NRECA Business Travel Accident Plan

SUMMARY PLAN DESCRIPTION

(BENEFITS BOOKLET)

PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE

01-26012-002

EFFECTIVE DATE: January 1, 2016

NRECA

A Touchstone Energy® Cooperative

Introduction

Summary Plan Description

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

Your Responsibilities

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

While reading this material be aware that:

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

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

Fraud Warning Statement

All States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Some states have their own fraud warnings. Please see chapter entitled *General Information* for the state-specific warning that may apply to your state of residence.

Table of Contents

Plan Information

Plan Name

The National Rural Electric Cooperative Association's Group Benefits Program

Plan Identification Number:	501
Plan Type:	Business Travel Accidental Death & Dismemberment Insurance
Year End:	December 31
Plan Effective Date:	January 1, 2016

Underwritten By

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

Plan Administrator and Named Fiduciary

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

Telephone number 703.907.5500

Plan Administrator Employer Identification Number: 54-2072724

Plan Sponsor

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

Plan Sponsor Employer Identification Number: 53-0116145

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

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

PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE
PO BOX 509
Hayti, MO 63851

Your Employer's Identification Number (EIN)

43-0452625

Agent for Service of Legal Process

Senior Vice-President

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

The agent for service of process receives all legal notices on behalf of the Plan Sponsor regarding claims or suits filed with respect to the Plans.

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

Plan Trustee, NRECA Group Benefits Trust

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

Claim Adjudicator

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

Chapter 1: Contact Information

For Information About	Contact
Claims for benefits	**MetLife** Group Life Claims P.O. Box 6100 Scranton, PA 18505 800.638.6420
General questions • **Eligibility** • **Enrollment** • **When coverage begins or ends** • **Cost of coverage** • **Changing your beneficiary**	**Benefits Administrator** PEMISCOT-DUNKLIN ELECTRIC COOPERATIVE PO BOX 509 Hayti, MO 63851

Chapter 2: Plan Highlights

This chapter includes the highlights of your Business Travel Accident (BTA) Insurance benefits under the Plan. For full details about these benefits, other benefits, and Plan exclusions, see the chapter entitled *Business Travel Accident Insurance Benefits*.

Business Travel Accidental Death and Dismemberment Insurance

Your coverage under BTA is based on your Class of coverage. For more information about which Class of coverage is available to you please see the chapter titled *Eligibility and Participation Information*.

For Classes 1, 2 and 3

Benefit	Benefit Amounts
Full Amount	$100,000

Covered Losses	
Event	**Coverage**
Loss of life	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%
Loss of an arm permanently severed at or above the elbow	50%
Loss of a leg permanently severed at or above the knee	50%
Loss of sight in one eye Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.	50%
Loss of the Thumb and Index Finger of the Same Hand Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.	25%

Covered Losses	
Event	**Coverage**
Loss of Speech and Loss of Hearing **Loss of speech** means a loss of speech continuing for **six** consecutive months after which a physician must determine the loss to be entire and irrecoverable. **Loss of hearing means a loss of hearing** continuing for **six** consecutive months after which a physician must determine the loss to be entire and irrecoverable.	100%
Loss of Speech or Loss of Hearing	50%
Paralysis[1] of both arms and legs Paralysis means loss of use of a limb, without severance. A physician must determine the loss of use to be permanent and irreversible.	100%
Paralysis[1] of both legs	50%
Paralysis[1] of the arm and leg on either side of the body	25%
Coma Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for seven consecutive days.	1% monthly beginning on the 7th day of the Coma and for the duration of the Coma to a maximum of 60 months
[1]***Paralysis*** *means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible*.	

Additional Benefits Highlights

In addition to the Benefit Amounts payable for the Covered Losses stated above, these Additional Benefits may also be available:

Benefit[1]	Amount	Benefits Minimum	Benefit Maximum
Air Bag	10% of Full Amount	$1,000	$5,000
Seat Belt	10% of Full Amount	$1,000	$10,000
Rehabilitative Physical Therapy	10% of the Full Amount	N/A	$25,000

Benefit[1]	Amount	Benefits Minimum	Benefit Maximum
Therapeutic Counseling	Actual charges for up to10 sessions up to 1% of Full Amount	N /A	$5,000
Wheelchair Access Modification	10% of Full Amount	N/A	$25,000

[1]*For specific requirements for these additional features please see the chapter entitled Business Travel Accident Insurance Benefits.*

If you sustain an accidental injury due to any one covered accident which is the direct and sole cause of more than one Covered Loss (see the *Additional Benefits Highlights* chart), the amount MetLife will pay will not exceed the Full Amount set forth in the beginning of this chapter. The Additional Benefits stated above will not be taken into account when determining if the amount MetLife pays exceeds the Full Amount.

