SUMMARY PLAN DESCRIPTION
for the
125 PLAN

BASE PLAN INFORMATION

Plan Options:

x **Premium Only Plan Option – Appendix A**
x **Health Flexible Spending Account Option – Appendix B**
x **Dependent Care Assistance Program Option – Appendix C**
☐ **Limited Use Health Flexible Spending Account Option– Appendix D**
☐ **Cash Benefit Option – Appendix E**
☐ **Health Savings Account Plan Option – Appendix F**

For the Employees of

Ozark Border Electric Cooperative

 # 26709

Effective Date: January 1, 2015

TABLE OF CONTENTS

Introduction to Your 125 Plan

This Summary Plan Description (SPD) and the attached plan option(s) are intended to describe the features of the 125 Plan (the Plan). Actual benefits are subject to the definitions and limitations in the Plan. If there is any conflict between this SPD and the 125 Plan Document, the 125 Plan Document will control.

Your employer is sponsoring this 125 Plan known as a "cafeteria plan." It is called a cafeteria plan because it allows you to choose among benefits provided by your employer so that you can design a benefit arrangement specifically tailored to your individual needs.

Contributions to a 125 Plan are generally paid on a pre-tax basis and are not subject to federal and FICA taxes, and may not be subject to state or local taxes (see your state tax rules for specific information).

Eligibility and Participation

Who is eligible to participate in this Plan?

To be eligible to participate in this Plan, you must:

- be an active employee designated by your employer as eligible to participate;
- be an employee who has worked or who the employer anticipates will have worked, at least 1,000 hours during his or her first 12 months of employment, or during the first Plan Year following his or her date of hire, whichever is earlier; and
- be eligible to participate in the NRECA Group Benefits Program or any other plan offered by your employer that provides health, disability, or life insurance benefits.

COBRA qualified beneficiaries may elect to continue coverage under certain plan options of this Plan at their own expense (see your Appendices to determine if COBRA is applicable to your plan option).

What happens if I do not complete 1,000 hours of service during a Plan Year?

Your participation in this Plan will end as of January 1st following the year in which you do not complete 1,000 hours of service. You will be eligible to participate again on the first day of the month following the month in which you perform 1,000 hours of service during a Plan Year.

How does a leave of absence that is subject to the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) affect my participation in this Plan?

If you take qualifying leave under FMLA or USERRA, your employer, to the extent required by FMLA or USERRA, will continue to maintain your 125 Plan account on the same terms and conditions as if you were still an active employee.

When does my participation in this Plan end?

If you terminate employment, are discharged from employment, or take an unpaid leave of absence (except a leave of absence under FMLA or USERRA), your participation in this Plan will end on the date your employment ends (if you do not elect to continue coverage under COBRA – please see your Appendix for specific plan option information) or you begin an unpaid leave of absence.

If you become totally disabled (as determined by your employer), your participation in this Plan will end on the date you became disabled and/or the date you are no longer entitled to compensation from your employer.

What happens to my pre-tax contributions if I have a short-term disability or insufficient pay?

If your salary during any 30-day period becomes insufficient to make the required Plan contributions, due to short-term disability or insufficient pay, your election to pay for benefits out of pre-tax dollars could be converted to an election to pay for these benefits with after-tax dollars. You may also elect to terminate your election.

What happens if I am rehired or return from an unpaid leave of absence during the same Plan Year?

If you become an eligible employee after your termination from employment or an unpaid leave of absence, you can elect to participate in this Plan under the following conditions:

If the period of time that you are not at work is **30 days or less** and there is no other event (please refer to the section **Mid-year Changes in Elections** in your Plan Option Appendix for more information) that otherwise permits a change in your elections, your prior elections will be reinstated for the remainder of the Plan Year.

If the period of time that you are not at work is **more than 30 days**, then you may make new elections for the remainder of the Plan Year.

How will participating in the Plan affect my Social Security and other benefits?

Participating in the Plan will reduce the amount of your taxable compensation from your employer. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., disability, life insurance, pension), which are based on taxable compensation. However, the tax savings that you realize through participation in the Plan will often more than offset any reduction in other benefits.

Benefit Options/Elections

Please see your Plan Option Appendix(ices) to this general SPD for your plan-specific options and election information under your 125 Plan.

Plan Information

- The Plan described in this Summary Plan Description and the attached appendix(ices) are identified as follows:
  The Plan name is the 125 Plan.
  The Plan Year is January 1 – December 31.
  The type of Plan is a Section 125 cafeteria plan.
  The Plan Number is: 525

- The Employer is the Plan Administrator and Plan Sponsor. The Employer, or a committee designated by the Employer, is the Named Fiduciary of the Plan for purposes of ERISA. The agent for service of process is the Plan Administrator. This is the person who receives all legal notices on behalf of the Plan regarding claims or suits filed with respect to the Plan. The name, address and telephone number of the Plan Administrator is:
  Stanley Estes
  PO Box 400
  Poplar Bluff, Mo. 63901
  Phone: (573) 785-4631

- The Employer Identification Number of your employer is:
  43-0445644

- The Claims Administrator for the Plan is:
  Cooperative Benefit Administrators, Inc. ("CBA")
  P.O. Box 6962
  Lincoln, NE 68506

- The 125 Plan is a contract administration plan. CBA processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurer is not responsible for the financing or administration of the Plan.

ERISA Rights

Certain plan options are provided under an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Participants who contribute to a Health FSA are entitled to certain rights and protections under ERISA.

Your Rights
ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the employer's office, all Plan documents.
- Obtain copies of all Plan documents and other Plan information upon written request to the employer. The employer may make a reasonable charge for the copies.
- File a suit in a federal court, if any materials requested are not received within 30 days of the participant's request, unless the materials were not sent because of matters beyond the control of the employer. The court may require the employer to pay up to $110 for each day's delay (beyond 30 days) until the materials are received.

Prudent Action by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries" in the law. Your employer, or committee appointed by your employer, is the named fiduciary with authority to control and manage the operation and administration of the Plan. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan. Your employer may not fire you nor discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim 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. If you are improperly denied a benefit in full or in part, you have a right to file suit in federal court after exhausting all mandatory appeal procedures under the Plan. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorney's 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 this statement or your rights under ERISA, you should contact your employer or the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

Qualified Medical Child Support Order

The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Other Important Administrative Information

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

Amendment or termination
This Plan may be amended or terminated at any time by your employer's Board of Directors. 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 month in which the Plan is terminated or amended. Any amendment or termination will take effect only as of the end of a pay period.

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.

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.

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.

125 PLAN SUMMARY PLAN DESCRIPTION
PLAN OPTION
APPENDIX A

PREMIUM ONLY PLAN

For the Employees of

Ozark Border Electric Cooperative

 # 26709

Effective Date: January 1, 2015

TABLE OF CONTENTS

Premium Only Plan Benefit

This Premium Only Plan Appendix is an attachment to, and part of, your 125 Plan Summary Plan Description (SPD).

The Premium Only Plan (POP) benefit allows you to pay your premium contributions for health benefits, disability benefits and life insurance benefits (maximum amount of coverage is $50,000) on a pre-tax basis.

