NRECA Group Term Life and AD&D Insurance Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

OZARK BORDER ELECTRIC COOPERATIVE

01-26033-002

EFFECTIVE DATE: January 1, 2018

NRECA

America's Electric Cooperatives

Introduction

Summary Plan Description

This is a summary plan description (SPD), also known as the *Benefits Booklet*. It describes the benefits provided by the National Rural Electric Cooperative Association (NRECA) Group Term Life and Accidental Death & Dismemberment Insurance (the Plan) to participants.

Your Responsibilities

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

While reading this material be aware that:

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

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

Fraud Warning Statement

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 concerning 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. Please see the chapter titled *General Information* for the state-specific warning that may apply to your state of residence.

For California Residents: Review this certificate carefully. If you are 65 or older on your effective date, under California law (Cal. Ins. Code § 786 effective 7/1/2015) you may return this Summary Plan Description to your cooperative's benefits administrator within 30 days from the date you receive it and they 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 National Rural Electric Cooperative Association's Group Benefits Program

Plan Identification Number:	501
Plan Type:	Group Term Life and Accidental Death & Dismemberment Insurance
Year End:	December 31
Plan Effective Date:	January 1, 2018

Underwritten By

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

Plan Administrator and Named Fiduciary

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

Telephone number 703.907.5500

Plan Administrator Employer Identification Number: 54-2072724

Plan Sponsor

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

Plan Sponsor Employer Identification Number: 53-0116145

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

In addition to the Senior Vice-President of the Insurance and Financial Services Department, the benefits administrator is the person with Plan Administrator responsibilities for your employer:

OZARK BORDER ELECTRIC COOPERATIVE
PO Box 400
Poplar Bluff, MO 63902

Your Employer's Identification Number (EIN)

43-0445644

Agent for Service of Legal Process

Senior Vice-President,

Insurance & 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, NRECA Group Benefits Trust

State Street Bank and Trust Company
225 Franklin Street
Boston, MA 02101

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** OZARK BORDER ELECTRIC COOPERATIVE PO Box 400 Poplar Bluff, MO 63902
Eligibility appeals	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203
Voluntary final appeals	**NRECA Appeals Committee** Attn: Senior VP, Insurance and Financial Services 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203

Chapter 2: Group Term Life and AD&D Plan Highlights

This chapter includes highlights of your Life Insurance and your Accidental Death and Dismemberment (AD&D) Insurance benefits under the Plan. For full details about these benefits, other benefits, and Plan exclusions, refer to the chapters titled *Your Benefits During a Leave of Absence*, and *Term Life Benefits*.

Note: The Plan's maximum Life benefit is **8 times salary** (combination of Basic Life Insurance and Supplemental Life Insurance). The Plan's maximum AD&D benefit is **8 times salary** (combination of Basic AD&D Insurance and Supplemental AD&D Insurance).

You and your spouse and child will only be insured for the benefits:

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

Basic Life Insurance Benefit Highlights

Your Basic Life coverage automatically comes with a matching amount of AD&D coverage

Benefit Level	Coverage	Who Pays
5 x Salary	Life Insurance benefit equal to five times your Base Annual Earnings	Employer

Maximum Basic Life Insurance Benefit	$1,000,000
Accelerated Benefit Option	Up to 80% of your Basic Life Insurance amount not to exceed $500,000

Supplemental Life Insurance Benefit Highlights

Benefit Level	Coverage	Who Pays
1x salary	Life insurance benefit equal to your Base Annual Earnings	Employee
2x salary	Life Insurance benefit equal to twice your Base Annual Earnings	Employee
3x salary	Life Insurance benefit equal to three times your Base Annual Earnings	Employee

Benefit Level	Coverage	Who Pays
4x salary	Life Insurance benefit equal to four times your Base Annual Earnings	N/A
5x salary	Life Insurance benefit equal to five times your Base Annual Earnings	N/A

Maximum Supplemental Life Insurance Benefit	$1,500,000
Non-medical Issue Amount	Up to 2 times your Base Annual Earnings
Accelerated Benefit Option	Up to 80% of your Supplemental Life Insurance amount not to exceed $500,000

Basic AD&D Insurance Benefit Highlights

Full Amount for Basic AD&D Insurance Benefit	Is equal to your Basic Life Insurance benefit amount
Maximum AD&D Insurance Benefit	$1,000,000
Common Disaster Benefit	None
Hospital Confinement	Yes

Schedule of Covered Losses for Basic AD&D Insurance

All amounts listed are percentages of the full Basic AD&D Insurance coverage amount.

Event	Coverage
Loss of life	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%

Event	Coverage
Loss of sight in one eye This means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.	50%
Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of the same hand This means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.	25%
Loss of speech and loss of hearing This means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury and means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.	100%
Loss of speech or loss of hearing This means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury and means the entire or irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.	50%
Paralysis[1] of both arms and both legs	100%
Paralysis[1] of both arms or both legs	50%
Paralysis[1] of the arm and leg on either side of the body	50%
Paralysis[1] of one arm or leg	25%
Brain Damage This means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.	100%

Event	Coverage
Coma This means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.	1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months

[1]***Paralysis*** *means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible*.

Additional Basic AD&D Insurance Coverage Features

All amounts listed are percentages of the full Basic AD&D Insurance coverage amount.

Benefit*	Amount	Benefit Minimum	Benefit Maximum
Seat Belt Use	10% of Full Amount	$1,000	$25,000
Air Bag Use	5% of Full Amount	$1,000	$10,000
Child Care	Annual charges up to $5,000 per year for children under age 12	$1,000	12% of Full Amount (overall maximum)
Child Education	Annual charges up to $10,000 per year for up to 4 years	$1,000	20% of the Full Amount (overall maximum)
Spouse Education	Annual charge up to $5,000 for one academic year	$1,000	3% of the Full Amount (overall maximum)
Common Carrier	100% of the Full Amount	N/A	N/A
Rehabilitative Physical Therapy	Actual charges for up to 10% of the Full Amount	N/A	$25,000
Hospital Confinement	1% of Full Amount	N/A	$2,500
3rd Degree Burn	A percentage of the Full amount equal to the % of body surface suffering 3rd degree burn	N/A	Overall Maximum

Benefit*	Amount	Benefit Minimum	Benefit Maximum
**For specific requirements for these additional features please see the section titled Additional AD&D Insurance Features in the AD&D Insurance Benefits chapter.*			

Supplemental AD&D Insurance Benefit Highlights

Benefit Level	Coverage	Who Pays
1x salary	AD&D benefit equal to your Base Annual Earnings	Employee
2x salary	AD&D benefit equal to two times your Base Annual Earnings	Employee
3x salary	AD&D benefit equal to three times your Base Annual Earnings	Employee
4x salary	Not available at your employer	N/A
5x salary	Not available at your employer	N/A

Maximum Supplemental AD&D Insurance Benefit	$1,500,000
Common Disaster Benefit	Yes (your spouse must be a covered dependent in the family option of AD&D in order to be eligible for this benefit)

For additional features provided by Supplemental AD&D Insurance Coverage, please see the section in this chapter titled *Additional Basic AD&D Coverage Features*.

For the Schedule of Covered Losses, please see the section titled *Basic AD&D Insurance Benefit Highlights*.

Life Insurance Benefits for Your Child and Spouse Highlights

Benefit Level	Coverage	Who Pays

Benefit Level	Coverage	Who Pays
$10,000	Flat amount Life Insurance benefit for your child. Same premium whether you have 1 child or more than 1 child.	Employee
$10,000	Flat amount Life Insurance benefit for your spouse. Your Basic Life Insurance benefit must equal at least $10,000.	Employee
$25,000	Flat amount Life Insurance benefit for your spouse. Your Basic Life Insurance benefit must equal at least $25,000.	Employee
$50,000	Flat amount Life Insurance benefit for your spouse. Your Basic Life Insurance benefit must equal at least $50,000.	Employee
$75,000	Flat amount Life Insurance benefit for your spouse. Your Basic Life Insurance benefit must equal at least $75,000.	Employee
$100,000	Flat amount Life Insurance benefit for your spouse. Your Basic Life Insurance benefit must equal at least $100,000.	Employee

Note: *Your spouse's benefit level cannot be higher than your Basic Life and Supplemental Life benefit levels combined*.

Coverage	Benefit Level
Accelerated Benefit Option	Up to 80% of your Spouse Life Insurance amount not to exceed $80,000
Non-medical Issue Limit for Spouse Life Insurance	Up to $25,000
Non-medical For each of your Children	$10,000
Accelerated Benefit Option	Up to 80% of your Child Life Insurance amount not to exceed $8,000

AD&D Insurance Benefits for Your Spouse and Child Highlights

Full Amount for Family AD&D Insurance coverage is based on family unit at time of loss.

Benefit Level	Coverage	Who Pays
Spouse and child(ren)	An amount equal to a) 40% for your spouse, and b) 10% for each child of your Supplemental AD&D Insurance coverage	Employee
Spouse only	An amount equal to 50% of your Supplemental AD&D Insurance coverage	
Child only	An amount equal to 15% for each child of your Supplemental AD&D Insurance coverage	

For schedule of covered losses see Basic AD&D Insurance Coverage Highlights *above. These benefits are subject to the exclusions listed in the* Exclusions *section of the* AD&D Insurance Benefits *chapter.*

Reduction in Insurance at Age 70

If you are **age 70 or older** on your effective date of participation, your Basic Life and AD&D benefits will be limited to the percentage shown below and reduced thereafter to the percentage shown below based on your age.

If you are **under age 70** on your effective date of participation, your Basic Life and AD&D benefits will be reduced to the percentage shown below on the first day of the month following the date you attain age 70 and thereafter as follows.

Basic Life and AD&D will always reduce and continue to reduce.

If you experienced an age reduction prior to 1/1/2018 on any of the following Life benefits, Supplemental Life, Supplemental AD&D and Spouse Life; those reductions will remain in effect with no future reductions unless there is a plan change. Once a plan change occurs previous reductions for these plans will be removed.

Your Age	Percentage
70 through 74	60% of your current volume
75 through 79	40% of your current volume
80 and older	26% of your current volume

Your Basic Life and AD&D benefits are reduced on the first of the month following your attainment of the ages above. If your birthday is on the first of the month, your benefits are reduced on the first day of the month following your birthday month.

Your base annual earnings are used to calculate your Basic Life and AD&D benefits after age 70. Any pay increases you receive after age 70 will be included when the Plan calculates your benefits.

