NRECA Retired Life Insurance Plan

SUMMARY PLAN DESCRIPTION

ASSOCIATED ELECTRIC CO-OP
01-26073-001

EFFECTIVE DATE: January 1, 2026

NRECA
America's Electric Cooperatives

Introduction

Summary Plan Description

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

Your Responsibilities

You are responsible for reading the SPD and related Plan materials distributed by NRECA or by your Employer, such as premium contribution notices, summary of material modifications, and Employer benefits eligibility rules, completely and complying with the rules and Plan provisions described herein.

While reading this SPD, be aware that:

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

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Plan Information

Plan Name

The NRECA Retired Life Insurance plan, which is a component plan of the NRECA Group Benefits Program.

Plan Number:	501
Plan Type:	Retired Life Insurance
Year End:	December 31
Plan Effective Date:	January 1, 2026

Underwritten By

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

Plan Administration

Except where pre-empted by ERISA or other U.S. laws, the Plan's validity and any other provisions will be determined under the laws of the Commonwealth of Virginia. The Plan administration type is sponsor administration. Plan records are kept on a calendar-year basis.

Named Fiduciary

The named fiduciary of the NRECA Group Benefits Program (Program) is the Insurance and Financial Services Committee (I&FS Committee) of the NRECA Board of Directors (Board), whose members are appointed by the President of the Board from members of the Board. The I&FS Committee has both the central fiduciary responsibility for the Program, and is vested with the discretion to select providers for the Program, including the Plan Administrator, investment managers, and trustee. It is charged with management of the Program and the NRECA Group Benefits Trust. The I&FS Committee delegates authority to various entities and individuals to carry out required plan operations and then actively monitors its delegates to help ensure compliance with complex federal laws and regulations governing employee benefit plans.

Plan Sponsor

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

Plan Sponsor Employer Identification Number: 53-0116145

Plan Administrator

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

703.907.5500

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

In addition to the Senior Vice-President of the Insurance and Financial Services department, the person listed below has certain administration responsibilities for your Employer:

Benefits Administrator
ASSOCIATED ELECTRIC CO-OP
2814 South Golden
Springfield, MO 65807

Agent for Service of Legal Process

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

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

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

Plan Trustee

State Street Bank and Trust Company
1200 Crown Colony Drive, 5th Floor
Quincy, MA 02169

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 benefit questions • Eligibility • Enrollment • When coverage begins or ends • Cost of coverage • Changing your Beneficiary	**Benefits Administrator** ASSOCIATED ELECTRIC CO-OP 2814 South Golden Springfield, MO 65807
Eligibility appeals	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203
Voluntary final appeals	**NRECA Appeals Committee** Attn: Senior Vice-President, Insurance and Financial Services 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203

Chapter 2: Retired Life Plan Highlights

This chapter is a summary of the benefits provided under the Plan's Retired Life Insurance provisions. For a full description of all Plan benefits and exclusions, see the *Term Life Benefits* chapter.

You will be insured only for the benefits:

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

Retired Life Insurance Benefit Highlights

Benefit Level	Who Pays
$5,000	Retiree
$10,000	Retiree
$15,000	Retiree
$20,000	Retiree

Benefit Level	Coverage	Who Pays
Retired Life Insurance benefit prior to 2008	If you retired before your Employer's renewal date in 2008, your Retired Life Insurance benefit is the same as it was prior to the 2008 renewal date. You will continue coverage under the pre-2008 benefit as long as you are eligible.	Ask your benefits administrator

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

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

does not pay for part of your Retired Life Insurance, you may elect one of the four benefit levels of Retired Life Insurance noted in the chart above up to a maximum of $20,000.

Once you select a Retired Life Insurance benefit amount, it cannot be increased. However, you may choose a lower benefit amount during your Employer's annual enrollment or when a qualifying event occurs such as marriage or divorce. Once the coverage is reduced it cannot be reinstated or increased.

You may elect an Accelerated Benefit Option (ABO) of up to 80% of your Retired Life Insurance amount, not to exceed $16,000. Note, however, that ABO is not available if the value of your life insurance coverage is under $10,000.