Eligibility and Participation

Please see your 125 Plan SPD's Base Plan Information for specific information about eligibility and participation under the 125 Plan.

Premium Only Plan General Information

What is the POP?

You can elect to have your contributions for the following benefits deducted from your paycheck on a pre-tax basis if your employer offers these benefits:

- Medical benefits
- Prescription drug benefits
- Vision benefits
- Dental benefits
- Disability benefits (Note: If disability premiums are run through the POP, the benefits may be taxable to the disabled employee.)
- Group Life insurance benefits (maximum amount of coverage is $50,000)

However, certain premiums for other insurance programs, including Medicare, Medicaid, cancer insurance, intensive care riders, qualified long-term care insurance, or premiums paid for coverage under plans maintained by the employer of your spouse or dependent children cannot be paid on a pre-tax basis under the 125 Plan.

Elections

How do I initially enroll for POP benefits?

If you elect to participate in your employer's plans for health (medical, dental and/or vision) benefits, life insurance benefits and/or disability benefits, you are automatically enrolled in POP, and you pay any employee premium costs on a pre-tax basis, unless you opt out.

If you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to income and payroll taxes. From then on, you must pay your cost of coverage by having that portion deducted from each paycheck on a pre-tax basis (usually an equal portion from each paycheck, or an amount otherwise agreed to by your employer).

If you do not wish to participate in POP, you must submit your election not to participate to your employer within the 31-day period after you become a participant in the Plan. If you make this election after the 31-day period, your election not to participate will become effective the first day of the next Plan Year.

How do I elect POP benefits in subsequent Plan Years?

Following your initial eligibility in the POP, your participation in this Plan benefit will automatically continue for subsequent Plan Years unless you notify your employer in writing before the start of the next Plan Year that you do not wish to participate.

Mid-Year Changes in Elections

During the Plan Year, can I change my elections for benefits or contributions under the 125 Plan?

Generally, you cannot change your election to participate in Plan benefits or vary the amounts of your contributions during the Plan Year. However, under limited circumstances called "qualifying change in election events," you may change your elections during the Plan Year at a time other than open enrollment.

What are "qualifying change in election events" for the POP Option?

Qualifying change in election events for the POP option include the following:

- Changes in Status, such as marriage, death of your spouse, divorce, legal separation (if it results in loss of coverage), annulment or change in employment
- Change in number of dependents, including birth, death, adoption of a child or a child's placement for adoption
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage
- Leaves of Absence, Including leave under the Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Events subject to HIPAA Special Enrollment Rights
- Medicare and Medicaid Entitlement
- Judgments, Decrees or Orders
- Change in your Cost of Coverage
- Change in Coverage
    - Significant increase or decrease in coverage
    - Addition or improvement in coverage
    - Loss of coverage under another employer's plan or other group health plan

If you experience an event that you believe would qualify for a change in election during the Plan Year, please see your Benefits Administrator for assistance for completing and submitting the 125 Plan Change Form.

125 PLAN SUMMARY PLAN DESCRIPTION
PLAN OPTION
APPENDIX B

HEALTH FLEXIBLE SPENDING ACCOUNT

For the Employees of

Ozark Border Electric Cooperative

 # 26709

Effective Date: January 1, 2015

TABLE OF CONTENTS

Health Flexible Spending Account Benefit

This Health Flexible Spending Account (Health FSA) Benefit Option Appendix is an attachment to, and part of, your 125 Plan Summary Plan Description (SPD).

The Health FSA provides you with the opportunity to pay for certain eligible health care expenses with pre-tax dollars. The money you put in your account is exempt from federal income tax, most state income taxes, and Social Security tax. When you have an eligible expense, you file a claim and are reimbursed with money from your account. Because a Health FSA offers special tax advantages, the Internal Revenue Service (IRS) imposes several restrictions on its use. These restrictions are detailed later.

The Health FSA is part of a contract administration plan. CBA processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurer is not responsible for the financing or administration of the Plan.

Eligibility and Participation

Please see your 125 Plan SPD's Base Plan Information for specific information about eligibility and participation.

Please keep in mind that you, the employee, are the participant in the Health FSA. In addition to you, expenses for your spouse and dependent children are reimbursable. Eligibility of your spouse and dependent children is your responsibility.

For purposes of the Health FSA, spouse means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code (Code). Dependent means your tax dependent under the Code, except that an individual's status as a dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition. See your Benefits Administrator for more information about which individuals will qualify as your dependents.

Your dependent child up to age 26, regardless of whether the child qualifies as a tax dependent, is eligible for reimbursement of medical expenses under the Health FSA so long as those expenses are not otherwise covered under a medical, dental or vision plan.

Health Flexible Spending Account General Information

How does a Health FSA benefit me?

Your current medical plan should cover the majority of health care expenses that you expect to incur during the year. However, you probably have a number of out-of-pocket costs that are not covered, such as deductibles, co-payments, and certain other non-covered expenses. To be eligible for reimbursement through the Health FSA, these eligible health care expenses must relate to care provided or an expense incurred during the Plan Year and after the date you become a participant in the Plan.

What are the eligible expenses that may be reimbursed through a Health FSA?

Eligible expenses must first be submitted as claims to the applicable medical, vision, or dental plans. Generally, eligible expenses under the Health FSA include deductibles, co-payments, and other health care expenses which are considered tax-deductible medical expenses (as defined by the IRS). Eye exams, hearing aids and dental expenses may also be eligible under the Health FSA if these services/equipment are not otherwise provided under a medical, dental or vision plan. Information on medical expenses is available from IRS Publication 502 "Medical and Dental Expenses," available at the IRS website (www.irs.gov).

However, you may not request reimbursement for any expense for which you claim as a tax deduction on your tax returns. In addition, you may not request reimbursement for premiums.

You may request reimbursement for over-the-counter (OTC) drugs. OTC drugs are defined as items used for medical care, and not merely for an individual's general good health. To be eligible for reimbursement, an OTC drug must be:

- used for the diagnosis, cure, mitigation, treatment or prevention of disease;
- used by you, your spouse or your eligible dependents; and
- purchased during the period of coverage;
- an over-the-counter (OTC) medicine or drug (except insulin) that is prescribed by a medical practitioner. The prescription will need to accompany your claim for reimbursement. This is the case even though the medicine or drug is available without a prescription.

Only reasonable quantities of OTC drugs will be reimbursed under the 125 Plan in a single calendar month.

Medical-only items and supplies may still be eligible for reimbursement without a prescription.

OTC medicines or drugs and medical only items and supplies may include, but are not limited to, the following:

- **OTC medicines or drugs** – These medicines or drugs are generally eligible for reimbursement if primarily used to treat a medical condition *and prescribed by a medical practitioner*. Examples include antacids, allergy medications, pain relievers, cold medications, eye drops, cough drops, antibiotic ointments and sleep aids.

- **Medical-only items and supplies** – These items include bandages, crutches, contact lens solutions, durable medical equipment, sunburn ointments, nicotine gum or patches for smoking cessation, carpal tunnel wrist supports, pregnancy kits and diagnostic devices such as blood sugar test kits.