MetLife will pay benefits only once for any one Covered Loss resulting from the same accident.

Aggregate Maximum

MetLife will not pay more than $5,000,000 for all Covered Losses and injuries sustained by all insured persons under the Plan as a result of any one covered accident or series or combination of covered accidents directly arising out of one or more associated events. Events are associated if they have a common cause or are a chain of events forming part of a larger or broader event even if the individual events themselves are separate in time and place. If the total amount claimed by all insured persons is greater than this amount, then the amount MetLife will pay to each insured person will be reduced in the same proportion, so that the total amount does not exceed the maximum amount stated in this paragraph.

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

Table of Covered Persons

You will be covered for the risks and for the time periods described in the covered accident(s) applicable to the Class of Covered Persons to which you belong.

You will not be included as a member of more than one Covered Class at the same time. If you could be included in more than one Covered Class at the time of a covered accident, MetLife will consider you to be a member of the Covered Class that provides the greatest benefit.

Covered Class	Covered Accidents
Class 1: All active Full-Time U.S. employees of an Employer[2]	• 24-Hour Business Travel • Personal Deviation Business Travel
Class 2: All non-employee members of an Employer's Board of Directors[2]	• Board of Director Business Travel • Personal Deviation Business Travel
Class 3: All Guests of an Employer who are classified as retained attorneys[2]	• 24-Hour Business Travel • Personal Deviation Business Travel

[2]*Exposure to the Elements and Presumption of Death provisions (see the General Information chapter for details) apply to all Covered Classes.*

Who is Eligible

You are eligible to participate in the BTA Insurance Plan if you are an Active Employee who:

- Is in a covered job classification; and
- Has worked, or expects to work, at least 1,000 hours during your first 12 months in a covered job classification; and
- Continues to work at least 1,000 hours during subsequent calendar years; and
- Is actively at work on the day your coverage begins, **or** has worked at another rural electric employer within the past 6 months and meets these conditions.

Ineligible Class(es)

The following classifications of employees are not eligible for coverage:

This Plan does not have any excluded job classifications, positions or titles.

Director

If you are a director, and your Employer covers directors under this Plan, you are covered by the Plan during your term on the Employer's Board of Directors. Up to 3 directors emeritus can be covered by the Plan.

Retained Attorney

If you are an attorney retained by a participating cooperative, and your Employer covers a retained attorney under this Plan, you are covered by the Plan while serving in this capacity. Only one retained attorney may be covered by a cooperative.

When Coverage Begins

If you are an Active Employee, you are covered by the Plan after you have met all the eligibility requirements (see "*Who is Eligible"* in this chapter).

When you are a new hire, coverage is effective on the first day that you are eligible for coverage.

Enrolling in the Plan

You automatically will be enrolled in any benefits that your Employer is providing at no cost to you. Your Employer is paying the full cost of these benefits.

When you start working for your Employer, your benefits administrator will review the business travel accident options available to you during your initial benefits orientation.

Select Your Beneficiary

If a Beneficiary is a minor or incompetent to receive payment, MetLife will pay that person's court appointed property and estate guardianship or, MetLife will hold funds until the minor is of legal age.

Your beneficiary is the person who will receive your benefit upon your death if your death is due to an accident which occurred while traveling on business.

You may change your beneficiary at any time. Ask your benefits administrator for instructions on how to change your beneficiary.

When Coverage Ends

You are no longer eligible and your BTA Insurance coverage ends on the day that:

- You are no longer employed by your Employer; or
- You are no longer in a covered job classification; or
- You are no longer serving as a director or retained attorney for the cooperative; or
- You become disabled; or
- You go on uncompensated or military leave; or
- You retire; or
- You die; or
- Your Employer stops participating in the Plan; or
- The Plan ends.