Chapter 3: Eligibility and Participation Information

Eligibility to Participate

Eligible Class(es)

You are eligible for insurance under this Plan if you were:

- Participating in the NRECA Group Term Life and AD&D Insurance Plan;
- Covered by life insurance under such plan on the day immediately preceding the date of your retirement; and
- Have retired in accordance with your Employer's retirement plan, or reached the Normal Retirement Age of your Employer's retirement plan.

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

- A person who retires at or after age 55, regardless of years of service

Ineligible Class(es)

The following classifications of retired employees are not eligible for coverage:

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

Date You Are Eligible For Insurance

You will be eligible for the insurance described in this SPD on the day you retire. If You die within 31 calendar days of the effective date of retired life coverage, Proof of your death must be sent to MetLife. When MetLife receives such Proof with the claim, MetLife will review the claim and, if MetLife approves it, MetLife will pay your Beneficiary the amount of life insurance you were entitled to convert as an active/Disabled employee. Your Beneficiary will not be entitled to receive both previous coverage as an active/Disabled employee and retired life coverage. Only one coverage will be paid out.

If you contribute any portion of the premium for coverage, to be eligible to participate in the Plan, you must also enroll in benefits with your Employer using their enrollment process or complete and return the *NRECA Employee Worksheet* form to your benefits administrator within **31 calendar days** of your retirement.

If You Become a Director

If you enroll in the NRECA Director Life and AD&D Insurance Plan, you will no longer be eligible for insurance benefits as a retired employee under this Plan (see the *Porting or Converting Coverage* chapter for details). **Note** that if you enroll in the NRECA Director Life and AD&D Insurance Plan, you will not be eligible for coverage under this Plan after your Directorship ends.

If you choose to enroll in the NRECA's Director AD&D Only Insurance Plan, you are eligible for Life Insurance benefits as a retired employee under this Plan.

If You Return to Work

If you return to active, full-time employment, your Retired life coverage will end, and you will become eligible for basic life coverage if you are eligible. Upon subsequently separating, you

will be eligible to re-enroll in this plan, based on the age you are at the time of the latest separation. If you return to work as a part-time employee that works less than 1,000 hours each year, you can remain eligible for this plan. You cannot have both Retired life and Basic life coverage at the same time.

Enrollment Process

If you are eligible for insurance under this Plan, you may enroll by completing the required process. You must request enrollment no later than 31 calendar days from your initial eligibility for this Plan. If you enroll in Contributory Insurance, your Employer will notify you how much you will be required to contribute.

Date Your Insurance Ends

Your insurance will end on the earliest of:

- The date the Plan ends;
- The date insurance ends for your retiree classification; or
- The end of the period for which the last premium has been paid for you (or by you).
- The date you are re-hired or become a director and elect life coverage in the same Group plan.

Refer to the *Porting or Converting Coverage* chapter for information about the options to continue to an individual life insurance policy if your Retired Life Insurance ends.

Chapter 4: Term Life Benefits

Your Term Retired Life Benefits

Your Retired Life Plan is strictly Term Life insurance coverage through the Employer's plan. As such, no cash values accumulate nor are there any loan provisions in this Plan.

Benefit Payment

At the time of the claim, MetLife will offer your Beneficiary(ies) the option to receive payment of the claim either by check or by establishing a Total Control Account (TCA). A TCA is an interest-bearing account, established by MetLife from which your Beneficiary may immediately access the entire amount of the insurance proceeds.

MetLife pays interest on the balance in the TCA at a guaranteed minimum rate starting on the date the TCA is established. Thereafter, your Beneficiary can access the TCA balance at any time without charge or penalty by writing drafts from the TCA for $250 or more or by withdrawing the entire benefit immediately from the TCA, if desired. Note that the TCA is not a bank account and is not a checking, savings, or money market account.

Exclusions

There are no exclusions under this Plan.

Additional Retired Life Insurance Coverage Features

MetLife Will Preparation Benefit

You are eligible to use your MetLife Will Preparation benefit (which is provided by participating MetLife Legal Plan attorneys) once your Retired Life Insurance benefit becomes effective. When you use the MetLife Legal Plan's network, the Will Preparation benefit fully covers the following legal fees:

- Telephone and office consultations to discuss the preparation or updating of your will or your Spouse's will;
- Preparation of the will(s);
- Updating of the will(s);
- Preparation of codicils; and
- Documents such as living wills, powers of attorney.