Medical practitioners include any health care professional, licensed by the appropriate state agency and acting within the scope of his or her license. Medical practitioners may include but are not limited to a medical doctor, doctor of osteopathy, optometrist, dentist, dental hygienist, psychologist, certified nurse practitioner, pharmacist, clinical psychologist, chiropractor and podiatrist.

In determining whether an OTC drug is eligible for reimbursement under the 125 Plan, keep in mind three categories:

- **Excluded items** – These items are never eligible for reimbursement, and are primarily used for general health and well-being. Examples of excluded items include cosmetics, toiletries, toothpaste, toothbrushes, face creams, maternity clothing, insurance plan premiums and multivitamins.

- **Medical-only items** – These items are generally eligible for reimbursement and are primarily used to treat a medical condition. Examples of medical-only items include antacids, allergy medication, pain relievers, cold medications, sunburn ointments, acne medication, orthopedic shoes and/or inserts, nicotine gum or patches for smoking cessation, eye drops, cough drops, band aids and bandages, carpal tunnel wrist supports, pregnancy kits and any item formerly a prescription drug.

- **Dual-purpose items** – These items could be used for general good health as well as for medicinal purposes. Dual-purpose items could include B-12 vitamins prescribed to treat disease, prenatal vitamins, sunscreen, nasal sprays for snoring, glucosamine for arthritis, OTC hormone therapy, weight-loss drugs, medical-grade face masks, skin products, anti-bacterial hand sanitizers, fluoride rinses, petroleum jelly and fiber supplements. In order for dual-purpose items to be reimbursed, CBA requires a medical practitioner's certification stating that the individual has a medical condition, the item is being used to treat the condition and that the condition is not cosmetic in nature. Medical practitioners include any health care professional, licensed by the appropriate state agency and acting within the scope of his or her license. Medical practitioners may include but are not limited to a medical doctor, doctor of osteopathy, optometrist, dentist, psychologist, certified nurse practitioner, pharmacist, clinical psychologist, chiropractor and podiatrist.

What are expenses that may <u>not</u> be reimbursed through a Health FSA?

The following list specifies certain expenses that are not reimbursable, even if they meet the definition of "medical care" under Code § 213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if the expenses do not meet the definition of "medical care" under Code § 213(d) and other requirements for reimbursement under the Health FSA.

Exclusions are as follows:

- health insurance premiums for any other plan;
- long-term care services;
- the salary expenses of a nurse to care for a healthy newborn at home;
- cosmetic surgery or similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from a trauma, or accident, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- funeral and burial expenses;
- custodial care;
- household and domestic help (even if recommended by a qualified physician due to an employee's or dependent's inability to perform physical house work);
- costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- bottled water;

- social activities, such as dance lessons (even if recommended by a physician);
- cosmetics, toiletries, toothpaste, etc.;
- automobile insurance premiums;
- maternity clothing, or other such uniforms or special clothing;
- marijuana and other controlled substances that are in violation of federal law;
- transportation expenses of any sort, including transportation expenses to receive medical care;
- any item that doesn't constitute "medical care" under Code § 213(d); and
- any item that isn't reimbursable under applicable regulations.

The costs of special foods and/or beverages—even if prescribed by a physician—that substitute for other foods or beverages which a person would normally consume and which satisfy nutritional requirements (such as bananas for potassium deficiency or a phenylalanine-free diet for Phenylketonuria) are not considered costs for medical care by the IRS, and thus are not eligible for coverage under the health FSA of the 125 Plan. However, special foods or beverages that are prescribed by a physician are reimbursable under the 125 Plan if (1) the food alleviates or treats an illness or disease, (2) is not part of the patient's normal nutritional needs, and (3) a copy of the prescription is provided to CBA. The cost of a special food or beverage is reimbursable only to the extent that such cost is greater than the cost of the commonly available version of the same product. Documentation of the cost of the commonly available version of the same product must be submitted with the claim.

The costs of non-medical services (such as labor coaching) of doulas and other childbirth service providers are not considered costs for medical care by the IRS, and thus are not eligible for coverage under the Health FSA of 125 Plan.

For more information about what items are not eligible medical care expenses, see IRS Publication 502 "Medical and Dental Expenses," available at the IRS website (www.irs.gov). Please use Publication 502 with caution, because it is intended only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in Publication 502 are not correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several significant differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, though generally they cannot be reimbursed from your Health FSA.) And not all expenses that are reimbursable under a Health FSA are deductible. (For example, Health FSAs may reimburse OTC drugs if they qualify as medical care, but they are still not deductible on your federal tax forms.)

Ask your benefits administrator or contact the NRECA Member Contact Center at 1.866. 673.2299 if you need further information about which expenses are—and are not—likely to be reimbursable.

When must medical care expenses be incurred for reimbursement from the Health FSA?

For medical care expenses to be reimbursed to you from your Health FSA for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the 12-

month period starting January 1 and ending on December 31. In addition, as discussed below, you may be reimbursed from unused amounts remaining in your Health FSA at the end of a Plan Year for eligible expenses incurred during the "grace period" following the end of the Plan Year. The grace period will begin on January 1 and will end on March 15 of the next Plan Year.

A medical care expense is incurred when the service that incurs the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before your Health FSA became effective, for any expense incurred after the close of the Plan Year (except for eligible expenses incurred during the grace period, as discussed below), or after your employment ends (except for coverage under COBRA).

In order to take advantage of the grace period, you must be:

- a Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates (December 31); or
- a qualified beneficiary who has COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates (December 31).

The following additional rules will apply to medical care expenses that are incurred during a grace period:

- Medical care expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your Health FSA at the end of the 2014 Plan Year and that you have also elected $2,400 of Health FSA coverage for 2015. If you submit a $500 medical care expense that was incurred on January 15, 2015, $200 of your claim will be paid out of the unused amounts remaining in your Health FSA from the 2014 Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for medical care expenses incurred in the 2015 Plan Year.
- Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 grace period expense, you discover $200 of 2014 medical care expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2014 expenses. The Plan will not reprocess the $500 grace period expense so as to pay it entirely from your 2015 Health FSA. For this reason, if you also have Health FSA coverage for the current year, you may want to wait to submit medical care expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

- Expenses incurred during a grace period must be submitted by June 15 following the close of the Plan Year to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year.

Will I be taxed on the Health FSA benefits that I receive?

Generally, you will not be taxed on your Health FSA benefits. However, your employer cannot guarantee that specific tax consequences will result from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your eligible expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined not to be for eligible expenses, then you will be required to repay the amount.

It is your responsibility to determine whether any reimbursement under the Health FSA constitutes an eligible medical expense that qualifies for the federal income tax exclusion. Ask your Benefits Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that your Benefits Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

How much can I contribute to my Health FSA?

You may set aside the lesser of the amount designated by your employer or $2,500 (as established by the Plan) each calendar year in the Health FSA. If your employer makes a contribution to the Health FSA, the $5,000 limit, established by the Plan, is applied in the aggregate and includes the employer contribution. There is no minimum plan contribution.

Will my employer contribute to my Health FSA?

Your employer will credit your Health FSA with employer contributions as follows: Ozark Border Electric Cooperative does not make employer contributions Health FSA's.

What is my maximum annual reimbursement?

