Retiree Health Reimbursement Arrangement (HRA) Plan

SUMMARY PLAN DESCRIPTION

Ozark Border Electric Cooperative

26708

EFFECTIVE DATE: March 1, 2016

This sample Summary Plan Description for the Retiree Health Reimbursement Arrangement (HRA) Plan has been prepared for use with the sample Retiree Health Reimbursement Arrangement (HRA) Plan document and the sample Retiree Health Reimbursement Arrangement (HRA) Plan Administrative Guide. The information set forth in the sample SPD is not intended to constitute legal or tax advice. You should review this document with your legal counsel prior to use.

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Chapter 1: Introduction to Your Retiree HRA Plan

This Summary Plan Description is intended to highlight only the basic features of the Retiree Health Reimbursement Arrangement Plan (the "HRA" or "Plan"). Actual benefits are subject to the definitions and limitations in the Plan. If there is any conflict between this Summary Plan Description and the Plan document, the Plan document will control.

The purpose of the Plan is to reimburse eligible retirees for the following expenses which are not otherwise reimbursed (Eligible Health Expenses):

____ health care premiums which include:

____ medical plan premiums (Medicare Supplement or Medicare Advantage)

____ Medicare Part D prescription drug plan premiums

____ dental plan premiums

____ vision plan premiums

____ health care expenses (such as out-of-pocket expenses for medical care, vision care, dental care, prescription drugs (except for prescription drugs covered under a Medicare Part D prescription drug plan), health care premiums and certain over-the-counter drugs).

To be an Eligible Health Expense, the expense must constitute "medical care" within the meaning of Section 213(d) of the Internal Revenue Code, as amended (Code) and the regulations thereunder.

The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (Code), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Plan is effective January 1, 2016. The Plan year is the calendar year.

Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

Chapter 2: Eligibility and Participation

Who is eligible to participate in this Plan?

To be eligible to participate in this Plan, you must be a retiree who was employed by your employer (that sponsors this Plan) as a common law employee. A "retiree" for purposes of eligibility to participate in this Plan is an employee of the employer who terminates employment at age 55 or later.

In addition to retirees described above, surviving spouses aged 65 or over of retirees or employees of the employer are eligible to participate in this Plan if they were covered under the NRECA Medical Plan on December 31, 2015.

Are my dependents eligible for coverage under this Plan?
Yes. If you are eligible to participate in the Plan, then your eligible dependents are eligible to be covered under the Plan as well. Your eligible dependents include:

- Your spouse who is any individual legally married to you as determined under applicable state law (and who is treated as a spouse under the Internal Revenue Code).

- Your children who include your unmarried and/or married children up to age 26 who are your biological children, adopted children, stepchildren, children for whom you have legal guardianship or children who are recognized under a Qualified Medical Child Support Order as having a right to coverage under the Plan if they are otherwise eligible. Your incapacitated adult child who is over the age of 25 is eligible for coverage under this Plan as well if the child is unmarried, and the child qualifies as your tax dependent on an annual basis because the child is permanently and totally disabled as defined by the Internal Revenue Service (IRS).

Your employer may request documentation to substantiate eligibility.

When does my participation in this Plan begin?

Your participation in this Plan begins after you have completed and submitted a Retiree HRA Plan enrollment form to your employer.

As a participant, you may request reimbursement of the Eligible Health Expenses (see Chapter 4 – *Introduction to Your Retiree HRA Plan*) that you and your covered dependents incur during a Period of Coverage (see Chapter 4 - *What is a "Period of Coverage"?*).

Are there any special enrollment rights under this Plan for new dependents?

Yes. You may enroll your new dependents in the Plan if you gain a dependent due to marriage, birth, adoption or placement for adoption, so long as you request coverage any time prior to but not later than 31 days after the date of such event. Please contact your employer for more information.

However, if you are a surviving spouse, you may not enroll a new dependent acquired through marriage.

When does my eligibility under the Plan or participation in this Plan end?

Your participation in the Plan ends upon the earliest of (a) the date you exhaust the funds in your HRA account and your HRA account has a zero balance, (b) your date of death (see Chapter 3 regarding the participation rights of your surviving eligible dependents), or (c) the date on which the Plan terminates (see Chapter 7). You will forfeit your HRA account balance if the Plan terminates.

Chapter 3: Account Funding and Account Management

How much money will my employer credit to my HRA account?

The employer will credit your HRA account as described in Chapter 10 – *Employer Funding Policy*.