There is no limit to the number of wills or updates to your will(s) or your Spouse's will(s) that are covered under this benefit.

The following services are **not** covered under this Will Preparation benefit:

- Tax planning;
- Non-attorney fees; and
- A living trust, which is a trust that takes effect during a person's lifetime.

You may use an attorney outside of the MetLife Legal Plans' network and be reimbursed up to $150 (for an Employee) and $200 (for an Employee and Spouse) for attorneys' fees for preparation of your will(s). Further information is available through Hyatt Legal Plans.

Program details and contact information can be obtained from your benefits administrator or by visiting the Employee Benefits website. Go to cooperative.com > My Benefits, click on **Life & Disability** (in the top right) and then click on **Will Preparation**.

Chapter 5: Accelerated Benefit Option (ABO)

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

If you become Terminally Ill, you or your legal representative may request that MetLife pay ABO-eligible Life Insurance before your death. This is called an accelerated benefit. The request must be made while ABO-eligible Life Insurance is in effect.

You or your legal representative should contact your former Employer to obtain a claim form and information regarding the accelerated benefit. **“Terminally Ill” or “Terminal Illness”** means that, due to injury or sickness, you are expected to die within 12 months. **For residents of Texas only**, **“**Terminally Ill” or “Terminal Illness” means that, due to injury or sickness, you are expected to die within 24 months.

Requirements for Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, MetLife will pay an accelerated benefit to you or your legal representative if MetLife has received Proof that you are Terminally Ill.

MetLife will pay an accelerated benefit for the ABO-eligible Life Insurance benefit **only once.**

Proof of Your Terminal Illness

MetLife requires the following Proof of your Terminal Illness:

- A completed accelerated benefit claim form;
- A Signed physician’s certification that you are Terminally Ill; and
- An examination by a Physician of MetLife’s choice, at MetLife’s expense, if MetLife requests it.

Upon MetLife’s receipt of your request to accelerate benefits, MetLife will send you a letter with information about the accelerated benefit payment you requested. MetLife’s letter will describe the accelerated benefits payment amounts and the remaining amount of Retired Life Insurance after the accelerated benefit is paid. The remaining benefit will be paid to your Beneficiary upon your death.

Accelerated Benefit Amount

MetLife will pay an accelerated benefit up to the percentage shown in the *Retired Life Plan Highlights* chapter for the ABO-eligible Life Insurance benefit in effect for you, subject to the following:

- **Maximum Accelerated Benefit Amount**. The maximum amount MetLife will pay for each ABO-eligible Life Insurance benefit is show in the *Retired Life Plan Highlights* chapter.
- **Previous Conversion of an ABO-eligible Life Insurance Benefit.** MetLife will not pay an accelerated benefit for any ABO-eligible Life Insurance that you previously converted under the provisions described in the *Porting or Converting Coverage* chapter.

MetLife will pay the accelerated benefit in one sum unless you or your legal representative select another payment mode.

Effect of Payment of an Accelerated Benefit

On the premium for Your Life Insurance: After MetLife pays the accelerated benefit, any premium you are required to pay will be based upon the amount of your Retired Life Insurance remaining after the accelerated benefit is paid.

On Your Life Insurance at Your death: The amount of Retired Life Insurance that MetLife will pay at your death will be decreased by the amount of the accelerated benefit paid by MetLife.

On Your Life Insurance at conversion/port: The amount that you are entitled to convert/port under the chapter titled (see the *Porting or Converting Coverage* chapter) will be decreased by the amount of the accelerated benefit paid by MetLife.

Date Your Option to Accelerate Benefits Ends

The accelerated benefit option ends on the earliest of:

- The date the ABO-eligible Life Insurance ends;
- The date you or your legal representative have accelerated all ABO-eligible Life Insurance benefits; or
- Upon your death.