You do not have the option to convert this insurance into an individual policy.

When You Are Covered by More than One Employer

If you are covered by more than one participating employer during the same business trip, you will receive benefits through only one employer.

Chapter 4: Your Benefits During a Leave of Absence

General Information

Your employer offers various types of leaves of absence. A leave of absence means time away from work, as permitted by your employer, for reasons such as military duty, a medically certified health condition, family care or personal needs.

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

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

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

Compensated and Uncompensated Leave of Absence

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

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

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

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

Eligibility to Participate During Your Leave of Absence

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

If you are on an employer-approved **uncompensated** leave of absence, your eligibility to participate in this plan terminates on the date your uncompensated leave begins.

Annual Benefits Enrollment

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

Paying for Benefits During Your Leave of Absence

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

Returning From a Leave of Absence

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

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

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

If You Terminate Employment While on a Leave of Absence

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

Workers' Compensation

Workers' compensation may be compensated or uncompensated leave. If your period of workers' compensation is compensated (see the section in this chapter titled *Compensated and Uncompensated Leave of Absence*), then you are eligible to continue your benefits. If you do not receive compensation during your period of workers' compensation, benefits will continue for up to 90 days.

Family Medical Leave Act (FMLA)

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

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Military Leave of 31 or Fewer Days

Coverage under this plan is not subject to USERRA. Coverage ends on your last day of work.

Military Leave Longer Than 31 Days

Coverage under this plan is not subject to USERRA. Coverage ends on your last day of work.

Chapter 5: Business Travel Accident Insurance Benefits

Exposure to the Elements

If you sustain an accidental bodily injury in a covered accident, MetLife will not deny a claim because the injury was not the direct and sole cause of the Covered Loss if:

- The Covered Loss results from unavoidable exposure to the elements; and
- The exposure is a direct result of a Covered Accident independent of other causes.

Presumption of Death

For purposes of any benefits paid under this Plan, MetLife will presume that the Covered Loss sustained by you for such loss is loss of life if:

- An aircraft or other vehicle in which you were Traveling on Business for which coverage is provided under a Covered Accident disappears, sinks, or is wrecked; and
- Your body is not found within one year of:
    - The date the aircraft or other vehicle was scheduled to have arrived at its destination, if travelling in an aircraft or other vehicle operated by a Common Carrier; or
    - The date you are reported missing to the authorities, if traveling in any other aircraft or vehicle.

24-Hour Business Travel

MetLife will pay the benefit amount(s) stated in the *Plan Highlights* chapter if, while traveling on business for the employer, an accidental bodily injury resulting in a Covered Loss is sustained as described in this SPD.

MetLife will deem that your regular place of employment has changed and that traveling on business has ended if:

- You are expected to remain in the location to which you have Traveled on Business for more than 60 days; or
- The employer deems a new location to be your regular place of employment

Board of Directors Business Travel

MetLife will pay the benefit amount(s) stated in the Plan Highlights chapter if, while traveling on business for the employer, an accidental bodily injury resulting in a Covered Loss is sustained by a Director as described in this SPD.

Personal Deviation Business Travel Guidelines

MetLife will pay the benefit amount(s) described in the *Plan Highlights* chapter if, while making a personal deviation, an accidental bodily injury resulting in a Covered Loss is sustained as described in this SPD and the personal deviation:

- Takes place while on a business trip requested, authorized or consented to by the employer, for the purpose of furthering the business of the employer and at the expense of the employer;

- Takes place more than 100 miles from your primary residence or regular place of employment;
- Is not longer than three days; and
- Is not done during chargeable vacation time or leaves of absence.

These guidelines are applicable to all covered Classes.

Additional Business Travel Accident Benefits

Air Bag Use

If you die as a result of an accidental injury sustained in a covered accident, MetLife will pay this additional benefit if:

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

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

Benefit Amount

The air bag Use Benefit is an additional benefit equal to 10% of the Full Amount shown in the *Plan Highlights* chapter. However, the amount MetLife will pay for this benefit will not be less than $1,000 or more than $5,000.

