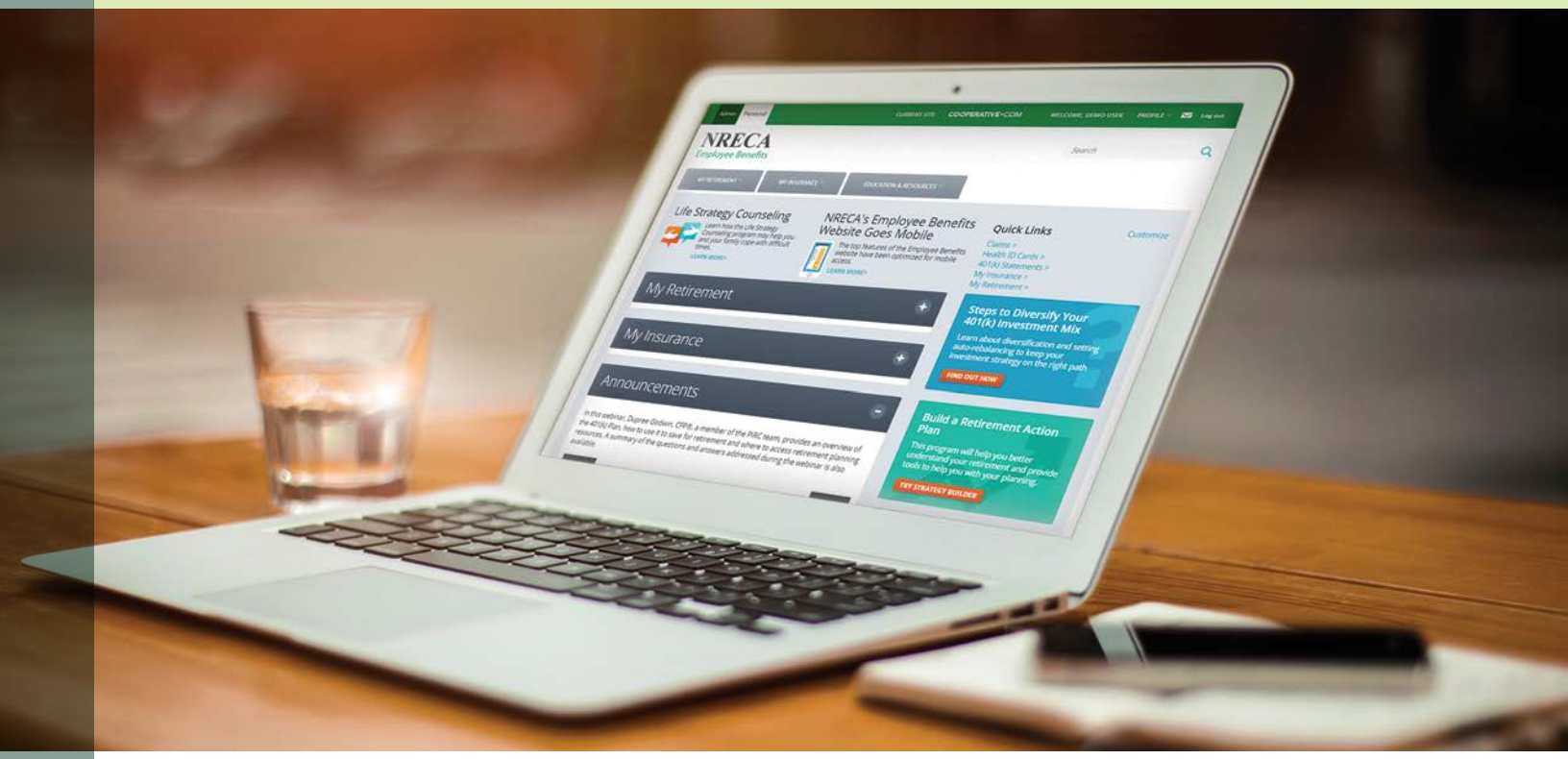
NRECA
Employee Benefits Website

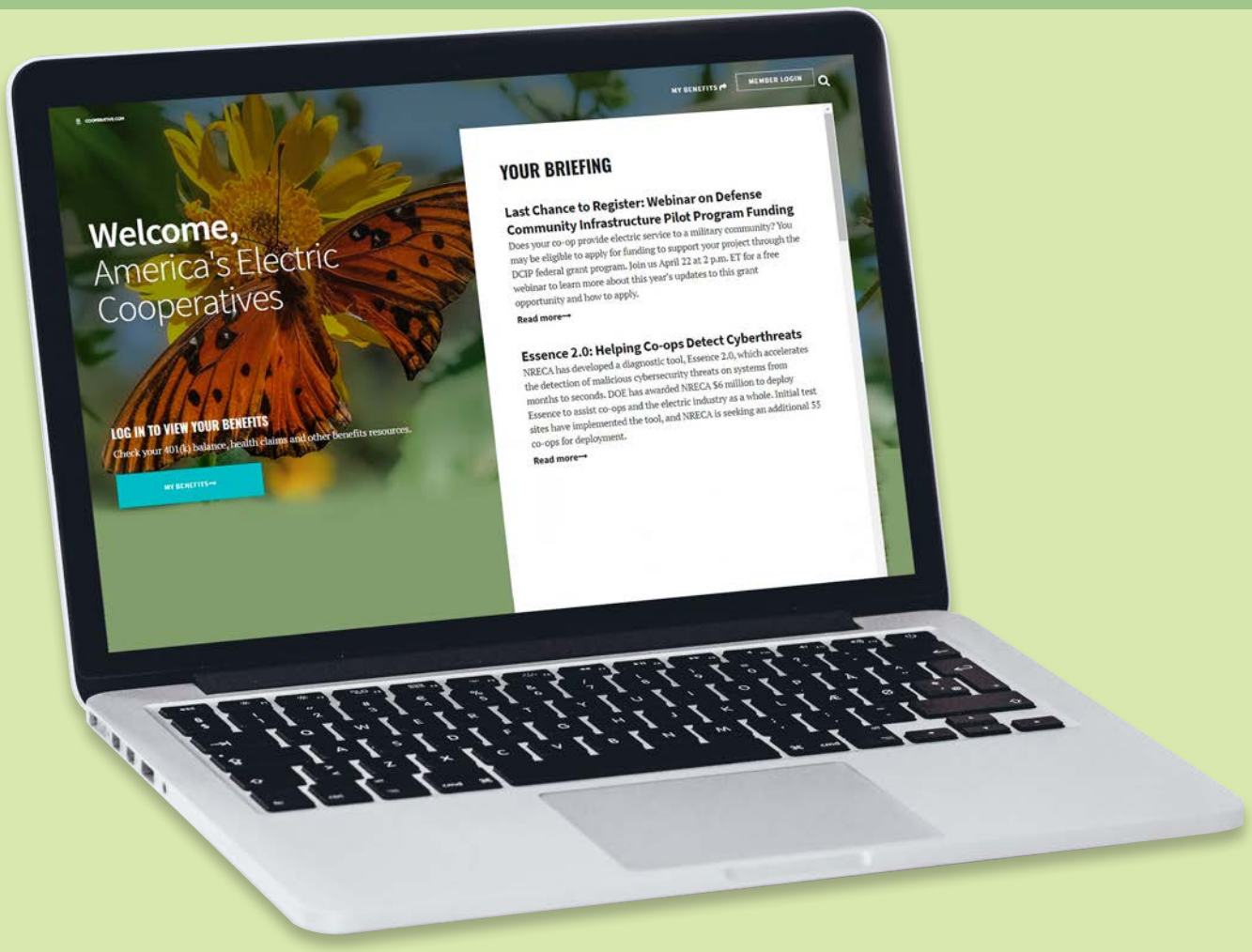


A QUICK TOUR

NRECA
America's Electric Cooperatives

Cooperative.com > My Benefits