Am I permitted to make contributions to my HRA account?

No. Contributions from participants are not permitted under the Plan.

Will Plan funds be held in a trust fund?

No. Your HRA account is merely a bookkeeping, notional account on the employer's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the employer's general assets.

What happens to the balance in my HRA account if I die?

If you die and have no surviving eligible dependents, your participation in this Plan ends on your date of death, and any balance in your HRA account will be forfeited. Your estate may submit claims on your behalf for reimbursement of Eligible Medical Expenses incurred by you prior to your death.

If you die and have surviving eligible dependents, your participation in this Plan ends on your date of death, but your surviving eligible dependents may continue to use your remaining account balance for the reimbursement of Eligible Health Expenses. The employer will continue to credit your HRA account with funds as described in Chapter 10 – *Employer Funding Policy*. When your last surviving eligible dependent becomes no longer eligible or dies, his or her participation ends on such date.

What happens to the balance in my HRA account at the end of the Period of Coverage (see Chapter 4 – *Benefits: What is a Period of Coverage?*)?

Your remaining account balance, if any, at the end of the Period of Coverage will be carried forward to the next Period of Coverage to pay Eligible Health Expenses incurred during that next Period of Coverage.

What will the Plan do with HRA account balances that have been forfeited?
If your HRA account balance is forfeited, your employer may use the monies to pay reasonable expenses of the Plan or to credit other eligible retirees' HRA accounts.

Chapter 4: Benefits

How does this Plan benefit me?
The Plan is designed to reimburse you for Eligible Health Expenses (see Chapter 1 – *Introduction to Your Retiree HRA Plan*) that you and your eligible dependents incur.

However, to be eligible for reimbursement under this Plan, such Eligible Health Expenses may not be reimbursed or reimbursable from any other source, such as another health plan (including a health care flexible spending account or a spouse's plan), may not be taken as a deduction on your federal income tax return, and must be paid by you prior to submitting claims for reimbursement.

Any unused balance remaining in your HRA account at the end of a Period of Coverage (in most cases, the Plan year, but see *What is a "Period of Coverage"?* below) may be carried forward to the next Period of Coverage to pay Eligible Health Expenses that you and your eligible dependents incur during that next Period of Coverage. There is no limit on the amount of your unused HRA account balance that may be carried forward.

What is my maximum reimbursement available from my HRA account?
The maximum reimbursement available from your HRA account at any time during a Period of Coverage is your HRA account balance.

What is a "Period of Coverage"?
A Period of Coverage is generally the Plan year (January 1 – December 31). If you spend your HRA account down to zero during the Plan year, the Period of Coverage is the portion of that Plan year prior to the date such spend-down occurs.

How will the Plan work?
The Plan will reimburse you for Eligible Health Expenses that you and your eligible dependents incur during a Period of Coverage if your HRA account has a positive balance. The procedure for reimbursement is as follows:

- You must submit a claim for reimbursement and any additional requested documentation to CBA, the Plan's third-party administrator (see Chapter 6);

- The claim for reimbursement must relate to Eligible Health Expenses incurred by you or your eligible dependents during a Period of Coverage;
- If you are covered under NRECA's Retiree Insurance Solutions program and have elected the premium claims interface option, claims for reimbursement of premiums will be submitted automatically to CBA;
- If you are covered under the NRECA Medical Plan and have elected the medical claims interface option, claims for reimbursement of medical plan out-of-pocket expenses will be submitted automatically to CBA; and
- The claim for reimbursement must be submitted by March 31 following the close of the Plan year in which the Eligible Health Expense was incurred.

What are Eligible Health Expenses that are reimbursable under this Plan?
Eligible Health Expenses are those expenses described in Chapter 4 – *Introduction to Your Retiree HRA Plan*. Eligible Health Expenses that are reimbursable under this Plan include the out-of-pocket expenses you or your eligible dependents incur for "medical care," as that term is defined in Section 213(d) of the Internal Revenue Code. "Medical care" is related to the diagnosis, care, mitigation, treatment and prevention of disease, and expenses for "Medical care" include, but are not limited to:

- Expenses for medical services (Expenses for medical services are expenses that are related to the diagnosis, care, mitigation, treatment or prevention of disease. Some examples of medical care expenses are (a) prescription medicines; (b) dermatology; and (c) physical therapy.)
- Prescription drugs (except for prescription drugs covered under a Medicare Part D prescription drug plan)
- Over-the-counter (OTC) drugs or medicines that are purchased with a prescription, even though the OTC drug or medicine can be purchased without a prescription
- Over-the-counter health items other than medicines and drugs (*e.g.*, equipment, supplies and medical devices, including items such as crutches, bandages, blood sugar test kits and eyeglasses)
- Dental services
- Birth control pills
- Chiropractor treatments
- Vision services
- Hearing aids
- Wheelchairs
- Premiums paid for health insurance coverage (*e.g.*, medical, dental, vision, Medicare)

Your employer can provide you with more information about which expenses are eligible for reimbursement. You may also wish to consult IRS Publication 502 *Medical and Dental Expenses*, available at the IRS website (www.irs.gov/formspubs/index.html). (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1050, Schedule A, not what is reimbursable under a health reimbursement account.)

Are there any other limitations on benefits available from the Plan?

As mentioned above, this Plan will reimburse only out-of-pocket Eligible Health Expenses that have not been previously reimbursed and are not reimbursable under any other health plan (including a health care flexible spending account), that were incurred during the Period of Coverage, that you will not claim as a tax deduction on your federal income tax return, and that you have paid. Expenses incurred prior to the date that you became a participant in the HRA and expenses incurred after the date that you cease to be a participant in the HRA, are not eligible for reimbursement under the Plan.

Eligible expenses are "incurred" when the medical care is provided, not when you or your eligible dependents are billed, charged or pay for the expense. Thus, an expense that had been paid but not incurred (*i.e.* pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

What are examples of some expenses that are not Eligible Health Expenses?
Examples of some expenses that are not Eligible Health Expenses and are not eligible for reimbursement under this Plan include the following:

- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a physician due to a participant's, spouse's or dependent's inability to perform physical housework).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Massage therapy without a physician's prescription indicating necessity for treatment of a defect or illness.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Food supplements, even if prescribed by a physician.
- Uniforms or special clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.

- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Vitamins without a physician's prescription indicating necessity for treatment of a medical condition.
- Any item that does not constitute "medical care" as defined under Section 213(d) of the Internal Revenue Code.

You may also wish to consult IRS Publication 502 *Medical and Dental Expenses*, available at the IRS website (www.irs.gov/formspubs/index.html) under the heading "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1050, Schedule A, not what is reimbursable under a health reimbursement account.)

Are my benefits taxable?
The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the Plan generally are not taxable to you. However, your employer cannot guarantee the tax treatment to any given participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

Chapter 5: COBRA

How does COBRA apply to my HRA account?
Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), when you experience a qualifying event (described below) that causes you to lose eligibility for coverage under this Plan, you, as a qualified beneficiary (described below), have the option of continuing coverage under this Plan at your own expense (known as COBRA coverage). COBRA coverage is also available to your spouse and dependent children (if covered under this Plan – see Chapter 2) who are qualified beneficiaries. COBRA coverage is only available after your participation in this Plan begins (see Chapter 2).

Your qualified beneficiaries will have the right to elect COBRA coverage for this Plan as a stand-alone plan. Qualified beneficiaries who elect COBRA will continue to have access to at least a portion of your HRA account balance during the COBRA coverage period.

Note: If your former spouse or former dependent child elects COBRA coverage on account of divorce or loss of dependent status, respectively, NRECA may divide your HRA account balance between you (including any remaining covered dependents) and the COBRA beneficiary on a pro rata basis.

Who are "qualified beneficiaries"?
Qualified beneficiaries are generally you, your eligible spouse and your eligible dependent children on the day before a qualifying event. Qualified beneficiaries also include children born to, or placed for adoption with, you during the COBRA coverage period.

What are "qualifying events"?
A qualifying event is a specific event that causes you, your eligible spouse or your dependent children to lose coverage under this Plan. Qualifying events under COBRA that cause a loss of coverage under this Plan are:

- Your divorce
- Your dependent child no longer satisfies the dependent eligibility requirements.

Note: The events above will cause your spouse or dependent child to lose coverage, but will not cause you to lose coverage.

Which qualifying events require notification?
You or your spouse must notify your employer of the following qualifying events:

- Your divorce
- Loss of dependent eligibility for your dependent child

Important: Failure to follow the following procedures for notifying your employer may result in the loss of eligibility for COBRA coverage.

Who must receive the notification at the employer?
You must send the notification to the person named in the *General Notice of COBRA Continuation Rights* as the Plan Information Contact.

When must I notify the employer?
You or your spouse must provide notice to your employer within 60 days after the date of the qualifying event. Failure to do so will result in the loss of the qualified beneficiary's right to elect COBRA coverage.