Benefit Payment

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

Seat Belt Use Benefit

If you die as a result of an accidental injury sustained in a covered accident, MetLife will pay this additional seat belt benefit if:

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

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

Benefit Amount

The seat belt Use Benefit is an additional benefit equal to 10% of the Full Amount shown in the *Plan Highlights* chapter. However, the amount MetLife will pay for this benefit will not be less than $1,000 or more than $10,000.

Benefit Payment

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

Rehabilitative Physical Therapy Benefit

MetLife will pay this additional benefit if:

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

Such rehabilitative physical therapy must be provided within 1 year of the prescription by a physician or therapist licensed to provide the therapy in the jurisdiction where such services are performed.

Benefit Amount

MetLife will pay an amount equal to the least of:

- 10% of the Full Amount as shown in the *Plan Highlights* chapter; or
- $25,000

Benefit Payment

MetLife will pay this benefit quarterly when MetLife receives proof that charges for Rehabilitative Physical Therapy have been paid. Payment will be made to you.

Therapeutic Counseling Benefit

MetLife will pay this additional benefit if:

- MetLife pays a benefit for a Covered Loss for you;
- MetLife receives proof that therapeutic counseling has been prescribed for:
    - You;
    - Your spouse; or
    - Your natural, adopted or stepchildren.
- Within **90 days** of the Covered Loss by the attending physician as necessary to treat an emotional or psychological condition resulting from the Covered Loss; and
- This benefit is in effect on the date of the injury.

Such therapeutic counseling must be provided within 1 year of the prescription by a physician, therapist or counselor licensed to provide the counseling in the jurisdiction where such services are performed.

Benefit Amount

MetLife will pay an amount equal to the lesser of:

- The actual charges incurred for 10 sessions for such therapeutic counseling;

- 1% of the Full Amount as shown in the *Plan Highlights* chapter; or
- $5,000.

Benefit Payment

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

Wheelchair Access Modification Benefit

If you are injured as a result of an accidental injury sustained in a covered accident, MetLife will pay this additional benefit if:

- MetLife pays a benefit for a Covered Loss;
- This benefit is in effect on the date of the injury;
- Due to the Covered Loss, the permanent use of a wheelchair is required to be ambulatory;
- In order to provide wheelchair accessibility, alterations are done to your primary residence, to one vehicle you use, or to both; and
- The alterations to your primary residence are done by a licensed contractor.

The home alteration expenses may include installing ramps, widening doors, and lowering cabinets. They may not include remodelling expenses that have no direct relationship to providing wheelchair accessibility.

Benefit Amount

MetLife will pay an amount equal to the lesser of:

- 10% of the Full Amount as shown in the *Plan Highlights* chapter; or
- $25,000.

Benefit Payment

Benefit payments will be made **to you**. In the event of your death, benefit payments will be made to your beneficiary.

General Exclusions

MetLife will not pay benefits for any loss caused or contributed to by:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Infection, other than infection occurring in an external accidental wound or from accidental food poisoning;
- Participation in Hazardous Activities such as: scuba diving; bungee jumping; skydiving; hang gliding; ballooning; drag racing; driving a car fitted for competitive racing; aerial hunting; aerial skiing; or travel in an aircraft for the purpose of parachuting or otherwise exiting an aircraft while the aircraft is in flight except for the purpose of self-preservation;
- Service in the armed forces of any country or international authority, except the United States National Guard;

- Any nuclear reaction or release of nuclear energy. This includes the radioactive, toxic, explosive or other hazardous or contaminating properties of radioactive matter;
- The emission, discharge, dispersal, release or escape of any solid , liquid or gaseous chemical or biological agent;
- Any incident related to travel in an aircraft:
    - As a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
    - And parachuting or otherwise exiting from such aircraft while the aircraft is in flight except for the purpose of self-preservation;
    - That does not have a valid Certificate of Airworthiness;
    - That is not flown by a pilot with a valid license to operate that aircraft;
    - Which is Owned, Leased, Controlled, or Chartered by the employer;
    - Or device used:
        - For testing or experimental purposes;
        - By or for any military authority;
        - For travel or designed for travel beyond the earth's atmosphere;
        - For crop dusting, spraying, or seeding;
        - For firefighting;
        - For sky diving;
        - For hang gliding;
        - For pipeline or power line inspection;
        - For sky writing;
        - For aerial photography or exploration;
        - For racing, endurance tests, stunt or acrobatic flying; or
        - For any use which requires a special permit from the Federal Aviation Administration.
- War, whether declared or undeclared; or act of war, insurrection, rebellion, riot or terrorist act.

