NRECA GROUP BENEFITS PROGRAM
SUMMARY OF MATERIAL MODIFICATIONS
For
NRECA Long Term Disability Plan

EFFECTIVE: February 6, 2018 (First change below)
April 1, 2018 (For all other changes below)

System name: Ozark Border Electric Cooperative

RUS/Subgroup Number: 26033-003

Employer Tax Identification Number: 43-0445644

This Summary of Material Modifications (SMM) describes changes to the National Rural Electric Cooperative Association Long Term Disability Plan (the Plan) and supplements the Plan's Summary Plan Description (SPD) – also known as the Benefits Booklet. The effective date of this change is noted above. You should read this SMM very carefully and retain this SMM with your SPD for future reference. If you have any questions regarding this change, please see your Benefits Administrator.

The Changes for your NRECA Long Term Disability Plan SPD are as follows:

Chapter 5: Long-term Disability Benefits

Effective February 6, 2018, the "Income and FICA Tax Withholding" section was updated as follows:

Federal Income taxes will be withheld on any taxable Disability benefits. The default withholding is **twenty-two percent (22%)** of the taxable benefit, unless you submit an IRS Form W-4 to Cooperative Benefit Administrators (CBA) to change the withholding amount, in which case federal income taxes shall be withheld according to the instructions on your IRS Form W-4.

Chapter 6: Claims and Appeals

For claims initially filed on or after April 1, 2018, the "General Information" section was updated to add the following new subsections to the end of that section:

Coverage Rescissions. Notwithstanding the foregoing, if the Plan retroactively cancels coverage (e.g., due to a misstatement on an application), the coverage rescission is treated as a benefit denial, requiring the Plan to give the participant the opportunity to appeal the decision. The exception is when the cancellation of coverage stems from a failure to timely pay required premiums or contributions toward the cost of coverage.

A rescission of coverage is a cancellation, termination or discontinuance of coverage that has retroactive effect, meaning that it will be effective as of the date on which you were ineligible for coverage under the Plan. The Plan will rescind your coverage with 30 days' advance written notice if the Plan determines in its sole discretion that your fraud against the Plan or your intentional misrepresentation of a material fact resulted in your eligibility for coverage under the Plan when you in fact were/are not eligible for coverage under the Plan. An intentional misrepresentation of fact includes, but is not limited to, your failure to report a change in eligibility status in accordance with the terms of the Plan. Your enrollment as an

ineligible individual or your failure otherwise to comply with the Plan's requirements for eligibility will constitute fraud or an intentional misrepresentation of material fact.

The following coverage terminations are not rescissions of coverage. They do not require the Plan to give you 30 days' advance written notice of coverage termination.

1. The Plan terminates your coverage retroactive to your employment termination date when (a) there is a delay in your employer's administrative recordkeeping that results in your employer's failure to notify the Plan of your termination of employment in a timely manner, and (b) you paid no Plan premiums or contributions after your employment termination date.
2. You failed to pay required Plan premiums or contributions for coverage under the Plan on a timely basis, and the Plan terminates your coverage retroactive to the last date of coverage for which you did pay required Plan premiums or contributions on a timely basis.

For unintentional mistakes or errors which result in your coverage under the Plan which should not have occurred, the Plan will terminate your coverage prospectively (going forward), once the mistake or error is identified. Because such termination is not a rescission of coverage, the Plan will not give you 30 days' advance written notice.

If you experience a coverage rescission and have questions, contact the Member Contact Center at 1-866-673-2299.

Culturally and Linguistically Appropriate Benefit Denial Notices. Benefit denial notices will be available in a culturally and linguistically appropriate manner if 10% or more of the population in the county where you reside is literate only in the following same non-English language, as determined by the US Census Bureau: Chinese, Tagalog, Navajo and Spanish, and will include a prominent statement in the relevant non-English language detailing how you can access language services. You can contact the Member Contact Center at 1-866-673-2299 for oral customer service in that non-English language, and the Plan will provide written notices translated into that non-English language upon request.

Deemed Exhaustion of the Plan's Claims and Appeals Processes. If the Plan fails to comply with its claims processing rules, you may be treated as having exhausted the administrative remedies available to you under the Plan. This means that you can file a lawsuit immediately without regard to whether you have requested an appeal of your benefit denial. If you believe that the Plan has failed to comply with its claims processing rules, you may contact CBA (see *Claims and Appeals Contacts* below) to request that CBA explain the violation(s). CBA must provide a written explanation of the violation to you within 10 days of your request, including why CBA believes that the violation(s) should not cause the Plan's administrative remedies to be exhausted. The violation(s) will not cause the Plan's administrative remedies to be exhausted if the violation is de minimis, non-prejudicial to you, attributable to good cause or matters beyond the Plan's control, happens in the course of an ongoing good-faith exchange of information between you and the Plan, and is not reflective of a pattern or practice of non-compliance. If a court rejects your request for immediate review on the basis that the Plan met the standards for the exception described in the previous sentence, your claim will be considered refiled on appeal once the Plan receives the court's decision and provides you with notice of such refiling on appeal.

New or Additional Evidence and/or Rationale Considered by the Plan on Appeal. For benefit denials on appeal – whether at the first-level appeal or the voluntary final appeal – before the appeal decision-maker can issue a benefit denial decision on appeal, it must give you the following free of charge and as soon as possible and sufficiently in advance of the date on which the benefit denial decision is required to be provided to you:

- any new or additional evidence that the appeal decision-maker (or other person at its direction) considered, relied upon or generated in connection with your appeal; and
- any new or additional rationale on which the benefit denial decision on appeal would be based.