Your maximum annual reimbursement from your Health FSA at any time during the period of coverage (usually the Plan Year) is the total amount that you (and/or your employer, as applicable) have elected to contribute for that period, less any prior reimbursements already paid to you.

What happens to my Health FSA if I terminate employment?

If you terminate employment, you will only be eligible to receive reimbursements for health expenses incurred during the current Plan Year prior to your termination. Refer to the section, **Continuation of Health FSA Benefits under COBRA** for more information.

If you cease to make required contributions to the Health FSA for any other reason (refer to the **Mid-Year Election Changes** section), you will not receive any reimbursements for health care expenses incurred after your last contribution is made. However, the period of coverage will continue for the remainder of a Plan Year if your employer has made a contribution to your

Health FSA. No benefits will be paid for any health expenses incurred after the end of that period of coverage.

If you are re-employed during the Plan Year, you may re-enroll in the Health FSA for the remaining portion of the Plan Year and, under limited circumstances, may be able to change your previous election. Refer to the **Annual Elections** section for more information.

Annual Elections

How do I enroll in the Health FSA?

You must submit an election form to your employer indicating the amount you wish to receive as reimbursement from the Plan (and thus have deducted from your pay) for the Plan Year. If your employer makes a contribution on behalf of all eligible employees and you do not wish to make any contributions yourself, you may not need to submit an election form, depending on your employer's requirements. Please see your Benefits Administrator.

How long does this election last?

Once you enroll in the Health FSA, your election remains in effect until the end of the Plan Year for which it was made, unless you qualify for a mid-year election change (see the **Mid-Year Changes in Elections** section, which follows).

What happens if I don't use all my benefits?

This account is subject to the ***"use it or lose it"*** rule. According to federal law, you must use all the money in your account for eligible expenses incurred during the Plan Year. Unused funds may not be carried over to the next year. Any monies in your account at the end of the Plan Year will be forfeited.

If your plan has a grace period, any money left in your account after March 15th following the end of the Plan Year is forfeited. In light of these rules, **it is extremely important to carefully estimate your eligible expenses for the year and elect to defer only the money that you need to cover those expenses.**

What is Open Enrollment?

The Health FSA operates on a calendar-year basis. You must make your annual elections during the open enrollment period specified by your employer.

If your health insurance plan does not renew on a calendar-year basis, you cannot make changes to your Health FSA elections mid-year to accommodate changes in your health plan that would affect co-payments, deductibles, or other out of pocket eligible health care expenses. Changes in cost or coverage of your health insurance plan are not "qualifying change in election events" as discussed in the section below.

Mid-Year Changes in Elections

During the Plan Year, can I change my election for benefits under the Health FSA?

Generally, you cannot change your benefit or vary the amounts of your contributions during the Plan Year. However, under limited circumstances called "qualifying change in election events," you may change your elections during the Plan Year at a time other than open enrollment.

What are "qualifying change in election events"?

"Qualifying changes in election" for the Health FSA include the following:

- Change in Status, such as marriage, divorce, change in employment, or birth of a child
- Leaves of Absence, including leave under the Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Medicare and Medicaid Entitlement
- Judgments, Decrees or Orders

If you experience an event that you believe would qualify for a change in election, please see your Benefits Administrator for assistance for completing and submitting the 125 Plan Change Form.

What is the effect of a mid-year change on the amount that can be reimbursed from my Health FSA?

Any change in an election, affecting your annual contributions, will change the maximum amount that can be reimbursed. Reimbursements for the period of coverage following an election change shall be limited to the benefit elected for the period of coverage remaining. If you want to reduce your benefit to zero for the period of coverage remaining in a Plan Year, you will no longer receive any reimbursement from the Plan—even if you have not received your maximum election amount prior to the mid-year election change to zero.

Family and Medical Leave Act (FMLA)

How does a leave of absence taken under the FMLA affect my Health FSA?

If you take paid or unpaid leave under the FMLA, you may revoke your existing Plan contribution elections under the Health FSA for the balance of the Plan Year. If the leave under FMLA is unpaid leave (you are not receiving a paycheck), you may elect to:

- pre-pay the amounts that will be due during your leave (the payments may be made on a pre-tax basis from your paycheck or after-tax basis from any taxable compensation), or
- pay the amounts that will be due during your leave on a pay-as-you-go basis on an after-tax basis, or
- repay your employer when you return to work, on a pre-tax basis or after-tax basis, if your employer continues the necessary payments on your behalf during your FMLA leave.

You have the same rights to revoke or change an election, as does a participant who is not on leave of absence.

What happens to my Health FSA when I return to work after my FMLA leave?

Upon your return to work, you may elect to resume participation on the same basis as before your leave of absence occurred.

If you revoked coverage under the Health FSA or if you continued coverage during your FMLA leave but you failed to make the required contributions under the "pay-as-you-go" option, upon return to work, you may either:

- reinstate the level of coverage in effect when the leave began and make up the missed contributions or
- reinstate the level of coverage reduced by the amount of the contributions missed during your leave.

Under either option, expenses incurred during the period that the Health FSA was not in force are not eligible for reimbursement.

Continuation of Health FSA Benefits Under COBRA

What is continuation of coverage under my Health FSA?

Health FSAs are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you, your spouse, or your dependent children have a right to receive the total amount available for reimbursement from your Health FSA account that was in place the day before a qualifying event if your participation otherwise would end because of the occurrence of the qualifying event.

What are "qualifying events"?

A qualifying event is a specific event that causes you or your covered dependents to lose coverage. Qualifying events under COBRA are:

- Termination of your employment for any reason except gross misconduct.
- Reduction in your work hours that result in loss of coverage.
- Your death.
- Divorce.
- Your dependent ceases to meet the eligibility requirements.
- Your becoming entitled to receive Medicare benefits.

What are the COBRA notification rules?

For a qualifying event other than a death or change in your employment status, the qualified beneficiary is required to notify the Plan Administrator of the qualifying event within **60 days** of its occurrence. Failure to do so will result in the loss of the qualified beneficiary's right to elect continuation of coverage under the Health FSA.

The Plan Administrator is required to notify the qualified beneficiary of his or her right to continuation of coverage within 44 days following any other qualifying event. The qualified

beneficiary is required to provide your employer with all information needed to meet its obligation of providing notice and continuation coverage.

What is the COBRA period of continued coverage for Health FSA benefits?

For most Health FSAs, the period of continued coverage is limited and extends only through the end of the Plan Year in which a qualifying event occurs if:

- You have other coverage available through a group health plan of your employer and that coverage cannot be limited to dental and/or vision.
- The maximum benefit reimbursed under the Health FSA is not more than two times your annual Plan contribution, or if greater, your annual Plan contribution plus $500.
- The maximum annual COBRA cost for Health FSA continuation coverage is equal to or greater than the maximum annual reimbursement amount.

COBRA continuation coverage will terminate at the end of the Plan Year and cannot be continued for the next Plan Year. The continuation of the Health FSA benefits only applies if you were participating in the Health FSA prior to your loss of coverage.

What happens if the Health FSA does not meet the requirements for limited COBRA continuation?