Specific Exclusions

Intoxication Exclusion

MetLife will not pay benefits for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

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

Exclusion for Commission of a Felony

MetLife will not pay benefits on behalf of a Covered Person for any loss caused or contributed to by the injured party committing or attempting to commit a felony.

Exclusion for Drugs; Alcohol; Poison Gas; or Fumes

MetLife will not pay benefits on behalf of a Covered Person for any loss caused by or contributed to by that person's voluntary intake or use by any means of:

- Any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a physician, or
    - An over the counter drug, medication or sedative taken as directed;
- Alcohol in combination with any drug, medication, or sedative; or
- Poison, gas, or fumes.

Chapter 6: Claims and Appeals

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

Your claim will be processed for payment according to the applicable plan provisions and the guidelines used by MetLife. General contact information for MetLife is available in the chapter entitled *Contact Information* and specific claims and appeals process contact information is described this chapter.

An issue or dispute solely regarding your eligibility for coverage or participation in the Plan is not considered a claim for benefits and is not governed by the claims and appeals procedures described in this chapter. For more information, please contact your benefits administrator.

Claims and Appeals Contacts

Purpose	Contact
Authorizing a representative	**Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard Arlington, VA 22203-1860 703.907.6601 703.907.6602 privacyofficer@nreca.coop
Filing a claim	**MetLife** **Group Life Claims** P.O. Box 6100 Group Life Claims Scranton, PA 18505
Filing an appeal (adverse benefit determination)	**MetLife** Group Insurance Claims Review 1.800.638.6420 *Send to the address of the MetLife office that processed the claim*
Filing an appeal (eligibility)	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203
Filing a voluntary final appeal (eligibility)	**NRECA Appeals Committee** Attn: Senior VP, I&FS 4301 Wilson Blvd., Mailstop IFS7-333 Arlington, VA 22203

Authorizing a Representative

Your beneficiary may authorize someone other than themselves to speak with MetLife, if verbal consent is given by the beneficiary for MetLife to speak with that individual. Any forms would still need to be signed by the beneficiary. Contact the MetLife claims representative for more information.

Your beneficiary may designate someone to handle their affairs. A power of attorney or guardian would need to be appointed and that documentation would need to be on file with MetLife. Contact the MetLife claims representative for more information

Claims

A claim is any request for a plan benefit made in accordance with the procedures described in this chapter. You must submit a claim for plan benefits in writing to the benefits administrator. Ask your benefits administrator if you need help obtaining a claim form.

A claim is considered filed when it is received by MetLife in accordance with these claims procedures. MetLife's time period to provide you with a determination notice starts when the claim is filed, regardless of whether MetLife has all of the information necessary to decide the claim when it is first filed.

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

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

Filing a Claim

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

In addition to claim forms, you (the claimant) may be required to provide additional evidence (for example a death certificate or accident report) to establish the nature and extent of the loss or condition; MetLife's obligation to pay the claim; and the claimant's right to receive payment. Such additional evidence must be provided at the claimant's expense. MetLife will request this evidence directly from the claimant and, in its sole discretion, will determine if the submitted documentation is sufficient.

Upon receipt of all requested documentation, MetLife will determine what benefits are payable. If the claim is approved, the benefit is paid. The normal form of payment is one sum, but other alternative payments are available. For additional information about payment options, contact MetLife.

You may also ask your state's consumer assistance program or ombudsman for help filing your appeal, if applicable. To determine if your state has such resources, see the U.S. Department of Labor website at **www.dol.gov/ebsa/consumer_info_health.html** or call the Department of Labor Employee Benefits Security Administration (EBSA) at 1.866.444.EBSA (3272), or by mail to the Employee Benefits Security Administration, U.S. Department of Labor, Division of

Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C 20210.

Claim Submission Timeframe

Send the claim form and proof (as defined in *Appendix A: Key Terms)* to MetLife **within 90 days** of the date of loss

Claim Determinations, Determination Extensions, and Requests for Additional Information

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

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

Claim Determination Notice Content

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

- The specific reason(s) your claim was denied;
- Reference to the specific plan provisions on which the denial is based; and
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary.