Chapter 6: Claims and Appeals

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

Your claim will be processed according to applicable Plan provisions and the guidelines used by MetLife. General contact information for MetLife is listed in the *Contact Information* chapter. Specific contacts for claims and appeals are listed in this chapter.

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

For purposes of this chapter, “you” also includes your Authorized Representative.

Claims and Appeals Contacts

Type	Reviewer	Address
Authorizing a representative	NRECA Privacy Officer 703.907.6601 703.907.6602 privacyofficer@nreca.coop	**Privacy Officer** National Rural Electric Cooperative Association 4301 Wilson Boulevard Arlington, VA 22203-1860
Filing a claim	MetLife	**MetLife** Group Life Claims P.O. Box 6100 Scranton, PA 18505 **Overnight Address:** **MetLife** **Group Life Claims** 10 E. D. Preate Dr. Moosic, PA 18507
Filing an appeal of an adverse benefit determination	MetLife 800.638.6420	**MetLife** Group Insurance Claims Review *(Send to the address of the MetLife office that processed the claim)*
Filing an eligibility appeal	NRECA Appeals Administrator	**NRECA Appeals Administrator** Attn: Senior Life Insurance Product Advisor 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203

Claims and Appeals Contacts

Type	Reviewer	Address
Filing a voluntary final appeal (eligibility)	NRECA Appeals Committee	**NRECA Appeals Committee** Attn: Senior VP, I&FS 4301 Wilson Boulevard, Mailstop IFS7-333 Arlington, VA 22203

Authorizing a Representative

You or your Beneficiary, as may be applicable, may authorize another individual to speak with MetLife by giving verbal consent for MetLife to speak with that individual. Any required forms would still need to be Signed by you or your Beneficiary, depending upon the person eligible to receive payment for the claim. Contact the MetLife claims representative for more information.

Your Beneficiary may designate a power of attorney or guardian in Writing. Such documentation will be held on file with MetLife. Contact the MetLife claims representative for instructions.

Claims

A claim is any request for a plan benefit made in accordance with the procedures described in this chapter. A Claimant 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 procedures. MetLife's time frame 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 enough information for MetLife to make an initial benefit determination, a Claimant may be asked to supply additional information. If a Claimant does not provide that information within the applicable time, 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 *Authorizing a Representative* above for specifics about how to authorize a representative.

Filing a Claim

A Claimant must complete and return the appropriate claim forms to the benefits administrator, within 20 calendar days of the date of a loss (this only applies to AD&D coverage) who will verify eligibility and the benefits to be claimed, certify the forms, and forward all documents to NRECA. NRECA will then forward the forms to MetLife for processing.

In addition to claim forms, the Claimant may be required to provide additional evidence (e.g., a death certificate or accident report) that establishes 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 an appeal, if applicable. To determine if your state has such resources:

- See the U.S. Department of Labor website at www.dol.gov/ebsa/;
- Call the DOL's Employee Benefits Security Administration (EBSA) at 866.444.EBSA (3272); or
- Write to the EBSA at: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Claim Submission Timeframe	
Life Insurance Benefits	Send the claim form and Proof (as defined in *Appendix A: Key Terms*) to MetLife as soon as reasonably possible after the death of the insured.

Claim Determinations, Determination Extensions, and Requests for Additional Information

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

Contents of the Claim Determination Notice

For all claims, Written notice of any adverse benefit determination. The notice will include:

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

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

Appeals

If MetLife denies your claim for Plan benefits, if you believe you should be entitled to a different Benefit Amount, or if you disagree with any determination that has been made regarding your Plan benefits, you or your Authorized Representative may appeal the decision.

Documentation to Include with Your Appeal Request

The following information applies to all appeal levels. For purposes of this explanation, the "reviewer" means:

- MetLife Group Insurance Claims Review (for an **adverse benefit determination** appeal);
- NRECA Appeals Administrator (for **eligibility** appeals); and
- NRECA Appeals Committee (for **voluntary final eligibility** appeals).

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

- Your name;
- Plan name (i.e., the Retired Life Insurance);
- Reference to the initial decision; and
- An explanation of why you are appealing the decision.