If the Health FSA does not meet the requirements for limited COBRA continuation, the following continuation periods will apply:

- 18 months of continuous coverage for you, your spouse or dependent children, if the qualifying event is due to a termination of employment, reduction in hours, or if your employer does not offer retiree coverage.
- 36 months of coverage for any other qualifying event, such as death, divorce, or loss of dependent eligibility.
- 29 months if the individual is entitled to the disability extension.

In addition, you will receive a HIPAA certificate of creditable coverage at the time of your loss of coverage. This certificate is supplied by your employer.

Your Benefits Administrator can let you know which COBRA continuation period applies.

What is the COBRA premium and how do I pay for the cost of my available reimbursement amount?

The COBRA premium is set by your employer and may be up to 102% of the full cost of your available reimbursement amount. The Health FSA premium for the initial period—from the date of the qualifying event to the date of the election—must be paid within 45 days of the election. Additional premium payments must be paid within 30 days of the due date. The COBRA premium is based on both your contribution and employer contribution.

As an alternative to purchasing continuation of benefits in the Health FSA, if you are terminated or discharged from employment or if you are no longer an eligible employee, you may elect to continue to receive all or some of the Health FSA benefits covered by your Plan election in effect at the time of the termination or reduction in hours, by paying the Plan contribution due for health benefits for the balance of the Plan Year out of your final paycheck (in the case of a termination

of service) or last full-time paycheck (in the case of reduction of hours). If your paycheck is not sufficient to cover the full amount of the Plan contribution due for the balance of the Plan Year, you may pay any balance due to your employer by making an additional after-tax plan contribution within 10 days after termination of employment or reduction in hours.

When does the Health FSA continuation coverage terminate?

Continuation of the Health FSA coverage will terminate on the earliest of the following:

- The end of the Plan Year in which the qualifying event occurs, if the limited COBRA continuation period applies.
- The end of 18, 29 or 36 months, as applicable.
- The date of termination of the Health FSA benefit under the Plan along with all other health benefits provided by your employer.
- The date you or the qualified beneficiary fails to pay the plan contribution by the specified due date.
- The date you or the qualified beneficiary first becomes, after the date of the COBRA election, covered under any other group health plan which does not contain any applicable exclusion or limitation of a pre-existing condition affecting the qualified beneficiary (other than an exclusion or limitation that does not apply or is satisfied due to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The date you or the qualified beneficiary first becomes, after the date of the COBRA election, entitled to Medicare.

COBRA Rights

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

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

Claims and Appeals Procedures

How do I file a reimbursement request for eligible health care expenses?

Benefits will be paid under the Plan only if the Plan Administrator, the Claims Administrator, the Appeals Administrator or the Appeals Committee determines in their discretion that you are entitled to them. The Appeals Administrator or, in the case of a Final Appeal, the Appeals Committee is the final reviewer of claims for benefits, and its decisions are final.

Eligible expenses must first be submitted as claims to the applicable medical, vision or dental plans. Then submit your claim for reimbursement of eligible out-of-pocket expenses to this Plan using the 125 Plan Health Care Reimbursement Form. Ask your Benefits Administrator for the form. Alternatively, you can submit a claim for reimbursement online at cooperative.com. All expenses claimed for reimbursement must be incurred for the current Plan Year in which you are covered by this Plan. Cooperative Benefit Administrators ("CBA") is the Claims Administrator for the 125 Plan.

The reimbursement request must include the following information:

- The name of the person receiving the services;
- The date and nature of the service and the name of the service provider (enclose a copy of the Explanation of Benefits (EOB) if applicable). If you have no coverage for the type of service for which you are requesting reimbursement, please send an itemized bill and indicate that you have no coverage;
- The unreimbursed amount of the medical expense;
- Your certification that the expenses have not been reimbursed through any of your employer's or any other health plan and are not being used to claim any federal income tax deduction or credit.

If your employer participates in the CBA claims interface, NRECA-sponsored medical, prescription, vision and dental out-of-pocket expenses automatically roll over to this Plan for processing so you do not need to submit a paper reimbursement form. You may elect not to participate in the claims interface option on the annual election form.

How do I file a reimbursement request for over-the-counter drug expenses?

For over-the-counter drugs, cash register receipts specifying the date of the purchase, the name of the item purchased, the cost of the item, doctor's prescription and any other appropriate documentation should be attached to the 125 Plan Health Care Reimbursement Form. CBA prefers to process reimbursement requests for over-the-counter items on a quarterly basis.

What if the amount of my reimbursement request is more than my account balance?

You make contributions to your Health FSA each pay period. It is possible that the amount of your reimbursement request will be more than the amount in your account. Future payroll deductions will make up the difference. You will be reimbursed the full amount of your reimbursement request, up to the amount you elected to contribute or have received from your employer (if applicable) for the year, less any reimbursement requests already paid.

What is the procedure for filing claims and appeals under my Health FSA?

The following table explains the process for filing reimbursement claims and appeals. If you need more information, please contact your Benefits Administrator.

Process for Filing Claims and Appeals for Health FSA Benefits	
Time limit to file a claim for reimbursement under the Health FSA	[All reimbursement requests for the year must be received by the CBA not later than **March 31** following the end of the Plan Year. **Any balance remaining in your Health FSA after the last eligible expenses have been reimbursed for the Plan Year will be forfeited.]** ***Or*** **[**All reimbursement requests for the year must be received by CBA the not later than **June 15** following the end of the Plan Year. **Any balance remaining in your Health FSA after the last eligible expenses have been reimbursed for the Plan Year plus the 2½ month grace period will be forfeited.]**
Submit your claim to:	Claims Administrator Cooperative Benefit Administrators, Inc. P.O. Box 6962 Lincoln, NE 68506 CBA also accepts FAX submission of claims at 402.483.9388. Claims may also be submitted on line through Cooperative.com.
Date your claim is considered to be "filed":	The date CBA receives your complete claim in writing.
Time period that CBA has to notify you that your claim is approved or denied:	Not later than **30 days** from the date CBA receives your claim. CBA may require **one 15-day extension** if circumstances warrant and will notify you that it needs more time to evaluate your claim. CBA will notify you of the extension before the initial 30-day period is up. If CBA needs the 15-day extension because you did not provide all the information needed to process your claim, CBA will tell you what information is missing.
If your claim is incomplete, the time period that you have to submit the additional requested information to CBA:	Not later than **45 days** from the date CBA sent you the notice to tell you that your claim is missing information. This gives CBA additional time to respond to your claim. If you do not send CBA the missing information within this 45-day period, CBA will deny your claim.
Time period for deciding a claim is suspended while CBA waits for you to submit additional information about your claim:	The time period for deciding your claim is suspended from the date CBA notifies you that your claim is incomplete until the date you provide CBA with the requested information. CBA may then use the remainder of the review period to complete its evaluation of your claim.

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

If the Appeals Administrator denies your appeal, you will receive a notice that is readable and easily understood by the average person without an insurance background. The notice contains:	• Specific reasons why your appeal is denied. The reasons must be sound, logical and pertain to the facts of the claim. • Reference to the specific Plan provisions on which the denied appeal is based. • An explanation of your rights under the Plan's claims and appeals rules, including that you have the voluntary right to a final appeal by the Appeals Committee. • Your right to file suit under ERISA with respect to any adverse determination after appeal. You have now completed the Plan's appeal process

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rights Applicable to Health FSA Benefits

Participants who contribute to a Health FSA are entitled to certain rights under HIPAA. The 125 Plan is required by federal law to protect the privacy of your individually identifiable health information that it creates or receives ("Your Protected Health Information") and to provide you with information about its legal duties and privacy practices.