The notice will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appeals

If MetLife denies your claim for Plan benefits, if you believe you should be entitled to a different benefit amount, or if you disagree with any determination that has been made regarding your benefits under the Plan, you or your authorized representative may appeal the decision.

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

Documentation to Include with your Appeal Request

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

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

- Your name;
- Name of the plan (that is, the Business Travel Accident Insurance Plan);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

Your appeal may also include any additional written comments, documents (including additional medical information), records, or other information that supports your request for benefits.

The reviewer will conduct a full and fair review of your appeal if you have submitted it by the proper deadline.

Appealing an Adverse Benefit Determination

Your adverse benefit determination appeal must be filed in writing with MetLife by the filing deadline. The review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. If you want to grant the reviewer more than the stated time to make a determination, you may voluntarily agree to an extension by contacting the reviewer.

Adverse Benefit Determination Appeal Timeline	
Filing deadline	Within **60 days** of the date you receive MetLife's written adverse benefit determination
When you will be notified of a determination	Within **60 days** of the date MetLife receives the appeal unless you are notified by MetLife that an extension or more time is needed to evaluate your appeal before the initial 60-day period is over
Determination extension period (if needed)	One extension period of **up to 60 days**.

To help prepare your appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim. However, a request for documentation does not extend the time period allowed for you to file an appeal.

Adverse Benefit Determination Appeal Review and Determination

If your appeal is denied, the determination notice will include:

- The specific reason(s) your appeal was denied;
- The specific plan provision(s) on which the denial is based;
- If applicable, a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- An explanation of your rights under ERISA's claim and appeal rules; and
- Information about your right to file a civil action under ERISA within 12 months.

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

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

Eligibility Appeals

If NRECA denies benefits because you were not eligible to participate in the Plan, you have the right to file a written eligibility appeal with the NRECA – Appeals Administrator (the reviewer). The reviewer has full and discretionary authority to administer and interpret the Plan for all eligibility appeals.

Your eligibility appeal must be filed with the reviewer by the filing deadline (see the table entitled *Eligibility Appeal Timeline*). The review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. If the reviewer requires more than the stated time for their review in order to decide your appeal, they will send a letter stating an extension time.

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

To help prepare your appeal, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your initial claim, as noted below. However, a request for documentation does not extend the time period allowed for you to file an appeal.

Eligibility Appeal Review and Determination

If your eligibility appeal is denied in whole or in part, your decision notice will include:

- The specific reason(s) your appeal was denied;
- The specific plan provision(s) on which the denial was based;
- An explanation of your rights under ERISA's claim and appeal rules; and
- Information about your right to file a civil action under ERISA within 12 months

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

Voluntary Final Appeals for Eligibility Claims

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

Your voluntary final appeal must be filed in writing with the NRECA – Appeals Committee by the filing deadline described in the *Voluntary Final Appeal Timeline* for *Eligibility Claims* table). The

review period begins when the appeal is received, regardless of whether the reviewer has all of the information necessary to decide the appeal. The reviewer may need additional time to complete their review and may notify you of an extension.

Voluntary Final Appeal Timeline for Eligibility Claims	
Filing deadline	Within **60 days** of the date you receive NRECA's written denial of your eligibility appeal
You will be notified of a determination	Within **60 days** of the date MetLife receives the appeal unless you are notified by MetLife that an extension or more time is needed to evaluate your appeal before the initial 60-day period is over
Determination extension period	One period of **up to 60 days**

If your voluntary final appeal is denied in whole or in part, your decision notice will contain:

- The reason(s) why the final appeal was denied;
- The specific Plan provision(s) on which the denial was based;
- An explanation of your rights under ERISA's claim and appeal rules; and
- A statement of the claimant's right to bring a civil action under ERISA within 12 months.

Legal Action for Benefit Claims

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

Chapter 7: General Information

Beneficiary

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

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

You do not need the Beneficiary's consent to make a change. When NRECA receives the change, it will take effect as of the date you signed it. The change will not apply to any payment made in good faith by MetLife before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving designated beneficiary at the time of your death, MetLife may determine the beneficiary to be one or more of the following who survive you:

- Your spouse;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

Instead of making payment to any of the above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment.