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

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

Appealing an Adverse Benefit Determination

Your adverse benefit determination appeal must be filed in Writing with MetLife by the filing deadline. The review period begins when the appeal is received, regardless of whether the reviewer has all 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 calendar days** of the date you receive MetLife's Written adverse benefit determination
When you will be notified of a determination	Within **60 calendar 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 calendar day period is over
Determination extension period (if needed)	One extension period of **up to 60 calendar 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 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, describe any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- Explain your rights under ERISA's claim and appeal rules; and
- Explain your right to file a civil action under ERISA within 12 months.

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

If your Written benefit appeal is denied, you may voluntarily take part in one more review process called the **Voluntary Final Appeal Process for Benefits**. If you do not choose to use the voluntary final appeal process, you may seek legal action.

Legal Action for Benefit Claims

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

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 *Eligibility Appeal Timeline* below). The review period begins when the appeal is received, regardless of whether the reviewer has all information necessary to decide the appeal. If the reviewer requires more than the stated time to decide your appeal, he or she will send a letter stating an extension time.

Eligibility Appeal Timeline	
Filing deadline	Within **60 calendar days** of the date you receive the denial notice due to eligibility
When you will be notified of a determination	Within **60 calendar days** after receipt of the appeal request unless NRECA requests an extension
Determination extension period (if needed)	One period of up to **60 calendar 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, requesting documentation does not extend the time allowed for you to file an appeal.

Eligibility Appeal Review and Determination

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

- Contain the specific reason(s) your appeal was denied;
- List the specific Plan provision(s) on which the denial was based;
- Explain your rights under ERISA's claim and appeal rules;
- Explain your right to file a civil action under ERISA within 12 months; and
- Contain the procedures you must follow to take part in the voluntary final appeal process and the time limits for such procedures.

Voluntary Final Appeal Process for Eligibility

If you wish to have the NRECA Appeals Committee review your denied appeal, you may follow the voluntary final appeal process for eligibility. Using this process has no effect on your right to other benefits under this Plan or on your right to take legal action. Before you submit your voluntary final appeal, you may request additional information about the process by calling NRECA's Cooperative Benefit Administrators, Inc. (CBA), at 866.673.2299.

You must file a voluntary final appeal with the NRECA Appeals Committee, in Writing, by the filing deadline described in the timeline table below. The review period begins when the appeal is received, regardless of whether the reviewer has all information necessary to decide the appeal. The reviewer may need additional time to complete his or her review and, if so, will notify you of an extension.

Voluntary Final Appeal Process Timeline for Eligibility	
Filing deadline	Within **60 calendar days** of the date you receive NRECA's Written denial of your eligibility appeal
When you will be notified of a determination	Within **60 calendar 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 calendar 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, within 12 months, to bring a civil action under ERISA.

Chapter 7: Porting or Converting Coverage

If your coverage ends, you may continue all or a part of your Plan benefits through either Conversion or Portability.

Conversion

If all or part of your life insurance ends or is reduced for one of the reasons below, you have the option to buy an individual whole life insurance policy (a new policy) from MetLife during the application period in accordance with the conditions and requirements of this section. Whole life coverage has a set premium that does not increase. This option is only available for life insurance coverage and does not include AD&D coverage. This is called the "option to convert." Evidence of insurability will **not** be required; however, if you complete a SOH and are approved, your premium costs could be lower.

When You Have the Option to Convert

You have the option to convert when:

- Your Retired Life Insurance ends because:
  - You cease to be in an eligible class of retiree;
  - The Plan ends, provided you have been insured for life insurance for at least five continuous years;
  - The Plan is amended to end life insurance for an eligible class of which you are a member, provided you have been insured for life insurance for at least five continuous years; or
- Your life insurance is reduced:
  - Because you change from one eligible class to another; or
  - Due to a Plan amendment.

If you choose not to convert a reduction in the amount of your life insurance that occurred for reasons described above, you will not have the option to convert that amount later. A reduction in the amount of your life insurance resulting from an accelerated benefit payment will not give rise to a right to convert under this section.

Conversion Application Period

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

If you are given Written notice of the option to convert **within 15 calendar days before or after** the date your life insurance ends or is reduced, the application period begins on the date that such life insurance ends or is reduced and expires **31 calendar days** after such date.