How must I notify the employer?
You must notify NRECA by providing the required information on the form and in the format specifically required by NRECA. This form, required by NRECA, is available upon request from the Plan Information Contact named in the *General Notice of COBRA Continuation Rights*.

Notifications must contain the following information:

- Name(s) of the qualified beneficiary(ies)
- Address of the qualified beneficiary(ies)
- Telephone number(s) of the qualified beneficiary(ies)
- Qualifying event
- Date of the qualifying event

Your employer will require additional information or documentation as proof of the qualifying event. Additional information or documentation needed by your employer may include:

- If the qualifying event is divorce, a copy of the first and last page of the divorce decree.
- If the qualifying event is loss of dependent eligibility, a statement as to the reason (*e.g.*, age).

Your employer reserves the right to request additional information or documentation if the information or documentation you provided is not sufficient for your employer to make its determination.

Who may provide the notification?

- You as an eligible employee or participant may provide notice on behalf of your spouse or your dependent children.
- Your spouse may provide notice on behalf of him/herself or your dependent children.
- Your dependent child may provide notice on his/her own behalf.
- Any representative acting on behalf of your spouse or your dependent children.

Notice provided to your employer by one qualified beneficiary is considered notice for all related qualified beneficiaries.

How will the employer notify me if COBRA coverage is available?
If COBRA coverage is available as a result of an initial qualifying event, your employer will provide your spouse or your dependent children with an election notice and an election form. The election notice contains information regarding COBRA rights to continued coverage. The election form is an administrative form to continue coverage under this Plan, and is to be provided to your employer.

If COBRA does not apply, your employer will send your spouse or your dependent children a *Notice of Unavailability of Coverage*, explaining the reasons why COBRA coverage is not available.

How does my spouse or my dependent children elect COBRA coverage?
Your employer will provide your spouse and/or your dependent children with an election notice and an election form. The election notice contains information regarding COBRA rights to continued coverage. The election form is an administrative form to continue coverage under this Plan. Each qualified beneficiary will have an independent right to elect COBRA coverage for this Plan as a stand-alone plan.

If your spouse or your dependent children wish to continue coverage under this Plan, they must respond to the election notice within 60 days of the date they receive the notice or the date of the qualifying event, whichever is later. Failure to respond within this 60-day period will result in the loss of the right to elect COBRA coverage.

You must submit the completed election form to:

Benefits Administrator
Ozark Border Electric Cooperative
PO Box 400
Poplar Bluff MO 63902-0400
(573) 785-4631

How long will my COBRA coverage last?
If your spouse or your dependent children elect COBRA coverage, the coverage begins on the date of the qualifying event. If your spouse or your dependent children decide not to elect COBRA coverage, they may still decide to elect COBRA coverage within the 60-day COBRA election period. In this case, the COBRA coverage begins on the date of the election, not on the date of the qualifying event.

COBRA coverage is temporary. The length of COBRA coverage depends on the qualifying event. Your spouse or your dependent children are entitled to elect COBRA coverage for the maximum period of 36 months of coverage if the qualifying event is your divorce or a dependent child's loss of dependent eligibility.

What is the COBRA premium and how do I pay it?
A qualified beneficiary must pay the full cost of COBRA coverage under the Plan on a monthly basis. A qualified beneficiary may also be required to pay a 2% administrative fee, for a total of 102% of the cost. After a qualified beneficiary elects COBRA coverage, he or she will receive a bill for the initial premium, which must be paid in full within 45 days of the date he or she elects COBRA coverage. Each subsequent premium must be paid in full within 30 days of the first of each month. Failure to pay the initial or subsequent premiums on time will result in the termination of a qualified beneficiary's COBRA coverage.

When does COBRA coverage end?
COBRA coverage will terminate on the earliest of the following events:

- COBRA premiums are not paid in full within the required payment periods.
- Your employer terminates the Plan for all employees.
- The end of the 36-month COBRA period.

Chapter 6: Claims and Appeals Procedures

How do I file a reimbursement request for Eligible Health Expenses?
Cooperative Benefit Administrators (CBA) is the Claims Administrator for this Plan. Benefits will be paid under the Plan only if the Plan Administrator, the Claims Administrator and the Appeals Administrator, as applicable, determines in its sole discretion that you are entitled to them.

You will need to submit a written request for reimbursement of these expenses.