If you experienced a reduction in Basic Life and AD&D benefits **prior to 1/1/2018,** your reduced benefits will be based on your base annual earnings at age 70, and any pay increases you receive(d) after age 70 will not be included when the Plan calculates your volume.

If you experienced a reduction in Basic Life and AD&D benefits **prior to 1/1/2018**, those reduced benefits will remain in force with no future reductions for your Supplemental Life benefits, Supplemental AD&D benefits, Spouse Life benefits and Family AD&D benefits, as applicable.

Example prior to 1/1/2018: Bridget has base annual earnings of $25,000 when she reaches age 70, at which time her Basic Life and AD&D benefits were reduced. The next year her pay increases to $27,000. Her Basic Life and AD&D benefits will continue to be based on the $25,000 salary she had when she turned age 70.

Age 70 basic life (current Salary of $25,000) volume: 60% of $25,000 reduction $15,000

Age 71 basic life (current Salary of $27,000) volume: 60% of $25,000 = $15,000

Example after 1/1/2018: Mike has base annual earnings of $45,000 when he reaches age 70, at which time his Basic Life and AD&D benefits were reduced. The next year his pay increases to $57,000. His Basic Life and AD&D benefits reduction will now be based on the new higher salary of $57,000 salary he now has at age 71.

Age 70 basic life (current Salary of $45,000) volume: 60% of $45,000 reduction $27,000

Age 71 basic life (current Salary of $57,000) volume: 60% of $57,000 = $34,200

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

Eligible Class(es)

All employees who are full-time actively at work at the employer are eligible for the Plan if elected by your employer. If you are enrolled under this Plan **as a director**, you are not eligible under this Plan **as an employee** (see the section in this chapter titled *If You Become a Director*).

To be considered eligible for participation you must be:

In a covered job classification, and

- Have completed the eligibility waiting period (see the section titled *Eligibility Waiting Period*), if any, for your employer, or have worked at another rural electric cooperative (co-op) within the past 6 months and met these conditions; and
- Be expected to work at least 1,000 hours for your employer as an active employee during your first 12 months of employment; and
- Have worked
  - At least 1,000 hours for your employer each subsequent calendar year; or
  - At another co-op within the past six months and met the other criteria noted in the bullets above.

A co-op means for purposes of the 2nd and 5th bullets below:

- Your employer;
- Any member co-op of NRECA (even if the co-op doesn't participate in NRECA plans);
- An employer that is an affiliate of a member co-op;
- An employer that has since become a member co-op of NRECA; or
- An employer that has since merged with, been consolidated with or been liquidated into a current member co-op of NRECA.

Ineligible Class(es)

The following classifications of 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 are eligible only for the insurance available for your eligible class as shown in the *Plan Highlights* chapter.

You will be eligible for insurance described in this SPD on the later of:

- Your employer's effective date; or
- The day after the date you complete the eligibility waiting period applicable to you.

Eligibility Waiting Period

Eligibility waiting period means the period of continuous membership in an eligible class that must be completed before you become eligible for insurance. This period begins on the date you enter an eligible class and ends on the date you complete the period(s) specified.

The Waiting Period for this Plan is: No Waiting Period is required by this Plan.

If You Become a Director

If you become a director, you may choose to enroll in a Director's Life and AD&D Insurance Plan, a Director's AD&D Only Insurance Plan or both, if your employer participates in such plans and if you are eligible to participate in them.

If you enroll in the Director's Life and AD&D Insurance Plan, coverage under this Plan will end. If you choose the Director's AD&D Only Insurance Plan, you may continue Basic Life Insurance coverage under this Plan as an employee.

For more information, please see your benefits administrator.

Husband and Wife Both Work for Cooperatives

If you and your spouse both work for cooperatives that participate in the NRECA Group Term Life and AD&D Insurance Plan, then the following Group Term Life and AD&D Insurance Plan coverage is allowable, provided each employee is eligible for coverage separately:

- Husband and wife may be enrolled separately in Basic Life Insurance coverage as individual employees.
- Husband and wife may be enrolled separately in Supplemental Life and Supplemental AD&D Insurance coverage as individual employees.
- Husband and wife may each elect the Family AD&D Insurance coverage option for their spouse and child.
- Husband and wife may each elect the Spouse Life Insurance coverage option for their spouse.
- Husband and wife may each elect Child Life Insurance coverage for their child.

Date Insurance Takes Effect

Rules for Non-contributory Insurance

When you complete the enrollment process for non-contributory insurance, such insurance will take effect on the date you become eligible, provided you are actively at work on that date.

If you are not actively at work on the date the non-contributory insurance would otherwise take effect, the benefit will take effect on the day you resume active work.

Rules for Contributory Insurance

If you request contributory insurance **before** the date you become eligible for the life insurance coverage you are requesting, such insurance will take effect as follows:

- If you are **not required** to give evidence of your insurability (see the section titled *Evidence of Insurability*), such insurance will take effect on the date you become eligible, provided you are actively at work on that date. You are not required to give evidence of your

insurability for Basic Life Insurance and AD&D Insurance during your initial enrollment opportunity.

- If you are required to give evidence of your insurability and MetLife determines that you are insurable, such insurance will take effect on the date MetLife states in writing, provided you are actively at work on that date. AD&D Insurance does not require evidence of your insurability, but such insurance will not take effect until the day your Basic Life Insurance takes effect.

If you request contributory insurance **within 31 days after** the date you become eligible for such insurance, such insurance will take effect as follows:

- Upon enrollment, you are eligible for up to 2x salary of Supplemental Life Insurance coverage without completing a statement of health (SOH) form.
- If you are **not** required to give evidence of your insurability, such insurance benefit will take effect on the later of:
  - The date you become eligible for such insurance; or
  - The date you enroll provided you are actively at work on that date.
- You are not required to give evidence of your insurability for Basic Life Insurance and AD&D Insurance during your initial enrollment opportunity.
- If you are required to give evidence of your insurability and MetLife determines that you are insurable, such insurance will take effect on the date MetLife states in writing, provided you are actively at work on that date. AD&D Insurance does not require evidence of your insurability, but such insurance will not take effect until the day your Basic Life Insurance takes effect.

If you request contributory insurance (other than Supplemental AD&D Insurance) **more than 31 days after** the date you become eligible for such insurance, you must give evidence of your insurability satisfactory to MetLife. If MetLife determines that you are insurable, such insurance will take effect on the date MetLife states in writing, if you are actively at work on that date.

If you complete the enrollment process for contributory Supplemental AD&D Insurance **more than 31 days after** the date you become eligible for such insurance, such insurance will not take effect until the day your Basic Life Insurance takes effect. Supplemental AD&D Insurance does not require evidence of your insurability.

For more information on evidence of insurability, please see the section titled *Evidence of Insurability*.

Spouse and Child Life Insurance Enrollment Process

If you are eligible for spouse and Child Life Insurance coverage, you may apply for such insurance by completing an enrollment form for your spouse and each child to be insured. Upon your initial enrollment, your spouse is eligible for up to $25,000 in life coverage without providing evidence of insurability. If you enroll your spouse more than 31 days after you are first eligible, your spouse must give evidence of insurability satisfactory to MetLife if required to do so. Please see the section titled *Evidence of Insurability* for details.

Your child(ren) are eligible for $10,000 of coverage. Evidence of insurability is not required for Child Life Insurance coverage.

If you apply for contributory insurance, you must also give your employer written permission to deduct premiums from your pay for such insurance. You will be notified by your employer

regarding how much you will be required to contribute. The rate for Spouse Life is based on the age of the employee as of January 1 of the year the request is to take effect.

On the date the Spouse or Child Life Insurance is scheduled to take effect, the spouse or child must not be:

- Confined at home or under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

Spouse or Child Life Insurance will take effect on the date he or she is no longer:

- Confined at home or under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

Enrollment During Any Subsequent Annual Enrollment Period

During any annual enrollment period as determined by your employer, you may enroll in insurance for which you, your spouse or your child (ren) are eligible or choose a different option than the one for which you, your spouse or your child (ren) are currently enrolled. The insurance enrolled in, or the changes to your insurance made during an annual enrollment period will take effect as follows:

- For any coverage amount for which you are not required to give evidence of your insurability, such insurance that will take effect on the first day of the month following the annual enrollment period, if you are actively at work on that date. You are not required to give evidence of your insurability for Supplemental AD&D Insurance.
- For any coverage amount for which you are required to give evidence of your insurability and MetLife determines that you are insurable, such insurance will take effect on the date MetLife states in writing, if you are actively at work on that date. Supplemental AD&D and Child Life Insurance does not require evidence of your Insurability but such insurance will not take effect until the day your Basic Life Insurance takes effect.

If you are not actively at work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day you resume active work. For a contributory life insurance benefit to take effect, in addition to being actively at work on the date the insurance benefit is to take effect, you must also have been actively at work for at least 20 hours during the 7 calendar days preceding that date.

Increase in Insurance Coverage

An increase in insurance coverage due to a change in class of eligible employee or due to an increase in Your earnings will take effect on the date of such change in class of eligible employees or such change in earnings, provided that You are either Actively at Work, on sick leave, on FMLA leave or on leave with pay when either such change occurs.

If on the date of the change in class of eligible employees or the increase in earnings, You are not Actively at Work, not on sick leave, not on FMLA leave, and not on leave with pay, then the increase in insurance coverage will take effect when You become Actively at Work, on sick leave, on FMLA leave or on leave with pay.

Enrollment Due to a Qualifying Event

Under the rules of the Plan, you may apply for insurance for which you are eligible or change the amount of your insurance between annual enrollment periods only if you have a qualifying event. If you are not actively at work on the date insurance would otherwise take effect, insurance will take effect on the day you resume active work.

Qualifying Event includes:

- Marriage;
- The birth, adoption or placement for adoption of a dependent child; step or foster;
- Divorce or annulment;
- Court-appointed legal guardianship;
- The death of a spouse or child; or
- Child ceases to qualify as a child under the terms of the Plan.
- You or your dependents loss of group life coverage sponsored by another employer or provided by one of the U.S. armed forces.

If you have a qualifying event, you will have 31 days from the date of that event to make a request for enrollment. The insurance enrolled for or changes to your insurance made as a result of a qualifying event will take effect as follows:

- For any coverage amount for which you are **not required** to give evidence of your insurability, such insurance will take effect on the first day of the month following the date of your request, if you are actively at work on that date. You are not required to give evidence of your insurability for Supplemental AD&D Insurance.
- For any coverage amount for which you are required to give evidence of your insurability and MetLife determines that you are insurable, such insurance will take effect on the date MetLife states in writing, if you are actively at work on that date. Supplemental AD&D Insurances does not require evidence of your insurability but such insurance will not take effect until the day your Basic Life Insurance takes effect.