If a beneficiary is a minor or incompetent to receive payment, MetLife will pay that person's court appointed property and estate guardianship or, MetLife will hold funds until the minor is of legal age.

Benefit Payment

You or your beneficiary will receive payment of BTA Insurance benefits of $5,000 or more through an interest-bearing account with check-writing privileges known as a "Total Control Account (TCA)" that is guaranteed by MetLife. The TCA preserves your or your beneficiary's right to choose among other settlement options offered by MetLife at the time that it is established.

Entire Contract

Your insurance is provided under a contract of group insurance with MetLife. The entire contract with MetLife and NRECA Group Benefits Program is made up of the following:

- The Plan and its Exhibits, which include the SPD(s);
- NRECA's Group Benefits Program application; and
- Any amendments and endorsements to the Plan.

Physical Exams

If a claim is submitted for insurance benefits other than life insurance benefits, MetLife has the right to ask the insured to be examined by a physician(s) of MetLife's choice as often as is reasonably necessary to process the claim. MetLife will pay the cost of such exam.

Autopsy

MetLife has the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons MetLife is requesting the autopsy.

Fraud Warning Statements

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an

application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State Notices

Notice for Texas Residents:

For Texas Residents:

Important Notice

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

Premium or Claim Disputes: Should You have a dispute concerning Your premium or about a claim You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

Attach This Notice To Your Certificate:

This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

Aviso Importante

Para obtener informacion o para someter una queja: usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departmento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departmento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

Disputas Sobre Primas O Reclamos: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

Una Este Aviso A Su Certificado:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del document adjunto.

Notice For Residents of Arkansas:

If you have a question concerning your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, you still have a concern, you may call the toll free telephone number shown on the Certificate Face Page.

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

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
1-800-852-5494

Notice for Residents of Idaho:

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

Notice for Residents of Indiana:

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-800-638-5433

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800)622-4461; (317)232-2395
Complaints can be filed electronically at. www.in.gov/idoi

Notice for Residents of Missouri:

General Exclusions

If you reside in Missouri the exclusion for “suicide or attempted suicide” is as follows:

“suicide or attempted suicide while sane” and the exclusion for “intentionally self-inflicted injury” is as follows: “intentionally self-inflicted injury while sane, while insane if it is not attempted suicide”

Notice For Residents of Utah:

Notice of Protection Provided by

Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
    - $500,000 in death benefits
    - $200,000 in cash surrender or withdrawal values
- Health Insurance
    - $500,000 in hospital, medical and surgical insurance benefits
    - $500,000 in long-term care insurance benefits
    - $500,000 in disability income insurance benefits
    - $500,000 in other types of health insurance benefits
- Annuities
    - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and

there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 lA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.	Utah Insurance Department
60 East South Temple, Suite 500	3110 State Office Building
Salt Lake City UT 84111	Salt Lake City UT 84114-6901
(801) 320-9955	(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

For Residents of Virginia:

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
P.O. Box 789
Johnstown, Pennsylvania 15904
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission’s Bureau of Insurance at:

Life and Health Division Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 – national toll free
1-804-371-9691 – locally

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

For Residents of Vermont:

Civil Union Notice for Residents of Vermont

Vermont law provides that the following definitions apply to Your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.

- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.
- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.
- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- “Civil Union” means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled “Act Relating to Civil Unions”.

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under Your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of “dependent” as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in Your certificate. It broadens definitions and terms only to the extent required by Vermont law.

Disclosure:

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private Employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.

Notice for Residents of Wisconsin:

Keep this Notice with your insurance papers

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife
Attn: Corporate Consumer Relations Department
P.O. Box 789
Johnstown, Pennsylvania 15904
1-800-638-5433

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

Chapter 8: Important Notifications and Disclosures

Not a Contract of Employment

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

Non-Assignment of Benefits

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

Right of Recovery of Overpayment

If it is later determined that you received an overpayment or a payment was made in error, you will be required to refund the overpayment to the Plan. The Plan has the right to recover overpayments as a result of, but not limited to those:

- Due to fraud;
- Due to any error the Plan makes in processing a claim; and
- Benefits paid after the death of the Employee.