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

Conversion Conditions

The option to convert is subject to these conditions:

- MetLife's receipt within the application period of:
  - Your Written application for the new policy; and
  - The premium due for such new policy;
- The premium rates for the new policy will be based on:
  - MetLife's rates then in use;
  - The form and amount of insurance;
  - Your class of risk; and
  - Your attained age when your life insurance ends;
- The new policy may be on any form then customarily offered by MetLife excluding term insurance;
- The new policy will be issued without an accidental death and dismemberment benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and
- The new policy will take effect on the 32nd day after the date your life insurance ends, regardless of the length of the application period.

Maximum Amount of the New Policy

If your life insurance ends because the Plan ended or was amended to end life insurance for an eligible class of which you are a member, then the maximum amount of insurance that you may elect for the new policy is the lesser of $10,000 or the amount of your life insurance that ends under this Plan minus the amount of life insurance under any Plan for which you become eligible within 31 calendar days after the date this Plan's insurance ends.

If your life insurance ends for any reason other than Plan termination or amendment, as described above, the maximum amount of insurance that you may elect for the new policy is the amount of your life insurance that ends under the Plan.

If You Die Within 31 Calendar Days After Your Life Insurance Ends

If you die within **31 calendar days** after your life insurance ends, Proof of your death must be sent to MetLife. When MetLife receives such Proof with the claim, MetLife will review the claim and, if MetLife approves it, MetLife will pay the Beneficiary the amount of life insurance you were entitled to convert. If you were covered under Group Life, retire from employment and elect coverage under this Plan then die within **31 days**, your coverage under this Plan will be cancelled and your coverage while an active employee in Group Life will pay to your Beneficiary. Your Beneficiary cannot claim benefits under both Group Life and Retired Life. Only one will pay out a benefit.

Life Insurance Portability

The Portability option allows you to continue the term coverage you currently have for all or a part of your life insurance coverage. Term life insurance renews annually, and at that time premiums could increase. If your Portability-eligible Insurance ends for any of the reasons stated below, you have the option to continue that insurance under another policy, in accordance with the conditions and requirements of this section. This is referred to as Porting.

Evidence of your insurability will **not** be required; however, if you complete a SOH and are approved, your premium costs could be lower.

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

When Porting is an Option

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

If you choose not to Port, life insurance benefits may instead be converted in accordance with the section titled *Conversion of Life Insurance*. If you choose to neither convert nor port your Life and AD&D Insurance benefits, your coverage ends.

- You may choose to Port if Portability Eligible insurance ends because:
  - You cease to be in a class that is eligible for such insurance;
  - The Plan is amended to end the Portability Eligible Insurance, unless such insurance is replaced by similar insurance under another group insurance plan issued to the NRECA Group Benefits Program or its successor; or
  - This Policy has ended, unless such insurance is replaced by similar insurance under another group insurance policy issued to the NRECA Group Benefits Program or its successor.
- You may choose to Port the reduced amount of insurance if your Portability Eligible Insurance is reduced due to a Plan amendment that affects the amount of insurance for your employee classification.

If a request is made under this subsection, the Plan will issue a new Individual Policy which will explain the new insurance benefits. The insurance benefits under the new Policy may not be the same as those that ended under this Plan.

A request under this subsection may be made, if, on the date the Portability Eligible Insurance ended, the following requirement is met:

- The Plan is in effect;
- With respect to any amount of Portability Eligible Life Insurance that is to be Ported, no application has been made to convert that amount of insurance to an individual policy; and
- The person making the request resides in a jurisdiction that permits the portability feature.

Porting Request Period

For you to port, MetLife must receive a completed request form within the Request Period as described below.

If Written notice of the option to Port is given **within 15 calendar days before or after** the date such insurance ends, the Request Period:

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

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

- Begins on the date the insurance ends, and

- Expires **45 calendar days** after the date of the notice.

If Written notice of the option to Port is **not given within 91 calendar days** of the date such insurance ends, the Request Period:

- Begins on the date the insurance ends, and
- Expires at the end of such **91 calendar day** period.