Increase in Insurance Due to a Qualifying Event

A requested increase of coverage due to a qualifying event requires an SOH application for requested coverage amounts over the Non-medical issue amount, and will take effect as follows:

- If you are **not required** to give an SOH, the increase will take effect on the date of your request.
- If you are required to give an SOH (subject to approval from MetLife), the increase will take effect the day written approval is received.

If you are not actively at work on the date insurance would otherwise take effect, the insurance change will take effect on the day you resume active work. For a Contributory Life Insurance Benefit to take effect, in addition to being actively at work on the date the insurance benefit is to take effect, you must also have been actively at work for at least 20 hours during the 7 calendar days preceding that date.

Increase in Life Insurance for Your Spouse Due to a Qualifying Event

A requested increase in insurance for your spouse due to a qualifying event, will take effect as follows:

- If your spouse is **required** to give evidence of insurability, the increase will take effect on the date MetLife states in writing. If MetLife does not approve the SOH or if you do not submit one for your spouse, the increase in insurance for your spouse will not take effect.
- If your spouse is required to give evidence of insurability for a portion of the increase in insurance:
  - The portion of the increase in insurance that is not subject to evidence of insurability will take effect on the date of your request.
  - If MetLife approves the SOH, the portion of the increase in benefit that is subject to evidence of insurability will take effect on the date MetLife states in writing. If MetLife does not approve the SOH or you do not submit one for your spouse, the increase in insurance for your spouse will not take effect.
  - If your spouse is not required to give evidence of insurability, the increase will take effect on the date of your request.
- You must be actively at work on that date. If you are not actively at work on the date the increase would otherwise take effect, the increase will take effect on the day you resume active work.

Decrease in Insurance Due to a Qualifying Event

If you make a written application to decrease your or your spouse's insurance, that decrease will take effect as of the date of your application.

Date Your Insurance Ends

Your insurance will end on the earliest of:

- The date the Plan ends;
- The date insurance eligibility ends for your employee classification;
- The end of the period for which the last premium has been paid for you;
- The date your employment ends. Your employment will end if you cease to be actively at work in any eligible employee classification for your employer, except as provided in the section titled *When You Become Disabled*; or
- The date you retire in accordance with the employer's retirement plan.

You can convert or port all or part of your former coverage (see the chapter titled *Porting or Converting Coverage* for details). In certain cases your Life Insurance may be continued, such as if you are disabled. Please refer to the section titled *When You Become Disabled* for information regarding the option to continue your coverage while disabled and still employed by your employer.

Date Your Insurance for Your Spouse and Child Ends

A spouse's or child's insurance will end on the earliest of:

- For Spouse or Child Life Insurance, the date all of the life insurance under the Plan ends;
- For Family AD&D Insurance, the date your Supplemental AD&D Insurance under the Plan ends;
- The date you die;
- The date the Plan ends;

- The date insurance for your spouse and child ends under the Plan;
- The date insurance for your spouse and child ends for your class of employment;
- The date the person ceases to be a spouse or child;
- The date your employment ends (your employment will end if you cease to be actively at work in any eligible employee classification for your employer, except as provided in the section titled *When You Become Disabled*);
- The date you retire in accordance with the employer's retirement plan; or
- The end of the period for which the last premium has been paid for the Spouse or Child Life Insurance or Family AD&D Insurance.

Note: Coverage for your dependent child will end as of 11:59 pm on the last day of the month during which he or she becomes 26 years of age.

Please refer to the chapter titled *Porting or Converting Coverage* for information concerning the option to continue coverage through an individual policy of life insurance if life insurance for a spouse or child ends.

For Mentally or Physically Handicapped Children

Insurance for a child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to MetLife within **31 days** after the date the child attains the age limit and at reasonable intervals after such date.

Subject to the section titled *Date Your Insurance For Your Spouse and Child Ends*, insurance will continue while such child:

- Remains incapable of self-sustaining employment because of a mental or physical handicap; and
- Continues to qualify as a child, except for the age limit.

When You Become Disabled

If Your Disability Occurs Before Normal Retirement Age

If you become disabled before your employer's normal retirement age, you may qualify to continue your Basic Life Insurance, Basic AD&D Insurance and Supplemental Life Insurance coverage with premiums waived. NRECA will determine if you qualify for this continuation after proof is received, that you have satisfied the conditions of this section. The conditions are:

- You or your benefits administrator submit to NRECA the forms to qualify your disability;
- You meet the definition of disability or disabled;
- You keep your status as an employee and have not terminated your employment or retired;
- You continue to pay your share of the premiums, if any, and
- Your employer continues to participate in the NRECA Group Term Life and AD&D Insurance Plan.

If you meet all of the above conditions, your premiums for Basic Life Insurance, Basic AD&D Insurance and Supplemental Life Insurance are waived after six months of disability. This means you do not have to pay your share of the cost of your coverage after the waiver takes effect. This waiver takes effect on the first of the month on or after the date that is 180 days

from the date of onset of your disability. Premiums, however, must be paid when due for coverage for the first six months of disability. **Note:** Six months, for the purposes of the waiver of premium, will be 180 days from the date of disability.

The amount of insurance provided will be the same as the amount in force on the date last worked. For this purpose, your base annual earnings and life insurance amount in force are frozen as of the date last worked and remain at those amounts until you return to work, retire or terminate your employment.

The premium waiver does not apply to Spouse Life Insurance, Child Life Insurance, Supplemental AD&D Insurance and Family AD&D Insurance. You would have to pay the full premiums to continue these coverages until they would otherwise end or until you retire.

As a disabled employee, your **Life Insurance will end:**

- If you do not pay your premium between the date of your disability and the date your premium waiver takes effect;
- When you are no longer employed by your employer because you terminated your employment or retired;
- When you reach your employer's normal retirement age; or
- If your employer stops participating in the Plan.

As a disabled employee, your **waiver of premium will end:**

- When you reach your employer's normal retirement age;
- If you return to active employment; or
- Your insurance ends (as outlined above).

When your life insurance ends, you will no longer be able to participate in the Basic Life Insurance, Basic AD&D Insurance and Supplemental Life Insurance coverages, and the premium waiver ends.

You can convert or port all or part of your former coverage (see the chapter titled *Porting or Converting Coverage*).

If you retire while you are disabled, or reach your employer's normal retirement age while disabled, you may:

- Enroll in Retired Life Insurance if offered by your employer; or
- Convert or port to an individual policy (see the chapter titled *Porting or Converting Coverage*):
    - The amount of coverage not covered by Retired Life Insurance; *or*
    - The full amount of your coverage as a disabled employee if you decide not to enroll in Retired Life Insurance.

If Your Disability Occurs After Normal Retirement Age

If you are an active employee and become disabled after the normal retirement age for your employer, your Basic Life Insurance, Basic AD&D Insurance and Supplemental Life Insurance coverage will continue for 180 days after the date of onset of your disability: six months. **Note:** Six months, for the purposes of the life coverage, will be 180 days from the date of disability.

- Subject to any benefit reductions if you are over age 70; and

- So long as your employer continues to participate in the NRECA Group Term Life and AD&D Insurance Plan.

After such 180-day period, the Basic Life Insurance, Basic AD&D Insurance and Supplemental Life Insurance coverage you had as an employee, subject to any benefit reductions, will end.

You may:

- Enroll in Retired Life Insurance if offered by your employer; or
- Convert or port to an individual life insurance policy (see the chapter titled *Porting or Converting Coverage*) for the following amount:
  - The amount of coverage not covered by Retired Life Insurance; or
  - The full amount of your coverage as an active employee if you decide not to enroll in Retired Life Insurance.

For Family and Medical Leave

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) for continuation of insurance. Please contact the employer for information regarding the FMLA.

Employees Who Cease Active Work

The employer may elect to continue insurance by paying premiums for its employees who cease active work. Please see your employer for more information.

If your insurance ends, your spouse's and child's insurance will also end.

Evidence of Insurability

MetLife may require satisfactory evidence of insurability before it will issue coverage. The evidence of insurability is to be given by filing out an SOH form. **Evidence of insurability is needed in the following circumstances:**

- If you wish to increase the amount of your Supplemental or Spouse Life Insurance above a Non-medical Issue Amount during your initial eligibility or during a qualified life event:
  - Evidence of your insurability will be required by MetLife within 31 days of the date of the elected coverage. If such evidence of insurability is not submitted to or accepted by MetLife as satisfactory within 60 days, the amount of life insurance coverage will be limited to the amount previously in force or the Non-medical Issue Amount.
- If you wish to increase the amount of any Life Insurance coverage during your employers annual enrollment period:
  - Evidence of your insurability will be required by MetLife prior to the effective date of the elected coverage. If such evidence of insurability is not submitted to or accepted by MetLife as satisfactory within 60 days, the amount of life insurance coverage will be limited to the amount previously in force.
- If you make a late request for life insurance—either 31 days after initial eligibility or 31 days after a qualified event—you will then need to wait until your employer's next annual enrollment period or the next Qualifying Event.

If MetLife requests evidence of insurability due to the circumstances described above, either you or your spouse must complete an SOH form to determine if you or, your spouse can be insured by the Plan.

Chapter 4: Your Benefits During a Leave of Absence

General Information

Your employer offers various types of leaves of absence. A leave of absence means time away from work, as permitted by your employer, for reasons such as military duty, family care or personal needs. Time away from work does not include time off as a result of injury, sickness or disciplinary suspension.

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

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

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

Compensated and Uncompensated Leave of Absence

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

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

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

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

Eligibility to Participate During Your Leave of Absence

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

If you are on an employer-approved **uncompensated** leave of absence, eligibility to participate in this Plan may continue for up to 90 calendar days as long as the required applicable

premium is paid. If you obtain other employment during your uncompensated leave of absence, your eligibility to participate may end before 90 calendar days.

Note: If you participate in your employer's long-term disability (LTD) plan and you either have a claim pending with that plan (whether the initial claim, a claim for which an appeal is pending or a claim for which the appeals filing deadline has not expired) or you are waiting for the LTD plan's benefit waiting period to end, then your eligibility to participate in this Plan continues as long as the required premium is paid. If your LTD claim is approved, continued eligibility to participate in this Plan depends on your employer's policy. If your LTD claim is denied, then your eligibility to participate in this Plan ends on either the date your initial claim is denied or the date your claim is denied on appeal.