Use and Disclosure of Your Protected Health Information
The 125 Plan may use or disclose Your Protected Health Information to others without your authorization for purposes of treatment, payment or health care operations of the 125 Plan. Treatment includes providing, coordinating, and managing your health care and related services. Payment includes obtaining payment for your coverage, administering claims, coordinating benefits and aiding other health plans or health care providers in obtaining payment for their services. Health care operations include using or disclosing information for business planning, quality assessment, case management and disease management.

The 125 Plan may also disclose Your Protected Health Information to a limited group of employees of NRECA or CBA to carry out the 125 Plan Sponsor's responsibilities to administer plan payment and health care operations. The 125 Plan may not disclose Your Protected Health Information to the NRECA or CBA for any other reason without your authorization. However, health information derived from other sources, for example in connection with an application for disability benefits or a leave qualifying under the Family and Medical Leave Act, is not protected by HIPAA.

The 125 Plan is not restricted from using or disclosing any health information that does not identify an individual. Your eligibility and enrollment information may also be used by or disclosed to NRECA or CBA.

The 125 Plan may also use or disclose Your Protected Health Information without your authorization for the following purposes: to comply with the law, for public health and health oversight activities, in connection with judicial and administrative proceedings, to law enforcement and government officials, for health or safety purposes, or for workers' compensation purposes.

In most other cases, the 125 Plan cannot use or disclose Your Protected Health Information without your authorization. If you choose to authorize additional uses and disclosures of Your Protected Health Information, you may revoke your authorization at any time.

Your Rights
You may request additional restrictions on the use and disclosure of Your Protected Health Information for payment and health care operations; however, the 125 Plan does not have to grant your request.

You may request to receive Your Protected Health Information by an alternative means of communication or at another location if the standard method of communication will endanger you.

You have a right to inspect and copy Your Protected Health Information; however, the 125 Plan may deny your request under certain circumstances.

You have a right to request that the 125 Plan amend Your Protected Health Information in any system maintained by or for it, however the 125 Plan may deny your request under certain circumstances. If your physician or other health care provider created the information that you desire to amend, you should contact them directly.

You may obtain an accounting of certain disclosures of Your Protected Health Information made after April 14, 2004. You may be charged if you request an accounting more than once within a 12-month period.

You may exercise your rights through a personal representative if they produce evidence of their authority to act on your behalf. For purposes of the 125 Plan, a personal representative may not be a physician or other health care provider.

To exercise these rights or if you have additional questions, you should contact the Privacy Officer and/or Contact Person listed in the 125 Plan's Notice of Privacy Practices, which has previously been furnished to you.

Notice of availability of HIPAA Notice of Privacy Practices
The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) govern how health information about you may be used, and provide you with certain rights with respect to your health information. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your co-op's Privacy Officer:

Privacy Officer
Ozark Border Electric Cooperative
PO Box 400
Poplar Bluff, Mo.63902-0400
Phone: (573) 785-4631

125 PLAN SUMMARY PLAN DESCRIPTION
BENEFIT OPTION
APPENDIX C

DEPENDENT CARE ASSISTANCE PROGRAM

For the Employees of

Ozark Border Electric Cooperative

 # 26709

Effective Date: January, 1, 2015

TABLE OF CONTENTS

Dependent Care Assistance Program Benefit

This Dependent Care Assistance Program (DCAP) Benefit Option Appendix is an attachment to, and part of, your 125 Plan Summary Plan Description (SPD).

This option allows you to pay for certain eligible dependent care benefits with pre-tax dollars. The money you put in your account is exempt from federal income tax, most state income taxes, and Social Security tax. When you have an eligible expense, you file a claim and are reimbursed with money from your account. Because a DCAP offers special tax advantages, the Internal Revenue Service (IRS) imposes several restrictions on its use. These restrictions are detailed later.

Eligibility and Participation

Please see your 125 Plan SPD's Base Plan Information for specific information about eligibility and participation.

Dependent Care Assistance Program General Information

What is a DCAP?

The cost of providing care for your dependents, so that you are able to work, can be expensive. A DCAP permits you to pay for your qualifying dependent care expenses with pre-tax dollars that are not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your spouse's DCAP). DCAP is intended to help you pay a qualified care giver for day care and other eligible dependent care expenses that allow you (and your spouse, if applicable) to be gainfully employed. Therefore, if you are married, you can only use this account if your spouse is employed and has earned income.

You may set aside funds, up to the maximum amount discussed below, each calendar year in a DCAP. This account may be used to reimburse yourself for a variety of eligible dependent care expenses. These expenses must relate to care provided or incurred during the Plan Year and after the date you become a participant in the Plan.

How much can I contribute to my DCAP?

The IRS sets the maximum limit on the amount you may contribute to your DCAP. Your maximum annual contribution cannot exceed the lesser of:

- $5,000 if you are single or are married and file a joint federal income tax return; or
- $2,500 if you are married and file a separate federal income tax return; or
- your earned income, if you are single; or
- the earned income of the spouse who earned the lesser amount during the year, if you are married; or

- the amount designated by your employer.

If you enroll as a newly hired employee in the middle of the year, be sure that your FSA contributions through this Plan, combined with any prior contributions with a former employer, do not exceed the maximums. It is your responsibility to keep track of your contributions.

Can I participate in a DCAP if I am married and my spouse does not work?

No. If you have a spouse who does not work, he or she has no earned income. Under IRS rules summarized in the prior question, your maximum contribution would be zero because the IRS maximum contribution is the lesser of $5,000 *or* the earned income of the spouse who earned the lesser amount during the year, which in this case is $0.

An exception to this rule is a spouse who is incapacitated or who is a full-time student for at least 5 months of the year. In this case the spouse is treated as having earned income of not less than:

- $250 per month if you have one eligible dependent; or
- $500 per month if you have two or more eligible dependents.

For example, assume you are married, file jointly, your spouse is a full-time student, you earn $25,000, and you have one dependent. Your maximum contribution to a DCAP would be $3,000 because your maximum contribution is the lesser of $5,000 *or* your spouse's annual earned income which in this case is deemed to be $3,000 ($250 per month x 12 months).

Who is an eligible dependent?

You may use your DCAP to pay day care expenses for the following dependents:

- a person under age 13 who is your "qualifying child" under the IRS Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
- your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

Under a special rule for children of divorced or separated parents, a child is an eligible dependent with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See your Benefits Administrator for more information on which individuals will qualify as your eligible dependents.

Who is a qualified caregiver?

A qualified caregiver is a person who performs qualified dependent care services and **is not**:

- your dependent;
- your spouse;
- your child under the age of 19 (as of the end of the Plan Year in which qualified dependent care services are provided).

In addition, a qualified dependent care center is a licensed dependent care center for more than six individuals that operates in compliance with all applicable state and local laws.