To submit a written request for reimbursement, you will need to complete a reimbursement request form, which can be obtained from your Benefits Administrator.

The reimbursement request form requires the following information:

- Name of the person receiving the services;
- Date and nature of the service and the name of the service provider (enclose a copy of the explanation of benefits (EOB) statement if applicable). If you have no coverage for the type of service for which you are requesting reimbursement, please provide an itemized bill, and indicate that you have no coverage;
- Amount of the unreimbursed expense or premium and proof of prior payment, which could be a receipt reflecting a zero balance, a cancelled check, an invoice marked paid or a credit card statement reflecting payment; and
- Your certification that the expenses have not been reimbursed by any other source, including any other health plan (such as a health care flexible spending account) and will not be used to claim any federal income tax deduction or credit.

There are specific claim and appeal response periods for your claims.

May an Authorized Representative file on my behalf?
You may file claims for Plan benefits and appeal adverse claim decisions, either yourself or through an authorized representative. An authorized representative is a person you authorize in writing to act on your behalf. You also may provide CBA your written authorization to have a Physician or other health provider request appeals of benefit denials on your behalf.

Designating an Authorized Representative
If you use an authorized representative, you will need to complete the form "Authorization to Use and Disclose Protected Health Information." Ask your Benefits Administrator for the form. Before you submit the form to your employer, you may contact the Plan's Privacy Officer to ask questions about the use and disclosure of your health information. You may contact the Privacy Officer by telephone at (703) 907-6601, by fax at (703) 907-6602, or by email at privacyofficer@nreca.coop. Please send the completed form to the Plan's Privacy Officer at the following address to be reviewed and accepted:

Privacy Officer
Ozark Border Electric Cooperative
PO Box 400
Poplar Bluff MO 63902-0400

(573) 785-4631

The Plan will provide you with a copy of the signed Authorization form for your records.

What are claims under the Plan?
A claim for benefits is any claim for services or supplies already rendered and paid for. An example is a doctor's exam that has already been performed.

Are appeals of benefit denials available under the Plan?
An internal appeals process is available under this Plan for adverse benefit determinations—benefit denials and coverage rescissions.

What is the procedure for filing benefit claims and appealing adverse benefit determinations under the Plan?
The following table describes the process for filing claims for reimbursement and appeals of adverse benefit determinations. If you need more information, please contact your Benefits Administrator.

Process for Filing Claims for Benefits and Appeals for Adverse Benefits Determinations	
Time limit for filing a claim for reimbursement:	All reimbursement requests for the Plan year must be received by the Claims Administrator not later than **March 31st** following the end of the Plan year.
Submit your claim to:	Cooperative Benefit Administrators, Inc. P.O. Box 6962 Lincoln, NE 68506
Date your claim is considered to be "filed" with CBA:	The date CBA receives your complete claim in writing.
Time period within which CBA must notify you that your claim is approved or denied:	Not later than **30 days** from the date CBA receives your claim. CBA may require **one 15-day extension** if circumstances warrant. CBA will notify you of the extension before the initial 30-day period is up. If CBA needs the 15-day extension because you did not provide all the information needed to process your claim, CBA will tell you what information is missing.
If your claim is incomplete, the time period that you have to submit the additional requested information to CBA:	Not later than 45 days from the date CBA sent you the notice to tell you that your claim is missing information. This gives CBA additional time to respond to your claim. If you do not send CBA the missing information within this 45-day period, CBA will deny your claim.
Time period for deciding a claim is suspended while CBA waits for you to submit additional information about	The time period for deciding your claim is suspended from the date CBA notifies you that your claim is incomplete until the date you provide CBA with the requested information. CBA may then use