Annual Benefits Enrollment

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

Paying for Benefits During Your Leave of Absence

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

Returning From a Leave of Absence

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

If you return to work immediately following the end of your approved leave, you are eligible to be re-enrolled in this Plan. Your coverage is effective on the date you return to work. For additional information, contact your benefits administrator.

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

If You Terminate Employment While on a Leave of Absence

If your employment ends either during or at the end of your leave of absence and your benefit coverage was not terminated during the leave, you or your employer must make any required premium payments that did not occur. If you do not pay for all elected benefit coverages by the due date, your coverage will end on your last day worked.

Workers' Compensation

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

Family Medical Leave Act (FMLA)

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

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Note: Benefits will not be paid under the provisions of the accidental death and dismemberment coverage for any loss caused or contributed to by war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Military Leave of 31 or Fewer Days

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

Military Leave Longer Than 31 Days

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

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

If you drop your coverage upon going on a military leave or if your coverage lapses or terminates due to nonpayment, but you return to work within the applicable job reinstatement period in a benefits-eligible position, coverage and contributions can be reinstated to the extent required by USERRA. Coverage is effective upon your reemployment. If you do not reinstate your coverage within 31 days of your reemployment, you must wait until the next annual benefits enrollment period to reenroll, unless you have an applicable special enrollment right, life event or employment event.

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

Chapter 5: Term Life Benefits

Basic and Supplemental Life Insurance Benefit Calculations

For coverage purposes on salary multiple plans, your base annual earnings are rounded up to the next $1,000 then multiplied by the selected salary multiplier chosen for the plan amount (1x, 2x, 3x salary, etc.)

For example, if your annual base salary is $44,200 and you have 2 x Basic Life plan, the salary would be rounded up to $45,000 and your Basic Life benefit would be $90,000 of Basic Life and $90,000 of Basic AD&D.

Benefit Payment

In the event of your death, your beneficiary receives a benefit that is a multiple of your actual Base Annual pay in effect at the time of your death.

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 option or 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, simply by writing drafts from the TCA in amounts of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately from the TCA if desired. Please note the TCA is not a bank account and is not a checking, savings or money market account.

Additional Basic and Supplemental Life Insurance Coverage Features

MetLife Will Preparation Benefit

You will be eligible to use your MetLife Will Preparation benefit, provided by participating Hyatt Legal Plan attorneys, once your Basic Life Insurance benefit becomes effective.

When you use the Hyatt 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 Hyatt Legal Plans' network and receive reimbursement of up to $150 for an employee and up to $200 for an employee and spouse a pre-determined amount 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 the document library: cooperative.com > My Benefits > Education & Resources > Insurance Plan Documents.

MetLife Estate Resolution Services

Your beneficiary will automatically be eligible to use the Estate Resolution Services, provided by participating Hyatt Legal Plan attorneys, once your Basic Life Insurance benefit becomes effective and after your death.

Estate Resolution Services are available to your beneficiary and cover the following probate services when your beneficiary contacts the Hyatt Legal Plan's network:

- Telephone and office consultations to discuss matters related to probating your estate;
- Preparation of documents related to probating your estate;
- Representation at court proceedings related to probating your estate;
- Completion of correspondence necessary to transfer probate assets (insurance policies, joint; bank accounts, stock accounts and property); and
- Associated tax filings related to probating your estate.

Your beneficiary may use an attorney outside of the Hyatt Legal Plans' network and receive reimbursement of a pre-determined amount for attorneys' fees for Estate Resolution Services. 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 > Insurance Plan Documents.

Grief Counseling Services

MetLife offers grief counseling services for employees and their dependents to help cope with major losses. Individuals have access to a work/life counselor. They simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person, or by phone. Individuals can have up to five (5) grief counseling sessions per major loss. Losses include not just death, and can include divorce, job loss, financial hardship, terminal illness or the loss of a pet.

If further assistance is desired, the counselor will help you find services that are appropriate to your situation, preferences, finances and health insurance coverage.

Funeral Planning Services to Help Cope With Loss

MetLife offers funeral planning services ranging from planning for a loss to support following a loss to help in finding closure. These services are designed to simplify the process for you and your family.

Services offered:

- Locate funeral homes in your area;
- Obtain funeral cost estimates from providers in your area; compare cost information, services offered and funeral planning options;
- Identify other service providers such as florists, caterers and hotels;
- Locate back-up care for children or elderly;
- Locate cemetery options, including information on monument types;
- Identify monument and headstone vendors; and
- Locate Social Security and Veterans Affairs offices.

Specialists can also provide information on important tasks such as notifying the Social Security Administration, banks and utilities.

Help Is Just a Phone Call Away

To contact a professional grief counselor or to access helpful funeral planning related information and resources call 1-855-609-9989 or log on to https://griefcounseling.harrisrothenberg.net/default.aspx (Username: MetLife, Password: grief).

Benefit Reductions

Please see the section in the *Group Term Life and AD&D Plan Highlights* chapter titled *Reduction in Insurance at Age 70* for more information.

Exclusions

There are no exclusions under life insurance.

Chapter 6: AD&D Insurance Benefits

If you or a spouse or a child sustain(s) an accidental injury that is the direct and sole cause of a covered loss described in the *Plan Highlights* chapter, proof of the accidental injury and Covered Loss must be sent to MetLife. When MetLife receives such proof, it will review the claim and, if MetLife approves it, it will pay the insurance in effect on the date of the injury.

Direct and Sole Cause means that the covered loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Presumption of Death

You or a spouse or child will be presumed to have died as a result of an accidental injury if:

- The aircraft or other vehicle in which you, your spouse or child, or both were traveling disappears, sinks, or is wrecked; and
- The body of the person who has disappeared is not found within **one** year of:
  - The date the aircraft or other vehicle was scheduled to have arrived at its destination, if travelling in an aircraft or other vehicle operated by a common carrier; or
  - The date the person is reported missing to the authorities, if travelling in any other aircraft or other vehicle.

Benefit Payment

For the loss of your life, MetLife will pay the AD&D Insurance benefits to your beneficiary.

For any other loss sustained by you, or for any loss sustained by a spouse or child, MetLife will pay the AD&D Insurance benefits to you.

If you or a spouse or child sustain more than one covered loss due to an accidental injury, the amount MetLife will pay, on behalf of any such injured person, will not exceed the full amount of AD&D Insurance coverage (see the *Plan Highlights* chapter).

MetLife will pay AD&D Insurance benefits in one sum. Other modes of payment may be available upon request. For details call MetLife's toll free number 800.638.6420.

Total Control Account

If the benefit amount payable to you or 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 option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides you or 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. You or your beneficiary

can access the TCA balance at any time without charge or penalty, simply by writing drafts from the TCA in amounts of $250 or more. You or your beneficiary may withdraw the entire amount of the benefit payment immediately from the TCA if desired. Please note the TCA is not a bank account and is not a checking, savings or money market account."

Additional AD&D Insurance Features

The features set forth in this section apply to all AD&D Insurance described in this SPD, except as otherwise provided in specific sections.

Seat Belt Use Benefit

If you or a spouse or child die as a result of an accidental injury, MetLife will pay this additional seat belt use benefit if:

- MetLife pays an AD&D Insurance benefit for loss of life;
- This AD&D Insurance benefit is in effect on the date of the injury; and
- MetLife receives proof that the deceased person:
  - Was in an accident while driving or riding as a passenger in a passenger car;
  - Was wearing a seat belt which was properly fastened at the time of the accident; and
  - Died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the seat belt was properly fastened. A copy of such certification must be submitted to MetLife with the claim for benefits.

Benefit Amount

The seat belt use benefit is an additional benefit equal to 10% of your full amount of AD&D Insurance (see the *Additional Basic AD&D Insurance Coverage Features* table in the *Plan Highlights* chapter). However, the amount MetLife will pay for this benefit will not be less than $1,000 or more than $25,000.

Benefit Payment

For the loss of your life, MetLife will pay benefits to your beneficiary. For the loss of a spouse's or child's life, MetLife will pay benefits to you.

Air Bag Use Benefit

If you or a spouse or a child die(s) as a result of an accidental injury, MetLife will pay this additional benefit if:

- MetLife pays AD&D Insurance benefit for loss of life;
- This benefit is in effect on the date of the injury; and
- MetLife receives proof that the deceased person:
  - Was in an accident while driving or riding as a passenger in a passenger car equipped with an air bag(s);
  - Was riding in a seat protected by an air bag;
  - Was wearing a seat belt which was properly fastened at the time of the accident; and
  - Died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the seat belt was properly fastened and that the passenger car in which the deceased was travelling was equipped with air bags. A copy of such certification must be submitted to MetLife with the claim for benefits.

Benefit Amount

The air bag use benefit is an additional benefit equal to 5% of the full amount of AD&D Insurance benefits shown in the *Plan Highlights* chapter. However, the amount MetLife will pay for this benefit will not be less than $1,000 or more than $10,000.

Benefit Payment

For the loss of your life, MetLife will pay benefits to your beneficiary. For the loss of a spouse's or child's life, MetLife will pay benefits to you.

Child Care Benefit

If you died as a result of an accidental injury, MetLife will pay this additional child care benefit if:

- MetLife pays AD&D Insurance for the loss of your life;
- This benefit is in effect on the date of the injury; and
- MetLife receives proof that:
  - On the date of your death, a child was enrolled in a child care center; or
  - Within 12 months after the date of your death, a child was enrolled in a child care center.

Benefit Amount

For each child who qualifies for this benefit, MetLife will pay an amount equal to the child care center charges incurred for a period of up to 4 consecutive years, not to exceed:

- An annual maximum of $5,000; and
- An overall maximum of 12% of the full amount of AD&D Insurance benefits shown in the *Plan Highlights* chapter.

MetLife will not pay for child care center charges incurred after the date a child attains age 12.

MetLife may require proof of the child's continued enrollment in a child care center during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit quarterly when MetLife receives proof that child care center charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Child Education Benefit

If you die as a result of an accidental injury, MetLife will pay this additional child education benefit if:

- MetLife pays an AD&D Insurance benefit for the loss of your life;
- This benefit is in effect on the date of the injury; and
- MetLife receives proof that on the date of your death a child was:

- Enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
- At the 12th grade level and, within one year after the date of your death, enrolls as a full-time student in an accredited college, university or vocational school.