The "Disability Claim Filing Process" section was updated as follows:

If Your Claim is Denied

CBA will provide you a notice that contains:

- Specific reason(s) for the benefit denial;
- Reference to specific Plan provisions on which denial is based;
- A description of any additional information needed to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's appeal procedures and time limits that apply to them;
- An explanation of your rights under ERISA's claim and appeals rules; and
- A copy of any internal rule, guideline, protocol or similar criterion used to make the determination (or a statement that the material is available upon request for free).

For claims initially filed on or after April 1, 2018, the denial notice provided to you by CBA will also contain the following:

- The basis for disagreeing with, or not following, any disability determination made by the Social Security Administration that you presented;
- The basis for disagreeing with, or not following, the views of medical or vocational experts whose advise was obtained on behalf of the Plan – whether or not the advice was actually relied upon when making the benefit decision;
- The basis for disagreeing with, or not following, the views presented by health care professionals who treated you and the vocational professionals who evaluated you;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim, or, alternatively, a statement that such guidelines, protocols, standards or other similar criteria do not exist.
- A statement that you have the right to receive, upon request and free of charge, copies of, all documents, records and other information relevant to your claim for benefits. A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information
  (i) Was relied upon in making the benefit decision;
  (ii) Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether such document, record, or other information was relied upon in making the benefit decision;
  (iii) Demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim decisions are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants;
  (iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination; and
- (v) If the benefit denial was based on experimental or medical necessity criteria (or similar exclusion or limit), an explanation of the scientific or clinical judgment that the denial was based on, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The "First-Level Appeal Process" section was updated as follows:

If Your First-Level Appeal is Denied

The Appeals Administrator will provide you a notice that contains:

- Specific reason(s) for the benefit denial;
- Reference to specific Plan provisions on which denial is based;
- A description of any additional information needed to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's appeal procedures and time limits that apply to them;
- An explanation of your rights under ERISA's claim and appeals rules; and
- A copy of any internal rule, guideline, protocol, or similar criterion used in the decision or a statement that such rule, guideline, protocol, or similar criterion is available upon request for free.

For first-level appeal denials that are related to initial claims filed on or after April 1, 2018, the denial notice provided to you by the Appeals Administrator will also contain the following:

- The basis for disagreeing with, or not following, any disability determination made by the Social Security Administration that you presented;
- The basis for disagreeing with, or not following, the views of medical or vocational experts whose advise was obtained on behalf of the Plan – whether or not the advice was actually relied upon when making the benefit decision;
- The basis for disagreeing with, or not following, the views presented by health care professionals who treated you and the vocational professionals who evaluated you;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim, or, alternatively, a statement that such guidelines, protocols, standards or other similar criteria do not exist;
- A statement that you have the right to receive, upon request and free of charge, and copies of, all documents, records and other information relevant to your claim for benefits. A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information
  (i) Was relied upon in making the benefit decision;
  (ii) Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether such document, record, or other information was relied upon in making the benefit decision;
  (iii) Demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim decisions are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
  (iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination; and
- A statement of your right to file a lawsuit under ERISA and the date by which that lawsuit must be filed.

The "Voluntary Final Appeal Process" section was updated as follows:

If Your Voluntary Final Appeal is Denied

The Appeals Committee will provide you a notice that contains:

- Specific reason(s) for the benefit denial;

- Reference to specific Plan provisions on which denial is based;
- A description of any additional information needed to perfect the claim and an explanation of why such information is needed;
- An explanation of your rights under ERISA's claim and appeals rules; and
- A copy of any internal rule, guideline, protocol, or similar criterion used in the decision or a statement that such rule, guideline, protocol, or similar criterion is available upon request for free.

For voluntary final appeal denials that are related to initial claims filed on or after April 1, 2018, the denial notice provided to you by the Appeals Committee will also contain the following:

- The basis for disagreeing with, or not following, any disability determination made by the Social Security Administration that you presented;
- The basis for disagreeing with, or not following, the views of medical or vocational experts whose advise was obtained on behalf of the Plan – whether or not the advice was actually relied upon when making the benefit decision;
- The basis for disagreeing with, or not following, the views presented by health care professionals who treated you and the vocational professionals who evaluated you;
- The specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim, or, alternatively, a statement that such guidelines, protocols, standards or other similar criteria do not exist;
- A statement that you have the right to receive, upon request and free of charge, and copies of, all documents, records and other information relevant to your claim for benefits. A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information
  (i) Was relied upon in making the benefit decision;
  (ii) Was submitted, considered, or generated in the course of making the benefit decision, without regard to whether such document, record, or other information was relied upon in making the benefit decision;
  (iii) Demonstrates compliance with the administrative processes and safeguards required to ensure and to verify that benefit claim decisions are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
  (iv) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination; and
- A statement of your right to file a lawsuit under ERISA and the date by which that lawsuit must be filed.

No further changes have been made to your NRECA Long Term Disability Plan SPD.

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

Plan Sponsor: National Rural Electric Cooperative Association
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Plan Sponsor's Employer Identification Number: 53-0116145
Plan Number: 501