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

Amendment or Termination

This Plan may be amended or terminated at any time, for any reason, by action of the Plan Administrator or your employer. This includes the right to change the cost of coverage. These changes may be made with or without advance notice to Plan participants. However, your rights to claim benefits for the period prior to the termination or amendment will not be affected if such benefit is payable under the Plan as in effect before the Plan is terminated or amended.

Severability

If any provision of this Plan is held invalid, the invalid provision does not affect the remaining parts of this Plan. The Plan is construed and enforced as if the invalid provision had never been included.

Additional Procedures

The Plan Administrator may promulgate any rules, regulations or procedures not covered by this Plan that may be necessary for the proper administration of this Plan.

Statement of ERISA Rights

Your Rights

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

Appendix A: Key Terms

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

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

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

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

Air Bag means an inflatable restraint device that:

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

Airworthiness Certificate means:

- The standard airworthiness certificate issued by the Federal Aviation Agency or successor agency of the United States; or
- The equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

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

Beneficiary or **Beneficiaries** means, for the purposes of the Plan, the person or persons designated as the recipient of funds. If there is no beneficiary designated or no surviving beneficiary when you die, benefits are payable in this order: (1) your spouse; (2) your child(ren); (3) your parent(s); or your sibling(s).

Instead of making payment to any of the above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment. If a beneficiary is a minor or incompetent to receive payment, MetLife will pay that person's court appointed property and estate guardianship or, if the guardianship is general, MetLife will hold funds until the minor is of legal age.

Chartered Aircraft means an aircraft that is hired by the employer for a period of time which is less than 10 days.

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

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

The term does not include:

- Chartered or other privately arranged transportation;
- Taxis; or

- Limousines.

Covered Accident means an accident (i.e. an unexpected, unintentional or unforeseeable event or occurrence which happens suddenly and violently and occurs while coverage under this policy is in effect) which is listed as a covered accident in the Table of Covered Persons in the *Eligibility and Participation Information* chapter.

Direct and Sole Cause means that the Covered Loss occurs within 12 months of the date of an accidental injury sustained in a covered accident and is the direct result on that accidental injury independent of other causes.

Employer means a member cooperative of the Policyholder as referenced in the Table of Covered Persons (see the chapter entitled *Eligibility and Participation Information*).

Full-Time means active work on the employer's regular work schedule for the class of employees to which you belong. The work schedule must be at least 30 hours a week.

Hazardous Activity means an activity that exposes a Covered Person to dangerous conditions and significantly increases risk of death or bodily injury.

Leased or Controlled Aircraft means an aircraft which:

- Has been leased, rented or borrowed by the employer for at least 10 consecutive days;
- Subject to the terms of the lease agreement, can be used at the employer's discretion; and
- Cannot be altered or sold by the employer without the consent of the owner or lessor.

Owned Aircraft means an aircraft to which the employer holds legal or equitable title.

Personal Deviation means any travel or activity:

- Not reasonably related to the business of the employer; or
- Not incidental to the business trip;
- And not at the expense of the employer.

Physician means:

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

The term **does not include**:

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

Proof means written evidence satisfactory to Us that a person has met the conditions and requirements for any benefit described in this SPD. When a claim is made for any benefit described in this SPD, proof must establish:

- The nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- The claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Seat Belt means any non-inflatable restraint device that:

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

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

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to MetLife and consistent with applicable law.

Spouse means your lawful spouse.

Terrorist Act means a politically or socially-motivated act of violence carried out by an individual or group of persons who may or may not be operating on behalf of a sovereign state with the intent to change political or social policy. A terrorist act does not include any act of violence carried out by a branch of the armed forces of a sovereign state.

Traveling on Business means, for covered employees and covered retained attorneys acting as consultants to the employer, **traveling on business** includes regular driving assignments when you are driving between your work locations, as well as when you are driving between your regular place of employment and your work location. Accidents that occur at your work locations within your normal service area while you are performing your regular job will not be covered.

Traveling on Business does not include:

- Travel between your residence and regular place of employment (for retained attorneys acting as consultants to the employer, your regular place of assignment as determined by the employer will be deemed to be your regular place of employment);
- Leaves of absence;
- Vacations; or
- Personal deviations.

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