Benefit Amount

For each child who qualifies for this benefit, MetLife will pay an amount equal to the tuition charges incurred for a period of up to 4 consecutive academic years, not to exceed:

- An academic year maximum of $10,000; and
- An overall maximum of 20% of the full amount shown in the *Plan Highlights* chapter. MetLife may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who would qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Spouse Education Benefit

If you die as a result of an accidental injury, MetLife will pay this additional spouse education benefit if:

- MetLife pays an AD&D Insurance benefit for the loss of your life;
- This benefit is in effect on the date of the injury; and
- MetLife receives proof that:
  - On the date of your death, your spouse was enrolled as a full-time student in an accredited school; or
  - Within 12 months after the date of your death, your spouse enrolls as a full-time student in an accredited school.

Benefit Amount

MetLife will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed:

- An academic year maximum of $5,000; and
- An overall maximum of 3% of the full amount shown in the *Plan Highlights* chapter.

MetLife may require proof of the spouse's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to the spouse.

If this benefit is in effect on the date you die and there is no spouse who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Common Carrier Benefit

If you or a spouse or child dies as a result of an accidental injury, MetLife will pay this additional benefit if:

- MetLife pays an AD&D Insurance benefit for loss of life;
- This benefit is in effect on the date of the injury; and
- MetLife receives proof that the injury resulting in the deceased's death occurred while travelling in a common carrier.

Benefit Amount

The common carrier benefit is an amount equal to the full amount of AD&D Insurance benefits shown in the *Plan Highlights* chapter.

Benefit Payment

For the loss of your life, MetLife will pay benefits to your beneficiary. For the loss of your spouse's or child's life, MetLife will pay benefits to you.

Rehabilitative Physical Therapy Benefit

Subject to the terms of your AD&D Insurance, MetLife will pay this additional benefit if:

- MetLife receives proof that rehabilitative physical therapy has been prescribed within 90 days of the accidental injury by the attending physician as necessary to treat a physical condition resulting from the accidental injury; and
- This benefit is in effect on the date of the injury.

Such rehabilitative physical therapy must be provided within one year of the accidental injury by a physician or therapist licensed to provide the therapy in the jurisdiction where such services are performed.

Benefit Amount

MetLife will pay an amount equal to the least of:

- 10% of the full amount of AD&D Insurance coverage shown in the *Plan Highlights* chapter; or
- $25,000.

Benefit Payment

MetLife will pay this benefit quarterly when MetLife receives proof that charges for rehabilitative physical therapy have been paid. Payment will be made to you.

Hospital Confinement Benefit

Subject to the provisions of your AD&D Insurance, MetLife will pay this additional benefit if:

- MetLife receives proof that you are confined in a hospital as a result of an accidental injury which is the direct result of such confinement independent of other causes; and
- This benefit is in effect on the date of the injury.

Benefit Amount

MetLife will pay an amount for each full month of hospital confinement equal to the lesser of:

- 1% of the full amount shown in the Plan Highlights chapter; or
- $2,500.

MetLife will pay this benefit on a monthly basis beginning on the 5th day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

MetLife will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Benefit Payment

Benefit payments will be made monthly to you.

Common Disaster

If you and your spouse are injured in the same accident and die within 365 days as a result of injuries in such accident, the full amount of AD&D Insurance benefits that MetLife will pay for your spouse's loss of life will be increased to equal the full amount of AD&D Insurance benefits payable for the loss of your life.

Third-Degree Burn(s)

This benefit will pay a percentage of the Full Amount of Basic AD&D coverage equal to the percentage of body surface suffering third-degree burns for a covered loss.

AXA Travel Assistance Program – through MetLife

Protection When You Travel

Travel Assistance is a valuable benefit that is provided and administered by AXA Assistance USA, Inc. through an arrangement with MetLife. This service offers you and your dependents medical, travel, and concierge services, 24 hours a day, 365 days a year, while traveling internationally or domestically. With one quick toll--free phone (1-800-454-3679) call to the alarm center, you will receive assistance in obtaining the help you need through more than 600,000 pre--qualified providers worldwide. Best of all, you are automatically eligible for the Travel Assistance services with your MetLife Basic Accidental Death & Dismemberment coverage.

Travel and Financial Services Include:

- General travel information about visa, passport, inoculation requirements and local customs;
- Telephone interpretation;
- 24--hour pre--departure information (weather, currency, holidays);
- Emergency cash/bail assistance/legal referrals; and
- Lost document and luggage assistance.

Medical Assistance Services Include:

- Physician/hospital/dental referrals;
- Hospital admission validation;
- Evacuation and repatriation;
- Prescription transfer;
- Transportation to join patient; and

- Return of mortal remains.

Identity Theft Solutions Provides You and Your Dependents With:

- Education and Protection including: the identity theft risk & prevention tool kit and resolution guide.
- Personal Guidance including: Filing and obtaining police and credit reports, contacting creditor fraud departments, taking inventory of lost or stolen items and more.

You do not have to be traveling to take advantage of this benefit; you can access it whether you are home or away. Concierge Services Travel Assistance includes concierge assistance designed to fulfill various travel and entertainment requests as well as arrangements for business related services.

Concierge Services for upcoming and current travel include:

- Restaurant, shopping, hotel and airline recommendations/ reservations;
- Destination transport (rental car/limousine, etc.) information and reservations;
- Destination Information;
- Sporting, theater, night life and event information, recommendations and information;
- Golf course information, referrals, recommendations and tee times;
- City Calendar and Event Schedules;
- Private Drivers and Guides; and
- Driving Directions.

Traveling Abroad

The Mobile Assist Service provides you with information to help you avoid expensive mobile telephone charges when traveling internationally. This service offers a detailed guide which includes essential apps, resources and helpful hints on using a mobile phone internationally.

Exclusions:

The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non--medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted. 1 Travel Assistance and Identity Theft Solutions services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by Certain Underwriters at Lloyd's London (not incorporated) through Lloyd's

Illinois, Inc. Neither AXA Assistance USA Inc. nor the Lloyd's entities are affiliated with MetLife, and the services and benefits they provide are separate and apart.

Benefit Reductions

For more information, see the section in the *Group Term Life and AD&D Plan Highlights* chapter titled *Reduction in Insurance at Age 70*.

Exclusions

MetLife will not pay AD&D Insurance benefits under this chapter for any loss caused or contributed by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Service in the armed forces of any country or international authority, except the United States National Guard;
- Any incident related to:
  - Travel in an aircraft as a pilot, crew member, flight student;
  - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
  - Travel in an aircraft or device used:
    - For testing or experimental purposes;
    - By or for any military authority; or
    - For travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  - Any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a physician; or
    - An over the counter drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication, or sedative; or
  - Poison, gas, or fumes;
- War, whether declared or undeclared, or act of war, insurrection, rebellion or riot.

Exclusions for Intoxication

MetLife will not pay AD&D Insurance benefits under this chapter for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the accident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

Chapter 7: Accelerated Benefit Option (ABO)

Claims for Accelerated Benefit Options (ABO)

For purposes of this section, the term “ABO-eligible Life Insurance” means each of your life insurance coverages for which the Accelerated Benefit Option (ABO) is shown as available in the *Plan Highlights* chapter. This section includes your, your spouse’s and your child’s ABO. This section does not apply to your AD&D Insurance coverage.

If you become terminally ill, you or your legal representative have the option to request MetLife to 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 must contact the employer to obtain a claim form and information about 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:

- The amount of each ABO-eligible life insurance benefit to be accelerated equals or exceed $10,000; and
- MetLife has received proof that you are terminally ill.

MetLife will pay an accelerated benefit for **each** ABO-eligible life insurance benefit **only once**.

Proof of Your, Your Spouse’s, or Your Child’s Terminal Illness

MetLife will require 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.

When MetLife receives your request to accelerate benefits, MetLife will send you a letter with information about the accelerated benefit payment including the amount of accelerated benefits MetLife will pay and the amount of life insurance remaining 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 *Plan Highlights* chapter for each 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 shown in the *Plan Highlights* chapter.

- **Scheduled Reduction of an ABO-eligible Life Insurance Benefit.** If an ABO-eligible life insurance benefit is scheduled to reduce, due to age within the 12-month period after the date you or your legal representative request an accelerated benefit, MetLife will calculate the accelerated benefit using the amount of such ABO-eligible life insurance that will be in effect immediately after the reduction(s) scheduled for such period.
- **Scheduled End of an ABO-eligible Life Insurance Benefit**. If an ABO-eligible life insurance benefit is scheduled to end within 12 months after the date you or your legal representative request an accelerated benefit, then MetLife will not pay an accelerated benefit for such ABO-eligible Life insurance benefit.
- **Previous Conversion of an ABO-eligible Life Insurance Benefit.** MetLife will not pay an accelerated benefit for any amount of ABO-eligible life insurance which you previously converted under the features 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 an Accelerated Benefit Payment

On Your Life Insurance Premium

After MetLife pays the accelerated benefit, any premium you are required to pay will be based upon the amount of your life insurance remaining after the accelerated benefit is paid.

On Your Life Insurance at Your Death

The amount of 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/Portability

The amount of life insurance which you are entitled to continue (See the *Porting and Converting Coverage* chapter) will be decreased by the amount of the accelerated benefit paid by MetLife.

On Your AD&D Insurance Coverage

Payment of an accelerated benefit will not affect your AD&D Insurance coverage.

Date Your, Your Spouse's, or Your Child's Option to Accelerate Benefits Ends

The accelerated benefit option will end 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;
- The date you retire;
- The date you terminate employment; or
- Upon your death.

Please refer to the chapter titled *Porting or Converting Coverage* for information about the option to continue to an individual policy of life insurance if your life insurance ends.

Chapter 8: Claims and Appeals

The claims and appeals procedures stated in this chapter are intended to comply with applicable regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions and appeals of adverse benefit determinations. You must follow these procedures for all claims for benefits arising from this Plan.

Your claim will be processed for payment according to the applicable plan provisions and the guidelines used by MetLife. General contact information for MetLife is available in the chapter titled *Contact Information*. Contacts specific to the claims and appeals process 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, please contact your benefits administrator.

