voluntary Accidental Death and Dismemberment Insurance:

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO)

The Life Insurance accelerated benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term “step-child” appears in this certificate it shall be read to include the children of Your Domestic Partner.

Notice for Residents of Wisconsin:

Keep This Notice With Your Insurance Papers

Problems with your insurance? If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
800-438-6388

You can also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin’s insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
800-236-8517 outside of Madison or 608-266-0103 in Madison

Chapter 9: Important Notifications and Disclosures

Not a Contract of Employment

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

Non-assignment of Benefits

You 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 or another Plan Beneficiary 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 another Plan Beneficiary pursuant to a power of attorney is not a prohibited assignment of benefits with respect to the Plan.

Right of Recovery of Overpayment

If it is later determined that you received an overpayment or a payment was made in error, you will be required to refund the overpayment to the Plan. The Plan has the right to recover overpayments as a result of, but not limited to those:

- Due to fraud;
- Due to any error the Plan makes in processing a claim; and
- Benefits paid after the death of the employee.

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

Amendment or Termination

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 rules, 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 will be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require NRECA, as Plan Administrator, to provide the materials and pay you up to $159 a day, not to exceed $1,594 per request (2020 limit, as may be indexed annually) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Assistance with Your Questions

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

Appendix A: Key Terms

As used in this SPD, the terms listed in this Appendix will have the meanings set forth below. When defined terms are used in this SPD, they will be capitalized. The plural use of a term defined in the singular will share the same meaning.

Authorized Representative means a person you have authorized in Writing to represent you in the claims process, the appeals process, or both.

Beneficiary or Beneficiaries means, for the purposes of the Plan, the person or persons designated as the recipient of funds. If there is no Beneficiary designated or no surviving Beneficiary when you die, benefits are payable in this order: 1) your Spouse; 2) your child(ren); 3) your parent(s); or 4) your sibling(s).

Instead of making payment to any of the above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment. If a Beneficiary is a minor or incompetent to receive payment, MetLife will pay that person's court-appointed property and estate guardianship.

Claimant means an individual who is making a claim for Plan benefits.

Contributory Insurance means insurance for which the Employer requires you to pay any part of the premium.

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

Disabled or Disability means that, due to sickness or injury, you are unable to perform the duties of your regular job, or you are unable to perform any other job for which you are fit by training, education, or experience.

Employer means the organization, association, cooperative, system, entity, etc., from which you receive a salary for performing your job responsibilities and through which you receive Plan benefits.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Non-contributory Insurance means insurance for which the Employer does not require you to pay any part of the premium.

Normal Retirement Age means the age at which you are eligible for a full pension from your Employer. If your employer does not have a retirement plan, then the default would be age 65.

Plan Administrator means the person or entity responsible for keeping an employee benefit plan in compliance and managing the plan for the exclusive benefit of Plan participants as stated in the Plan Information Section of this Summary Plan Description.

Plan Sponsor means an employer or organization that offers a group health plan to its employees or other eligible members as stated in the Plan Information Section of this Summary Plan Description.

Policyholder means the NRECA Group Benefits Program.

Proof means Written evidence satisfactory to MetLife that a person has satisfied the conditions and requirements for any benefit described in this SPD. When a claim is made for any benefit described in this SPD, Proof must establish:

- The nature and extent of the loss or condition;

- MetLife's obligation to pay the claim; and
- The Claimant's right to receive payment.

Proof must be provided at the Claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media that is acceptable to MetLife and consistent with applicable law.

Statement of Health (SOH) means the form you must complete to determine if you can be insured by the Plan. In some cases, MetLife may ask for additional information, such as a Physician's report. If the benefits level you choose during first-time enrollment or for a qualifying event is denied due to the SOH, you will automatically be enrolled in the highest benefit amount that does not require a SOH. On other occasions, your coverage will remain at the benefit level in force before the SOH was required.

Written or Writing means a record that is on (or transmitted by) either paper or electronic media and that is acceptable to MetLife and consistent with applicable law.