What are eligible expenses?

Eligible expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be an eligible dependent as defined above. All of the following conditions must be met for such expenses to qualify as eligible expenses that are eligible for reimbursement:

- Each person for whom the expense is incurred must be an eligible dependent.
- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP account.

- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.
- The expenses are incurred for the care of an eligible dependent or for household services attributable in part to the care of an eligible dependent.
- If the expenses are incurred for services outside of your household for the care of an eligible dependent other than a person under age 13 who is your qualifying child, then the eligible dependent must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your spouse, a parent of your under-age-13 qualifying child, or a person for whom you (or your spouse) are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the eligible dependent stays overnight.

For more information about what items are—and are not—deductible dependent care expenses, consult IRS Publication 503 (Child and Dependent Care Expenses). Please use Publication 503 with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code § 21, not what is reimbursable under a DCAP. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable under your DCAP. This is because there are several differences between what expenses qualify for the Dependent Care Tax Credit (under Code § 21) and what expenses are reimbursable under a DCAP (under Code § 129). Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a DCAP. (For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the DCAP, the expense must have been incurred during the Plan Year for which reimbursement is sought.)

Ask your Benefits Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that your Benefits Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for eligible expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year;
- the earned income of your spouse for the calendar year (your spouse will be deemed to have earned income of $250 ($500 if you have two or more eligible dependents) for each month in which your spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
- either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status.

Any reimbursements that your employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your spouse also participates in a DCAP, the maximum amount that you and your spouse together can exclude from income is $5,000.

What are ineligible expenses?

You cannot use a DCAP to pay for:

- educational expenses such as tuition, room and board;
- meals;
- overnight or sleep-away camps;
- care provided by your spouse, dependent child, or other family member;
- expenses not allowed by the IRS.

What is the dependent care federal tax credit?

There is a second way to reduce your taxes if you have dependent care expenses: the dependent care federal tax credit. More information about the federal tax credit is available from IRS Publication 503 and IRS Form 2441, Child and Dependent Care Expenses, available on the IRS website (www.irs.gov). **However, as a general rule, you cannot use your Dependent Care Assistance Program and the federal tax credit.**

To decide which method is best, you should calculate your tax savings using the Dependent Care Worksheet found in IRS Publication 503 and compare it to the allowable federal tax credit. Which is better will depend on your tax bracket, the type of income tax return you file, the amount of your dependent care expenses, and the number of dependents you have. You should seek the advice of your tax advisor for more information.

What is my maximum reimbursement from my DCAP?

Your maximum monthly reimbursement under your DCAP at any time during the Plan Year in which you are covered is your actual year to date contributions, less any prior reimbursements already paid to you.

What happens if I terminate employment?

If you terminate employment, you will not receive any reimbursements for dependent care expenses incurred after your termination date.

If you are re-employed during the Plan Year, you may re-enroll in the DCAP for the remaining portion of the Plan Year only under limited circumstances. Refer to the **Election** section for more information.

Elections

How do I enroll in the Dependent Care Benefit?

You must submit an election form to your employer, indicating the amount you wish to receive as a reimbursement from the Plan.

How long will this election last?

Once you enroll in the DCAP, your election remains in effect until the end of the Plan Year for which it was made, unless you qualify for a mid year election change (See the **Mid Year Changes** section, which follows). You will need to make a new election before the beginning of each Plan Year.

What is Open Enrollment?

The DCAP is operated on a calendar-year basis. You must make your annual elections during the open enrollment period specified by your employer.

When must the dependent care expenses be incurred?

For eligible dependent care expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. While a 2½-month grace period may be provided for the Health FSA, no such grace period is provided for the DCAP. The Plan Year for the DCAP is the 12-month period beginning on January 1 and ending on December 31.

A dependent care expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service.

What must I do to be reimbursed for my Dependent Care Expenses?

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a DCAP Reimbursement Request Form that will be supplied to you, or submit a claim online at Cooperative.com. You must include written statements and/or bills from independent third parties stating that the dependent care expenses have been incurred and stating the amount of such dependent care expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough funds in your DCAP, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until March 31, after the end of the Plan Year in which to submit a claim for reimbursement for dependent care expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit a claim for reimbursement for dependent care expenses incurred prior to the date you ceased to be eligible; you can also be reimbursed for expenses incurred in the month following your termination of participation if such month is in the current Plan Year and your claim is submitted by the 90-day deadline. You will be notified in writing if any claim for benefits is denied.

Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the expenses that you incur during the Plan Year are less than the annual amount that you elected for the DCAP, you will forfeit the rest of that amount in your DCAP—this is called the “use-it-or-lose-it” rule under applicable tax laws. No grace period is provided under the DCAP. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for expenses during the Plan Year, even if amounts are still left in your DCAP. The difference between what you elected and what expenses were reimbursed will be forfeited at the time periods specified below.

What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP that are not applied to your expenses for DCAP benefits for any Plan Year by December 31 of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 60 days after the date you ceased to be eligible). Forfeited amounts will be used as follows: first, to offset any losses experienced by the employer as a result of making reimbursements in excess of contributions paid by all participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any DCAP benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the eligible expense was incurred shall be forfeited and applied as described above.

Will I be taxed on the DCAP benefits I receive?

Generally, you will not be taxed on your DCAP benefits. However, your employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (“Child and Dependent Care Expenses”) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for an eligible expense under your DCAP, then you will be required to repay the amount.

It is your responsibility to determine whether any reimbursement under the DCAP constitutes an eligible expense that qualifies for the federal income tax exclusion. Ask your Benefits Administrator if you need further information about which

expenses are—and are not—likely to be reimbursable, but remember that your Benefits Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP, although your eligible expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. For example, if you elect $3,000 in coverage under the DCAP and are reimbursed $3,000, but you had eligible expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Eligible dependents. Please consult your tax advisor for further information.

What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual dependent care expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one eligible dependent, or $6,000 for two or more eligible dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one eligible dependent, or $2,100 for two or more eligible dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one eligible dependent, or $1,200 for two or more eligible dependents). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000.

Example: Assume that you have one eligible dependent for whom you have incurred eligible expenses of $3,600, and that your adjusted gross income is $20,000. Since only one eligible dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more eligible dependents, your credit would have been $3,600 x 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication 503 (Child and Dependent Care Expenses) or please consult your tax advisor.

Would it be better to include the DCAP benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax free?

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of eligible dependents, earned income, etc., you will have to determine your individual tax position in order to make the decision. Use IRS Form 2441 (“Child and Dependent Care Expenses”) to assist you. You may wish to consult your tax advisor.

Mid-Year Changes in Elections

During the Plan Year, can I change my elections for benefits or contributions under the 125 Plan?

Generally, you cannot change your election to participate in Plan benefits or vary the amounts of your contributions during the Plan Year. However, under limited circumstances called “qualifying change in election events,” you may change your elections during the Plan Year at a time other than open enrollment.

What are “qualifying change in election events”?