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*

Type	Reviewer	Address
Filing an eligibility appeal	NRECA Appeals Administrator	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203
Filing a voluntary final appeal regarding eligibility	NRECA Appeals Committee	**NRECA Appeals Committee** Attn: Senior VP, I&FS 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203

Authorizing a Representative

Your beneficiary may authorize someone other than themselves to speak with MetLife, if verbal consent is given by the beneficiary 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 someone to handle their affairs. A power of attorney or guardian would need to be appointed and that documentation would need to be on file with MetLife. Contact the MetLife claims representative for more information.

Claims

A claim means 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 claims procedures. MetLife's time period 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 sufficient information for MetLife to make an initial benefit determination, you may be asked to provide additional information. If you do not provide that information within the applicable time period, your claim may be denied in whole or in part.

Within this chapter, "claimant" means you, your beneficiaries, the executor of your estate, or an authorized representative. See the section in this chapter titled *Authorizing a Representative* for more information about this topic.

Filing a Claim

After the appropriate claim forms are received, complete and return them to the benefits administrator, who will verify eligibility and benefits to be claimed, certify the forms and forward all documents to MetLife for processing.

In addition to claim forms, you (the claimant) may be required to provide additional evidence (for example a death certificate or accident report) to 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. 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 your appeal, if applicable. To determine if your state has such resources, see the U.S. Department of Labor website at **www.dol.gov/ebsa/consumer_ info_health.html** or call the Department of Labor Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272), or by mail to the Employee Benefits Security Administration, U.S. Department of Labor, Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C 20210.

Claim Submission Timeframe	
Accidental Death & Dismemberment Benefits	**All Benefits Described in this SPD**
Send the claim form and proof[1] to MetLife as soon as reasonably possible after the death of the insured	Send the claim form and proof[1] to MetLife within **90 days** of the date of loss

[1]Proof is defined in Appendix A: Key Terms.

Claim determinations, determination extensions, and requests for additional information

If you are eligible for benefits and have properly followed the claims procedure, and benefits are due to you, MetLife will issue a written determination within a reasonable period of time but not later than the time frame listed in the *Claim Review Timeline* table.

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

Claim Determination Notice Content

For all claims, you will receive a written notice of any adverse benefit determination that provides:

- The specific reason(s) your claim was denied;
- Reference to the specific plan provisions on which the denial is based; and
- 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 benefits under the Plan, you or your authorized representative may appeal the decision.

For purposes of this chapter, "you" also includes your authorized representative.

Documentation to Include with your Appeal Request

The following information applies to all levels of appeal. For purposes of this explanation, the "reviewer" means MetLife – Group Insurance Claims Review (for an adverse benefit determination appeal), the NRECA – Appeals Administrator (for eligibility appeals) and the NRECA – Appeals Committee (for voluntary final eligibility appeals).

Appeals must be submitted in writing by the filing deadline and must include at least the following information:

- Your name;
- Name of the plan (that is, the Group Term Life and Accidental Death & Dismemberment 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 of the information necessary to decide the appeal. If you want to grant the reviewer more than the stated time to make a determination, you may voluntarily agree to an extension by contacting the reviewer.

Adverse Benefit Determination Appeal Timeline	
Filing deadline	Within **60 days** of the date you receive MetLife's written adverse benefit determination

When you will be notified of a determination	Within **60 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
Extension of time for MetLife to make a determination on your appeal	One extension period of **up to 60 days**, if needed

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 period 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, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- An explanation of your rights under ERISA's claim and appeal rules; and
- An explanation of your right to file a civil action under ERISA within 12 months.

If your appeal of eligibility for coverage claim is denied, you may voluntarily take part in one more review process called the **Voluntary Final Appeal Process for Eligibility**. If you do not choose to use the Voluntary Final Appeal Process, you may seek legal action.

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

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 the table titled *Eligibility Appeal Timeline*). The review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. If the reviewer requires more than the stated time for their review in order to decide your appeal, they will send a letter stating an extension time.

Eligibility Appeal Timeline	
Filing deadline	Within **60 days** of the date you receive the denial notice due to eligibility
When you will be notified of a determination	Within **60 days** after receipt of the appeal request unless NRECA requests an extension

Extension of time for NRECA – Appeals Administrator to make a determination	One period of up to **60 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, as noted below. However, a request for documentation does not extend the time period 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 include:

- The specific reason(s) your 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
- Notice of your right to file a civil action under ERISA within 12 months.
- Further, the notice will contain the procedures you must follow to take part in the Voluntary Final Appeal process the time limits applicable for such procedures.

Voluntary Final Appeals for Eligibility Claims

If you wish to have the NRECA – Appeals Committee review your denied appeal, you may request a voluntary final appeal for eligibility claims. Using this process has no effect on your rights to any other benefits under the Group Term Life and Accidental Death & Dismemberment Insurance or your right to take legal action. Before you submit your voluntary final appeal, you may request additional information about the process by calling CBA.

Your voluntary final appeal must be filed in writing with the NRECA – Appeals Committee by the filing deadline described in the *Voluntary Final Appeal Timeline* for *Eligibility Claims* table). The review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. The reviewer may need additional time to complete their review and may notify you of an extension.

Voluntary Final Appeal Timeline for Eligibility Claims	
Filing deadline	Within **60 days** of the date you receive NRECA's written denial of your eligibility appeal
You will be notified of a determination	Within **60 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	One extension period of **up to 60 days**, if needed

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 to bring a civil action under ERISA within 12 months.

Legal Action for Benefit Claims

A legal action on a claim may only be brought against MetLife during a certain period. This period begins **60 days** after the date proof is filed and ends 3 years after the date such proof is required.

Chapter 9: Porting or Converting Coverage

For purposes of continuing coverage, you may continue all or a part of your Plan benefits through either Conversion or Portability.

Conversion of Life Insurance

If all or a portion of your life insurance ends for any reasons stated below, you have the option to buy an individual policy of life insurance (a new policy) from MetLife during the application period in accordance with the conditions and requirements of this section. This is called the "option to convert." Evidence of your insurability will **not** be required.

When You, Your Spouse and Your Child Will Have the Option to Convert

You will have the option to convert when:

- Your life insurance ends because:
  - You cease to be in an eligible class of employees;
  - Your employment ends, including due to retirement;
  - The Plan ends, provided you have been covered by 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 covered by life insurance for at least five years; or
- Your life insurance is reduced:
  - On or after the date you attain age 70;
  - Because you change from one eligible class of employees to another; or
  - Due to an amendment of the Plan; or
- Your spouse and child life Insurance ends because:
  - Child no longer meets the definition of child under the Plan;
  - You get divorced;
  - You die; or
  - Your coverage ends.

If you opt not to convert a reduction in the amount of your life insurance as described above, you will not have the option to convert that amount at a later date.

A reduction in the amount of your life insurance as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

Application Period

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

If you are given written notice of the option to convert within 15 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 days after such date.

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

Option 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;
- The new policy will be issued **without** an AD&D Insurance benefit, a continuation benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and
- The new policy will take effect on the 32nd day after the date your life insurance ends; this will be the case regardless of the duration of the application period.

Maximum Amount of the New Policy

If your life insurance ends due to the end of the Plan or the amendment of the Plan to end life insurance for an eligible class of which you are a member, the maximum amount of insurance that you may elect for the new policy is the lesser of:

- The amount of your life insurance that ends under the Plan less the amount of life insurance for which you become eligible under any Plan within 31 days after the date insurance ends under the Plan; or
- $2,000.

If your life insurance ends for any other reason, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance which ends under the Plan.

If You Die Within 31 Days After Your Life Insurance Ends

If you die within **31 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.

Portability for Life and AD&D Insurance

If your Portability Eligible Insurance or Portability Eligible spouse or child 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.

For purposes of this subsection the term “Portability Eligible Insurance” refers to your life insurance and AD&D Insurance benefits (shown in the *Plan Highlights* chapter) for which the Portability Eligible Insurance is available.

If insurance for your spouse or child is in effect, the term “Portability Eligible spouse or child insurance” refers to your life insurance and AD&D Insurance (shown in the *Plan Highlights* chapter) for your spouse or child for which the Portability Eligible spouse or child insurance is available.

When Porting is an Option

Porting may only be exercised by a request in writing during the request period specified below.

If you choose not to port, life insurance benefits may be converted in accordance with the section titled *Conversion of Life Insurance*. If you do not choose to convert or port your Life and AD&D Insurance benefits, your coverage ends.

You may choose to port if Portability Eligible Insurance or Portability Eligible spouse or child Insurance ends because:

- You retire from active service with the employer;
- Your employment ends, due to a reason other than retirement;
- You cease to be in a class that is eligible for such insurance;
- The Plan is amended to end the Portability Eligible insurance or Portability Eligible spouse or child 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 Plan has terminated, 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:

- Your age; or
- An amendment to the Plan which affects the amount of insurance for your employee classification.

Your spouse may choose to port if the Portability Eligible spouse insurance on his or her own life ends because:

- You die;
- Your marriage ends in divorce or annulment; or
- There is a reduction due to your age provided that the former spouse satisfies the Additional Requirements for spouse and child insurance in the chapter titled *Eligibility and Participation Information*.

Your spouse may also port Portability Eligible child insurance on your child if your spouse ports insurance on his or her own life and only if the child’s coverage is ending.

Your child may request to port Portability Eligible child insurance on his or her own life if that insurance ends because your child no longer meets the definition of child.

If a request is made to port coverage, 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 to port may be made, if on the date the Portability Eligible insurance ended, the following requirements are met:

- The Plan is in effect; and
- With respect to any amount of Portability Eligible life insurance or Portability Eligible Spouse or Child life insurance that is to be ported, no application has been made to convert that amount of insurance to an individual policy of life insurance as provided in the section of this chapter titled *Conversion of Life Insurance*.

Request Period

For you or a spouse or child 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 days before or after the date such insurance ends, the request period:

- Begins on the date the insurance ends, and
- Expires 31 days after the date.

If written notice of the option to port is given more than 15 days after but within 91 days of the date such insurance ends, the request period:

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

If written notice of the option to port is not given within 91 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-day period.

Chapter 10: General Information

Beneficiary

For your loss of life, MetLife will pay benefits to your beneficiary. For any other loss sustained by you, your Spouse, or your Child, MetLife will pay benefits to you.

You may designate a beneficiary during your enrollment process. You may change your beneficiary at any time. To do so, you must provide a signed and dated, written request to your employer using a form satisfactory to MetLife. Your written request to change the beneficiary must be provided to the employer within **30 days** of the date you sign such request.

You do not need the beneficiary's consent to make a change. When NRECA receives the change, it will take effect as of 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 two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving designated beneficiary 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 person's court appointed property and estate guardianship or, MetLife will hold funds until the minor is of legal age.

