NRECA GROUP BENEFITS PROGRAM
SUMMARY OF MATERIAL MODIFICATIONS

For

NRECA Voluntary Dental Plan

EFFECTIVE: January 1, 2023

System name: ASSOCIATED ELECTRIC CO-OP

RUS/Subgroup Number: 01-26073-002

This Summary of Material Modifications (SMM) describes changes to the National Rural Electric Cooperative Association (NRECA) Dental Plan (the Plan) and supplements the Plan's Summary Plan Description (SPD), also known as the Benefits Booklet. The effective date of these changes is noted above. You should read this SMM carefully and keep this SMM with your SPD for future reference. If you have any questions about these changes, please see your benefits administrator.

Summary of Changes for your Dental Plan SPD:

Chapter 1: Contact Information

The section titled "Contact Information" has been updated as follows:

For Information About	Contact
• **Preferred dental providers**	**GEHA Connection Dental Network** 877.277.6872 gehasolutions.com

Chapter 3: Eligibility and Participation Information

The subsection titled "Eligibility Requirements for Incapacitated Adult Children" under "Coverage for Your Dependents" has been updated as follows:

Coverage for a child may continue past the age limit if the child is incapable of self-sustaining employment because of a mental or physical disability, and if your child:

- Is at least 26 years of age;
- Is unmarried;
- Qualifies as your tax dependent on an annual basis because he or she is permanently and totally disabled (as defined by the Internal Revenue Service [IRS] in Publication 501); **and**
- Has been continually covered as your eligible dependent under the NRECA Dental Plan on the date just prior to the date participation would have ended due to age or another insurer prior to attaining age 26.

The section titled "When Coverage Ends" has been updated as follows:

Dependent coverage also ends:

- For a spouse, upon divorce at 11:59 pm the last day before your divorce is official. Your official divorce date is your first day without coverage under the Plan;

Chapter 5: Dental Plan Benefits

The subsection titled "The Dental PPO Network" under "How the Plan Works" has been updated as follows:

The Dental PPO Network

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

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

Remember these facts about the dental PPO network:

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

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

- Refer to the dental logo on your health ID card;
- Review the most current list of preferred providers online at gehasolutions.com; or
- Call GEHA Connection Dental Network at 877.277.6872 for assistance.

Chapter 6: Claims and Appeals

The section titled "External Review" has been updated as follows:

If the CBA Appeals Administrator denied your internal appeal based on Medical Judgment, or if you have otherwise exhausted the internal appeals process for a claim involving Medical Judgment, you have the right to request an External Review. Additionally, if your internal appeal of a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time) is denied, you have the right to request an External Review. All other Adverse Benefit Determinations (including a denial, reduction, or non-payment of benefits because you do not meet the Plan's eligibility requirements (excluding a rescission of coverage)) are not eligible for this Plan's External Review process.

Chapter 8: Important Notifications and Disclosures

The section titled "Statement of ERISA Rights" has been updated adding a new subsection as follows:

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

The subsection titled "Enforce Your Rights" under "Statement of ERISA Rights" has been updated as follows:

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 $171 a day, not to exceed $1,713 per request (2022 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.

No further changes have been made to your Plan's SPD.

All other rules, provisions, definitions and benefit amounts of the Plan SPD remain the same. If the terms of this SMM and the SPD conflict with any terms of the governing Plan document, then the terms of the governing Plan document will control in all cases.

Plan Sponsor: National Rural Electric Cooperative Association
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