Changes in election events in relation to the DCAP include the following:

- Change in Status, such as marriage, divorce, change in employment;

- Change in an Employee's number of Dependents, including birth, death, adoption of a child or a child's placement for adoption
- Dependent Loss of Eligibility (child no longer meets eligibility definition (e.g., turns age 13);
- Leaves of Absence, Including Leave Under the Family Medical Leave Act (FMLA) and USERRA;
- Change in Cost; or
- Change in Coverage (to the extent applicable).

Change in Cost refers to a significant increase in cost. An increase of 12.5% may be considered significant. Neither overpayment nor billing errors are defined as a "Change in Cost."

If you experience an event that you believe would qualify for a change in election, please see your Benefits Administrator for assistance completing and submitting the 125 Plan Change Form.

Family and Medical Leave Act ("FMLA")

How does a leave of absence taken under the FMLA affect my DCAP?

If you take paid or unpaid leave under the Family and Medical Leave Act (FMLA), you may revoke your existing Plan contribution elections the DCAP for the balance of the Plan Year. If the leave under the FMLA is unpaid leave (you are not receiving a paycheck), you may elect to:

- pre-pay the amounts that will be due during your leave (the payments may be made on a pre-tax basis from your paycheck or after-tax basis from any taxable compensation); or
- pay the amounts that will be due during your leave on a pay-as-you-go basis, on an after-tax basis; or
- repay your employer when you return to work, on a pre-tax basis or after-tax basis, of your employer continues the necessary payments on your behalf during your FMLA leave.

You have the same rights to revoke or change an election, as does a participant who is not on leave of absence.

What happens to my DCAP when I return to work after my FMLA leave?

Upon your return, if you terminated coverage while on FMLA leave, your employer may require that you resume participation on the same basis as before your leave of absence occurred, or you may make a new election. Please see your Benefits Administrator

Claims and Appeals Procedures

How do I file a reimbursement request for qualifying dependent care services?

Benefits will be paid under the Plan only if the Plan Administrator, the Claims Administrator, or the Appeals Committee determines in their discretion that you are entitled to them. The Appeals Committee is the final reviewer of claims for benefits, and its decisions are final.

All day care expenses claimed for reimbursement must be incurred for the current Plan Year in which you are covered by this Plan. Submit your expenses to the Plan using the 125 Plan Dependent Care Reimbursement Form. Ask your Benefits Administrator for the form.

The reimbursement request form should include the following general information:

- The dates and nature of the day care expenses;
- The dependents' names;
- The service provider's name, address and taxpayer identification number or Social Security number;
- The relationship, if any, of the service provider to you;
- The original bill or receipt showing the amount of the day care expense or evidence of your payment to the provider of the service;
- Your certification that the expenses are eligible expenses for your dependents (as defined by the Plan) and are not being used to claim any federal income tax deduction or credit.

If you are filing for reimbursement for qualifying dependent care services performed outside your home for a dependent who is incapable of caring for himself or herself, you need to provide a statement as to whether this dependent regularly spends at least eight hours a day in your home.

If you are filing for reimbursement for qualifying dependent care services performed for a dependent who is not your child, but who is capable of self-care, you need to provide a statement that this dependent is under the age of 13 and has gross income of less than the personal exemption amount in Code Section 151(d).

What if the amount of my dependent care reimbursement request is more than my account balance?

You make contributions to your Dependent Care Benefit each pay period. If the amount of your reimbursement request is *more* than the amount in your account, you will be reimbursed only the amount in your account. Payment of the reimbursement request in excess of the amount in your account will be delayed (but not delayed beyond the end of the Plan Year) until there are enough funds to cover the remaining amount of your reimbursement request.

What is the procedure for filing claims and appeals under my DCAP?

The following table explains the process for filing reimbursement claims and appeals. If you need more information, please contact your Benefits Administrator.

Process for Filing Claims and Appeals for DCAP	
Time limit to file a claim for reimbursement under the DCAP:	All reimbursement requests for the year must be received by the Claims Administrator not later than **March 31** following the end of the Plan Year. **Any balance remaining in your DCAP after the last eligible expenses have been reimbursed for the Plan Year will be forfeited.**
Submit your claim to:	Claims Administrator Cooperative Benefit Administrators, Inc. P.O. Box 6962 Lincoln, NE 68506 CBA also accepts FAX submission of claims at 402.483.9388.
If CBA fails to notify you of either the need for an extension or the final outcome for a claim, you may presume your claim has been denied, unless the aggregate pending claims that you submitted have exceeded the amount of funds in your DCAP.	
CBA will give you a notice if your claim is denied that contains:	• Specific reasons why your claim is denied • Reference to the specific Plan provisions on which the denied claim is based • Description of any additional information needed and why this information is needed for you to validate the claim • Explanation of the Plan's claims review and appeal procedures, including your right to review (upon request and at no charge) relevant documents and other information.
Time period that you have to request a claim appeal:	Not later than **180 days** from the date you receive the notice that your claim is denied. You may examine all pertinent documents. To support your appeal, you may submit issues and comments in writing.

Submit your written appeal to:	Appeals Committee PO Box 400 Poplar Bluff, Mo. 63902-0400
Time period that the Appeals Committee has to review your appeal and make a decision:	Not later than **60 days** from the date the Appeals Committee receives your appeal. The Appeals Committee may require **one 60-day extension** if circumstances warrant and will notify you that it needs more time to evaluate your appeal. The Appeals Committee will notify you of the extension before the initial 60-day period is up.
If your final appeal is denied, you will receive a notice that contains:	• Specific reasons why your appeal is denied • Reference to the specific Plan provisions on which the denied appeal is based The decision of the Appeals Committee shall be final and conclusive.

[SAMPLE FOR REVIEW BY COUNSEL]

125 PLAN
SUMMARY OF MATERIAL MODIFICATIONS
Re: Increase to Limitation on Health FSA and Limited-Use Health FSA Salary Reduction Contributions

System Name: _____

RUS/Subgroup Numbers: _____ - _____ - _____

Employer Tax Identification Number: _____ - _____

Plan Number: 525

Whenever a material change or clarification is made to an employee benefit plan, the law which regulates such plans requires that the sponsoring employer provide eligible participants with information concerning the change(s). The information in this Summary of Material Modifications (SMM) summarizes the change(s) and clarifications to your 125 Plan. To make sure you always refer to the most current information regarding your 125 Plan, you should keep a copy of this SMM with your Summary Plan Description for the 125 Plan.

INCREASE TO LIMITATION ON HEALTH FSA AND LIMITED-USE HEALTH FSA SALARY REDUCTION CONTRIBUTIONS

EFFECTIVE JANUARY 1, 2018, YOU MAY CONTRIBUTE UP TO $2,600 TO YOUR HEALTH FSA AND/OR LIMITED-USE HEALTH FSA.

The Patient Protection and Affordable Care Act imposes a limit on a participant's contributions to a health FSA and/or limited-use health FSA. That limit may be increased for inflation from time to time, and was increased recently to $2,600. If you participate in both a health FSA and a limited-use health FSA, your total salary reduction contributions may not exceed $2,600 for both plans combined.

All other rules, provisions, definitions and benefit amounts of the 125 Plan remain the same. It is important for you to understand your benefits. If you have any questions regarding this change or your 125 Plan, please see your Benefits Administrator or contact the NRECA Member Contact Center at 1.866.673.2299.