Entire Contract

Your insurance is provided under a contract of group insurance with MetLife. The entire contract with MetLife and 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.

Incontestability: Statements Made by You

Any statement made by you will be considered a representation and not a warranty. MetLife will not use such statement to contest life insurance, reduce benefits or defend a claim unless the following requirements are met:

- The statement is a written application or enrollment form;

- You have signed the application or enrollment form; and
- A copy of the application or enrollment form has been given to you or your beneficiary.

MetLife will not use your statements which relate to insurability to contest life insurance after it has been in force for two years during your life. In addition, MetLife will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for two years during your life.

Misstatement of Age

If your or your spouse's or child's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, MetLife will adjust the benefits, premiums, or both.

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

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.

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.

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.

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

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.

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

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
501.371.2640 or 800.852.5494

Notice for Residents of California:

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 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 dis-enroll 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.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

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.

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.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

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.

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 provision mean that due to injury or sickness, You are 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.

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 lA, 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.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.	Utah Insurance Department
60 East South Temple, Suite 500	3110 State Office Building
Salt Lake City UT 84111	Salt Lake City UT 84114-6901
801.320.9955	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 (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.

Notice for Residents of the State 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
Local: 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 11: 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 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;
- 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 and/or to offset future benefit payments until the overpayment is recouped. 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 shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require NRECA, as Plan Administrator, to provide the materials and pay you up to $147 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.

Appendix A: Key Terms

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

Actively at Work or **Active Work** means that you are performing all of the usual and customary duties of your job on a full-time basis. This must be done at:

- The employer's place of business;
- An alternate place approved by the employer; or
- A place to which the employer's business requires you to travel.

You will be deemed to be actively at work during weekends or employer approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding such time off.

Air Bag means an inflatable restraint device that:

- Meets published United States government safety standards;
- Is properly installed by the car manufacturer; and
- Is not altered after the installation.

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

Base Annual Earnings means your gross annual rate of pay as determined by your employer, excluding overtime and other extra pay.

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 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 or, if the guardianship is general, MetLife will hold funds until the minor is of legal age.

Child Care Center means a facility that:

- Is operated and licensed according to the law of the jurisdiction where it is located; and
- Provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

Child or Children means the following:

For AD&D Life Insurance, your natural child from live birth, your adopted child (including a child from the date of placement with the adopting parents until the legal adoption), your stepchild, your unmarried foster child; or any child under your custody and care who, in each case, is under age 26 and supported by you.

The term does **not** include any person who:

- Is insured under the Plan as an employee or spouse.

For **Texas residents, child** means the following for **Life Insurance:**

Your natural child from live birth, adopted child; stepchild, or unmarried foster child who resides with you and is supported by you, or a child who resides with you, who is supported by you and for whom you are the legally appointed guardian; and who, in each case, is under age 26. **The term also includes** your grandchild who is under age 26, unmarried and who was able to be claimed by you as a dependent for Federal income tax purposes at the time you applied for life insurance.

A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

The term does not include any person who:

- Is insured under the Plan as an employee or spouse.

For **Texas residents, Child** means the following for **AD&D Insurance**:

Your natural child from live birth; adopted child or stepchild or unmarried foster child who resides with you, is supported by you or who is under age 26. **The term also includes** your grandchild who is under age 26, unmarried and who was able to be claimed by you as a dependent for Federal income tax purposes at the time you applied for AD&D insurance.

A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

The term does **not** include any person who:

- Is insured under the Plan as an employee or spouse.

For **New Mexico residents**, child means the following for **AD&D Insurance**:

Your natural child from live birth, adopted child (including a child from the date of placement with the adopting parents until the legal adoption), stepchild or unmarried foster child who reside with you, is supported by you or is under age 26.

An adopted child includes a child placed in your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from your custody, the child's status as an adopted child will end.

No natural child from live birth, adopted child or stepchild will be denied AD&D insurance because such child was born out of wedlock, is not residing with you, or is not claimed by you as a deduction for Federal Income Taxes.

The term does not include any person who:

- Is insured under the Plan as an employee or spouse.

For **Utah residents**, child means the following for **AD&D insurance**:

Your natural child from live birth, adopted child stepchild who is unmarried or unmarried foster child who reside with you, is supported by you and under age 26.

A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

The term does not include any person who:

- Is insured under the Plan as an employee or spouse.

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

Common Carrier means a government regulated entity that is in the business of transporting fare paying passengers.

The term does not include:

- Chartered or other privately arranged transportation;
- Taxies; or
- Limousines.

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

Contributory insurance includes: Supplemental Life Insurance, Supplemental AD&D Insurance and Spouse or Child Life Insurance.

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

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

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

Directorship means status as a Director.

Disability or Disabled means a status of disability met due to an injury or sickness where:

- 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 education, training or experience.

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

Family means your spouse and child(ren).

Full-time means active work on the employer's regular work schedule for the eligible class of employees to which you belong.

Hospital means a facility which is licensed as such in the jurisdiction in which it is located and provides:

- A broad range of medical and surgical services on a 24-hour-a-day basis for injured and sick persons by or under the supervision of a staff of physicians; and
- A broad range of nursing care on a 24-hour-a-day basis by or under the direction of a registered professional nurse.

Hospitalized means:

- Admission for inpatient care in a hospital;
- Receipt of care in the following:
  - A hospice facility;
  - An intermediate care facility; or
  - A long-term care facility.
- Receipt of the following treatment, wherever performed:

- Chemotherapy;
- Radiation therapy; or
- Dialysis.

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

Non-medical Issue Amount means a level of insurance coverage that is guaranteed without medical evidence of insurability and available within 31 days when first offered or during a Qualifying Event (see the section titled *Supplemental Life Insurance Benefit Highlights*).

Normal Retirement Age means the age at which you are eligible for a full pension from your employer. For purposes of the life premium waiver, if you are disabled before the normal retirement age and your employer has a 30-year/age 62 retirement plan, the normal retirement age is age 62, whether or not you have completed 30 years of participation.

Passenger Car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

Physician means:

- A person licensed to practice medicine in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as physician's services for purposes of the Plan. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term **Physician does not** include:

- You;
- Your spouse; or
- Any member of your immediate family, including your and/or your Spouse's:
  - Parents;
  - Children (natural, step or adopted);
  - Siblings;
  - Grandparents; or
  - Grandchildren.

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.

Seat Belt means any restraint device that:

- Meets published United States Government safety standards;
- Is properly installed by the car manufacturer; and
- Is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

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 which is acceptable to MetLife and consistent with applicable law.

Spouse means your lawful spouse.

The term does **not** include any person who lives outside of the United States or Canada.

Statement of Health (SOH) means the form you or your spouse must complete to determine if you or, your spouse can be insured by the Plan. See the section titled *Evidence of Insurability* under *Your Benefits During a Leave of Absence* for more information on evidence of insurability. In some cases MetLife may ask for additional information, such as a physician's report. If the benefits level you choose is denied due to the SOH, you will automatically be enrolled in the highest benefit amount that does not require a SOH if first time offered or qualified event. Otherwise you will remain with what was in force prior to the SOH. The benefit amount that does not require a SOH is also called the non-medical issue amount.

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

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NRECA Retired Life Insurance Plan

SUMMARY PLAN DESCRIPTION

OZARK BORDER ELECTRIC COOPERATIVE

01-26033-002

EFFECTIVE DATE: January 1, 2018

NRECA
A Touchstone Energy® Cooperative

Introduction

Summary Plan Description

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

Your Responsibilities

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

While reading this material be aware that:

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

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

Fraud Warning Statement

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 concerning 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. Please see the chapter titled *General Information* for the state-specific warning that may apply to your state of residence.

For California Residents: Review this certificate carefully. If you are 65 or older on your effective date, under California law (Cal. Ins. Code § 786 effective 7/1/2015) you may return this Summary Plan Description to your cooperatives Benefits Administrator within 30 days from the date you receive it and they 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.

Table of Contents

Plan Information

Plan Name

The National Rural Electric Cooperative Association's Group Benefits Program

Plan Identification Number:	501
Plan Type:	Retired Life Insurance
Year End:	December 31
Plan Effective Date:	January 1, 2018

Underwritten by

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

Plan Administrator

Senior Vice-President
Insurance and Financial Services
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Arlington, VA 22203-1860
Telephone number 703.907.5500

Plan Administrator Employer Identification Number: 54-2072724

Plan Sponsor

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

Plan Sponsor Employer Identification Number: 53-0116145

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 benefits administrator is the person with Plan Administrator responsibilities for your Employer:

OZARK BORDER ELECTRIC COOPERATIVE
PO Box 400
Poplar Bluff, MO 63902

Your Employer's Identification Number (EIN)

43-0445644

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.

Agent for service of process

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

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

Plan Trustee, NRECA Group Benefits Trust

State Street Bank and Trust Company
225 Franklin Street
Boston, MA 02101

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** OZARK BORDER ELECTRIC COOPERATIVE PO Box 400 Poplar Bluff, MO 63902
Eligibility appeals	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203
Voluntary final appeals	**NRECA Appeals Committee** Attn: Senior VP, Insurance and Financial Services 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203

Chapter 2: Plan Highlights

This chapter includes the highlights of your Retired Life Insurance benefits under the Plan. For further information about these benefits, other benefits and Plan exclusions, please read the chapter titled *Term Life Benefits*.

You will only be insured for the benefits:

- For which you become and remain eligible;
- For which 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.	Talk to your benefits administrator.

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

You may elect an Accelerated Benefit Option (ABO) of up to 80% of your Retired Life Insurance amount, not to exceed $16,000.

Note: ABO is not available if the value of your life insurance coverage is under $10,000.

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

Even if your employer does not pay for an amount of 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, but once the coverage is reduced it cannot be reinstated or increased.

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.

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

Other: Please see your Benefits Administrator for your Employer's definition of Retiree

See your benefits administrator for your employer's definition of retiree.

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 insurance described in this SPD on the day you retire.

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 chapter titled *Porting or Converting Coverage* for details). If you choose to enroll in the NRECA's Directors AD&D Only Insurance Plan, you are eligible for insurance benefits as a retired employee under this Plan.

Note: 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.

Enrollment Process

If you are eligible for insurance under this Plan, you may enroll for such insurance by completing the required process. If you enroll in contributory insurance, you will be notified by the employer regarding 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).