your claim:	the remainder of the review period to complete its evaluation of your claim.
CBA will give you a notice if your claim is denied that contains:	• Specific reasons why your claim is denied • Reference to the specific Plan provisions on which the denied claim is based. • Description of any additional information needed and why this information is needed. • Explanation of the Plan's claims review and appeal procedures.
Time period that you, or your authorized representative, have to request an Appeal:	Not later than **180 days** from the date you receive the notice that your claim is denied.
"Authorized representative" definition:	A person you authorize in writing to act on your behalf. An authorized representative does not have to be a doctor or other health care provider.
Information you may request from the Plan, free of charge:	Copies of all documents, records and other information related to your denied claim.
Materials that you may submit with your appeal:	Written comments, records, documents and other information to support your appeal, whether or not you already submitted these items.
Submit your written appeal to:	Appeals Administrator Ozark Border Electric Cooperative PO Box 400 Poplar Bluff MO 63902-0400 (573) 785-4631
Identity of the Appeals Administrator:	The Appeals Administrator is a different person than the person who made the original decision to deny your claim and is not someone directly supervised by the original decision-maker.
Time period that the Appeals Administrator has to review your appeal and make a decision:	Not later than **60 days** from the date the Appeals Administrator receives your appeal. No extension of this appeal response deadline is permitted under ERISA. The Appeals Administrator will conduct a full and fair review of all documents and evidence submitted to support your claim for benefits and may consult with medical experts in order to make a decision about your appeal. These medical experts are different persons than the ones consulted previously. If the Appeals Administrator fails to notify you of the final outcome of the appeal, you may presume that your appeal is denied.
If the Appeals Administrator denies your appeal, you will receive a notice that is	• Specific reasons why your appeal is denied. The reasons must be sound, logical and pertain to the facts of the claim. • Reference to the specific Plan provisions on which the denied

readable and easily understood by the average person without an insurance background. The notice contains:	appeal is based. You have the right to file a civil action under ERISA within 12 months after the date you receive the Appeals Administrator's decision.

Chapter 7: Plan Information

Plan Name: Ozark Border Electric Cooperative Retiree Health Reimbursement Arrangement (HRA) Plan

Plan Number: ___

Type of Plan: Employer-provided health reimbursement plan under Code sections 105 and 106 and a health reimbursement arrangement as defined by IRS Notice 2002-45. The Plan is also intended to constitute a plan described in DOL Reg. 2590.732(b).

Plan Year: The Plan Year begins on January 1 and ends the following December 31.

Effective Date: January 1, 2015

Plan's Self-Insured Status: Coverage under the Plan is self-insured.

Administration: Except where pre-empted by ERISA or other U.S. laws, the validity of the Plan and any other provisions will be determined under the laws of Missouri.

Plan Sponsor: The name and address of the Plan Sponsor is:
Ozark Border Electric Cooperative
PO Box 400
Poplar Bluff MO 63902-0400
(573) 785-4631

Ozark Border Electric Cooperative, as the Plan Sponsor, must abide by the rules of the Plan when making decisions related to how the Plan operates and how benefits are paid.

Plan Sponsor's Employer Identification Number: 43-0445644

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

Ozark Border Electric Cooperative
PO Box 400
Poplar Bluff MO 63902-0400
(573) 785-4631

Claims Administrator: The Claims Administrator for the Plan is:

Cooperative Benefit Administrators, Inc.
P.O. Box 6962
Lincoln, NE 68506

Agent for Service of Legal Process: The agent of service of legal process is the Plan Administrator. This is the person who receives all legal notices on behalf of the Plan Sponsor regarding the claims or suits filed with respect to this Plan.

Chapter 8: Administrative Information

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.

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. However, any termination or amendment will not affect your right to claim benefits for that portion of the Plan year or Period of Coverage prior to such termination or amendment, to the extent such benefits are funded and such amounts are payable under the terms of the Plan as in effect prior to the calendar month in which the Plan is terminated or amended.

Nondiscriminatory Benefits

This Plan is intended not to discriminate in favor of highly compensated employees as to eligibility, contributions and/or plan benefits. The Plan Administrator can take appropriate action to assure nondiscrimination, including reducing plan contributions, benefits and participation.

Not a Contract of Employment

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

Non-Assignment of Benefits

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

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, and
- Due to any error the Plan makes in processing a claim.

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

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.

Chapter 9: Federal Laws Impacting This Plan

Statement of ERISA Rights

Your Rights

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

Receive Information About Your Plan and Benefits

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

Obtain, upon request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (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.

COBRA Rights

ERISA also provides that all Plan participants will be entitled to:

Continue health care coverage for yourself, your spouse or your 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require the employer, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the

materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

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

HIPAA Privacy Rights

Availability of HIPAA Notice of Privacy Practices
The privacy rules under HIPAA govern how health information about you may be used and disclosed by the Plan, and provide you with certain rights with respect to your health information. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan, and describe the Plan's legal duties and privacy practices relative to such information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your employer's Privacy Officer:

Ozark Border Electric Cooperative
PO Box 400
Poplar Bluff MO 63902-0400
(573) 785-4631

Chapter 10: Employer Funding Policy

The employer shall credit HRA Plan contributions to participants' accounts:

- One time upon retirement of employee, the value of unused leave time which has been previously banked by the retiring employee