Chapter 8: General Information

Entire Contract

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

Beneficiary

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

You may designate a Beneficiary during the enrollment process. To change your Beneficiary at any time you must provide a Signed and dated Written request to your Employer using a form satisfactory to MetLife. Your Employer must receive your Written request to change your Beneficiary during your lifetime within **30 calendar days** of the date you Sign such request.

You do not need your Beneficiary's consent to make a change. When NRECA receives the change, it will take effect on 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 you designate two or more Beneficiaries but do not specify their shares, your Beneficiaries will share the insurance equally.

If no Beneficiary is designated or if no surviving designated Beneficiary is surviving 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 Beneficiary's court-appointed property and estate guardianship.

State Notices

Coverage under the Plan is subject to ERISA and the applicable insurance laws for each state in which a covered person resides. These state-specific laws and requirements are updated periodically, with MetLife supplementing the policy terms with a notice for each state. The only applicable notice that applies to your coverage is the state where you or your covered dependents reside. Log in to cooperative.com > My Benefits, click on the Life & Disability menu at the top of the page to access and view the state notices. If you are unable to access the

NRECA Employee Benefits website, call NRECA's **Member Contact Center at 866.673.2299** to request a copy at no cost to you.

Where this SPD is inconsistent with any of the state notices for the Plan, the state notices will govern.

Chapter 9: Important Notifications and Disclosures

Not a Contract of Employment

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

Non-assignment of Benefits

You cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan to a third party before you receive it. An Authorized Representative designation made by you or another Plan Beneficiary in accordance with the Plan's procedures is not a prohibited assignment of benefits with respect to the Plan. An attorney-in-fact designation made by you or another Plan Beneficiary pursuant to a power of attorney is not a prohibited assignment of benefits with respect to the Plan.

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, to offset future benefit payments until the overpayment is recouped, or both. 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 Sponsor, MetLife, or your Employer. Your Employer also has the right to change the cost of coverage or change job classifications that are eligible to participate in the Plan. These changes may be made with or without advance notice to you. 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 will 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 Plan's operation, 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 Plan "fiduciaries," 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 a 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 that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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 in this Appendix will have the meanings set forth below. When defined terms are used in this SPD, they will be capitalized. The plural use of a term defined in the singular will share the same meaning.

Authorized Representative means a person your Beneficiary has authorized in Writing to represent them 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 4) your sibling(s).

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

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

Disabled or Disability means that, due to sickness or injury, you are unable to perform the duties of your regular job, or you are unable to perform any other job for which you are fit by training, education, or experience.

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

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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

Normal Retirement Age means the age at which you are eligible for a full pension from your Employer. If your Employer does not have a retirement plan, then the default would be age 65.

Physician means:

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

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse’s:
- parents;
- children (natural, step or adopted);
- siblings;
- grandparents; or
- grandchildren.

Plan Administrator means the person or entity responsible for keeping an employee benefit plan in compliance and managing the plan for the exclusive benefit of plan participants as stated in the plan Information Section of this Summary Plan Description.

Plan Sponsor means an employer or organization that offers a group health plan to its employees or other eligible members as stated in the plan Information Section of this Summary Plan Description.

Policyholder means the NRECA Group Benefits Program.

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

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

Proof must be provided at the Claimant's expense.

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

Spouse means your lawful Spouse. Wherever the term "Spouse" appears in this Plan it shall, unless otherwise specified, be read to include the definitions of Your Civil Union partner or Your Domestic Partner.

Statement of Health (SOH) means the form you must complete to determine if you can be insured by the Plan. In some cases, MetLife may ask for additional information, such as a Physician's report. If the benefits level you choose during first-time enrollment or for a qualifying event is denied due to the SOH, you will automatically be enrolled in the highest benefit amount that does not require a SOH. On other occasions, your coverage will remain at the benefit level in force before the SOH was required.

"Terminally Ill" or "Terminal Illness" means that, due to injury or sickness, you are expected to die within 12 months. **For residents of Texas only**, "Terminally Ill" or "Terminal Illness" means that, due to injury or sickness, you are expected to die within 24 months.

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