Please refer to the chapter titled *Porting or Converting Coverage* 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, there are **no** cash values accumulated 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 option or 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, simply by writing drafts from the TCA in amounts of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately from the TCA if desired. Please note 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.

Chapter 5: Accelerated Benefit Option (ABO)

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

If you become Terminally Ill, you or your legal representative have the option to request MetLife to 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 **each** 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 amount of the accelerated benefits MetLife will pay and the amount of Retired Life Insurance remaining 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 *Plan Highlights* chapter for each 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 *Plan Highlights* chapter.
- **Previous Conversion of an ABO-eligible Life Insurance Benefit.** MetLife will not pay an accelerated benefit for any amount of ABO-eligible Life Insurance which 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 to which you are entitled to convert/port under the chapter titled *General Information* 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 in this chapter are intended to comply with applicable regulations by providing reasonable procedures governing the filing of claims, notification 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 for payment according to the applicable plan provisions and the guidelines used by MetLife. General contact information for MetLife is available in the *Contact Information* chapter. Contacts specific to the claims and appeals process 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, please contact your benefits administrator.

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: 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 Blvd., Mailstop IFS7-333 Arlington, VA 22203
Filing a voluntary final appeal regarding eligibility	NRECA Appeals Committee	**NRECA Appeals Committee** Attn: Senior VP, I&FS 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203

Authorizing a Representative

An authorized representative is an individual you have designated in writing to represent you in the appeal process. You have the right to have someone file an appeal on your behalf or represent you in the appeal process.

To authorize someone (including your physician) to represent you through the claims or appeal process, you must complete, sign and submit a copy of the form titled “Authorization to Use and Disclose Protected Health Information (PHI).” This form is available in the My Benefits section of cooperative.com. After processing the form, the Privacy Officer will provide you with a copy of the signed form for your records.

Contact the NRECA Privacy Officer if you have questions about authorizing a representative or about the use and disclosure of your health information.

Note: Neither the insurer, NRECA nor participating employers are responsible for how your authorized representative discloses your protected information, or for his or her failure to protect such information.

Claims

A claim 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 claims procedures. MetLife’s time period 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 sufficient information for MetLife to make an initial benefit determination, you may be asked to provide additional information. If you do not provide that information within the applicable time period, your claim may be denied in whole or in part.

Within this chapter, “claimant” means you, your beneficiaries, the executor of your estate, or an authorized representative. See the section in this chapter titled *Authorizing a* Representative for more information about this topic.

Filing a claim

After the appropriate claim forms are received, complete and return them to the benefits administrator, who will verify eligibility and benefits to be claimed, certify the forms and forward all documents to MetLife for processing.

In addition to claim forms, you (the claimant) may be required to provide additional evidence (for example a death certificate or accident report) to 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. 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 your appeal, if applicable. To determine if your state has such resources, see the U.S. Department of Labor website at **www.dol.gov/ebsa/consumer_ info_health.html** or call the Department of Labor Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272), or by mail to the Employee Benefits Security Administration, U.S. Department of Labor, Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C 20210.

Claim Submission Timeframe	
Life Insurance Benefits	Send the claim form and proof[1] to MetLife as soon as reasonably possible after the death of the insured

[1]*See Appendix A: Key Terms for the definition*

Claim determinations, determination extensions, and requests for additional information

Claim Review Timeline	
You will be notified of a determination	Within a reasonable period of time, but not later than **90 days** after receipt of the claim, unless MetLife requests an extension or additional information
If MetLife needs an Extension of time to make a determination	MetLife will notify you of an extension of time of up to **90 additional days** and notify you of the reason for the extension and when it will render its decision.

Content of the Claim Determination Notice

For all claims, you will receive a written notice of any adverse benefit determination. The notice will include:

- The specific reason(s) your claim was denied;
- Reference to 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 benefits under the Plan, you or your authorized representative may appeal the decision.

For purposes of this chapter, references to "you" also include your authorized representative.

Documentation to Include with Your Appeal Request

The following information applies to all levels of appeal. For purposes of this explanation, the "reviewer" means MetLife – Group Insurance Claims Review (for an adverse benefit determination appeal), the NRECA – Appeals Administrator (for eligibility appeals) and the NRECA – Appeals Committee (for voluntary final eligibility appeals).

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

- Your name;
- The name of the plan (that is, 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 of the information necessary to decide the appeal. If you want to grant the reviewer more than the stated time to make a determination, you may voluntarily agree to an extension by contacting the reviewer.

Adverse Benefit Determination Appeal Timeline	
Filing deadline	Within **60 days** of the date you receive MetLife's written adverse benefit determination
When you will be notified of a determination	Within **60 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
Extension of time for MetLife to make a determination on your appeal	One extension period of **up to 60 days**, if needed

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 period 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;
- List 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;

- An explanation of your rights under ERISA's claim and appeal rules; and
- An explanation of your right to file a civil action under ERISA within 12 months.

If your appeal of an eligibility for coverage claim is denied, you may voluntarily take part in one more review process called the **Voluntary Final Appeal Process for Eligibility**. If you do not choose to use the Voluntary Final Appeal Process, you may seek legal action.

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

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 the table titled *Eligibility Appeal Timeline*). The review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. If the reviewer requires more than the stated time for their review in order to decide your appeal, they will send a letter stating an extension time.

Eligibility Appeal Timeline	
Filing deadline	Within **60 days** of the date you receive the denial notice due to eligibility
When you will be notified of a determination	Within **60 days** after receipt of the appeal request unless NRECA requests an extension
Extension of time for NRECA – Appeals Administrator to make a determination	One period of up to **60 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, as noted below. However, a request for documentation does not extend the time period 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; and
- Explain your right to file a civil action under ERISA within 12 months.

Further, the notice will contain the procedures you must follow to take part in the Voluntary Final Appeal process the time limits applicable for such procedures.

Voluntary Final Appeals for Eligibility Claims

If you wish to have the NRECA – Appeals Committee review your denied appeal, you may request a voluntary final appeal for eligibility claims. Using this process has no effect on your rights to any other benefits under the Retired Life Insurance or your right to take legal action. Before you submit your voluntary final appeal, you may request additional information about the process by calling CBA.

Your voluntary final appeal must be filed in writing with the NRECA – Appeals Committee by the filing deadline described in the *Voluntary Final Appeal Timeline* for *Eligibility Claims* table). The review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. The reviewer may need additional time to complete their review and may notify you of an extension.

Voluntary Final Appeal Timeline for Eligibility Claims	
Filing deadline	Within **60 days** of the date you receive NRECA's written denial of your eligibility appeal
You will be notified of a determination	Within **60 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	One extension period of **up to 60 days**, if needed

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;
- List the specific Plan provision(s) on which the denial was based;
- Explain your rights under ERISA's claim and appeal rules; and
- Include a statement of the claimant's right to bring a civil action under ERISA within 12 months.

Legal Action for Benefit Claims

A legal action on a claim may only be brought against MetLife during a certain period. This period begins **60 days** after the date proof is filed and ends 3 years after the date such proof is required.

Chapter 7: Porting or Converting Coverage

For purposes of continuing coverage, you may continue all or a part of your Plan benefits through either Conversion or Portability.

Conversion

If all or a portion of your life insurance ends for any reasons stated below, you have the option to buy an individual policy of life insurance (a new policy) from MetLife during the Application Period in accordance with the conditions and requirements of this section. This is called the "option to convert." Evidence of your insurability will **not** be required; however you have the option to complete a statement of health (SOH) form.

When You Will Have the Option to Convert

You will 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 5 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 an amendment of the Plan.

If you opt not to convert a reduction in the amount of your life insurance as described above, you will not have the option to convert that amount at a later date.

A reduction in the amount of your life insurance as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

Application Period

If you opt to convert your life insurance for any of the reasons stated above, MetLife must receive a completed conversion application form from you within the Application Period described below.

If you are given written notice of the option to convert within 15 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 days** after such date.

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

Option 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; this will be the case regardless of the duration of the Application Period.

Maximum Amount of the New Policy

If your life insurance ends due to the end of the Plan or the amendment of the Plan to end life insurance for an eligible class of which you are a member, the maximum amount of insurance that you may elect for the new policy is the lesser of:

- The amount of your life insurance that ends under the Plan less the amount of life insurance for which you become eligible under any the Plan within 31 days after the date insurance ends under the Plan; or
- $2,000.

If your life insurance ends for any other reason the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance which ends under the Plan.

If You Die Within 31 Days After Your life insurance Ends

If you die within **31 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.

Portability For Life Insurance

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 an SOH form.

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

When Porting is an Option

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

If you choose not to Port, life insurance benefits may be converted in accordance with the provisions in the section titled *Conversion*. If you do not choose to convert or Port your life 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.

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 days** before or after the date such insurance ends, the Request Period:

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

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

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

If written notice of the option to Port is not given within **91 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-day period.

Chapter 8: General Information

Beneficiary

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

You may designate a beneficiary during your enrollment process. You may change your beneficiary at any time. To do so, you must provide a signed and dated, written request to your employer using a form satisfactory to MetLife. Your written request to change the beneficiary must be provided to the employer within **30 days** of the date you sign such request.

You do not need the beneficiary's consent to make a change. When NRECA receives the change, it will take effect as of 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 two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving designated beneficiary 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 person's court appointed property and estate guardianship or, MetLife will hold funds until the minor is of legal age.

Entire Contract

Your insurance is provided under a contract of group insurance with MetLife. The entire contract with MetLife and 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.

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

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.

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.

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.

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

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.

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

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
501.371.2640 or 800.852.5494

Notice for Residents of California:

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 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 dis-enroll or eliminate insurance for such Child unless the insurer is provided satisfactory written evidence that:
    c) The court or administrative order is no longer in effect; or
    d) 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.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

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.

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.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

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.

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 provision mean that due to injury or sickness, You are 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.

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 or $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 lA, 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.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.	Utah Insurance Department

60 East South Temple, Suite 500	3110 State Office Building
Salt Lake City UT 84111	Salt Lake City UT 84114-6901
801.320.9955	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 (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.

Notice for Residents of the State 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
Local: 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 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;
- 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 and/or to offset future benefit payments until the overpayment is recouped. 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 shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such case, the court may require NRECA, as Plan Administrator, to provide the materials and pay you up to $147 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.

Appendix A: Key Terms:

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

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 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 or, if the guardianship is general, MetLife will hold funds until the minor is of legal age.

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

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 the benefits under the Plan.

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 which is acceptable to MetLife and consistent with applicable law.

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