Your source for benefits information

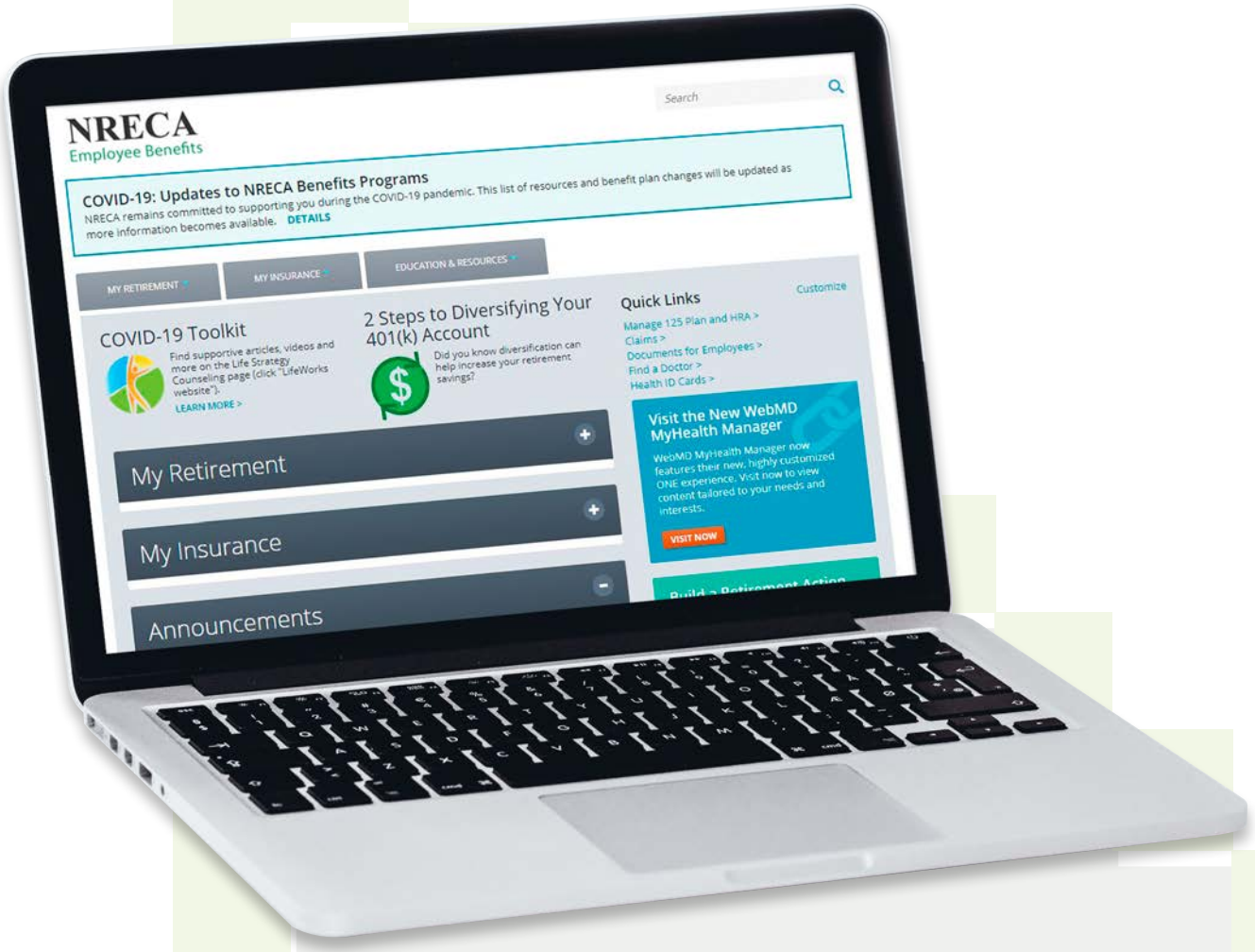


Explore the NRECA Employee Benefits website to learn about and manage all of your benefits in one place, view your 401(k) account balance, current benefits, claims information and more.

Getting started is as easy as 1-2-3!

1. **cooperative.com**
2. **My Benefits**
3. **Log In**

New Users: Simply follow the prompts to register initially.



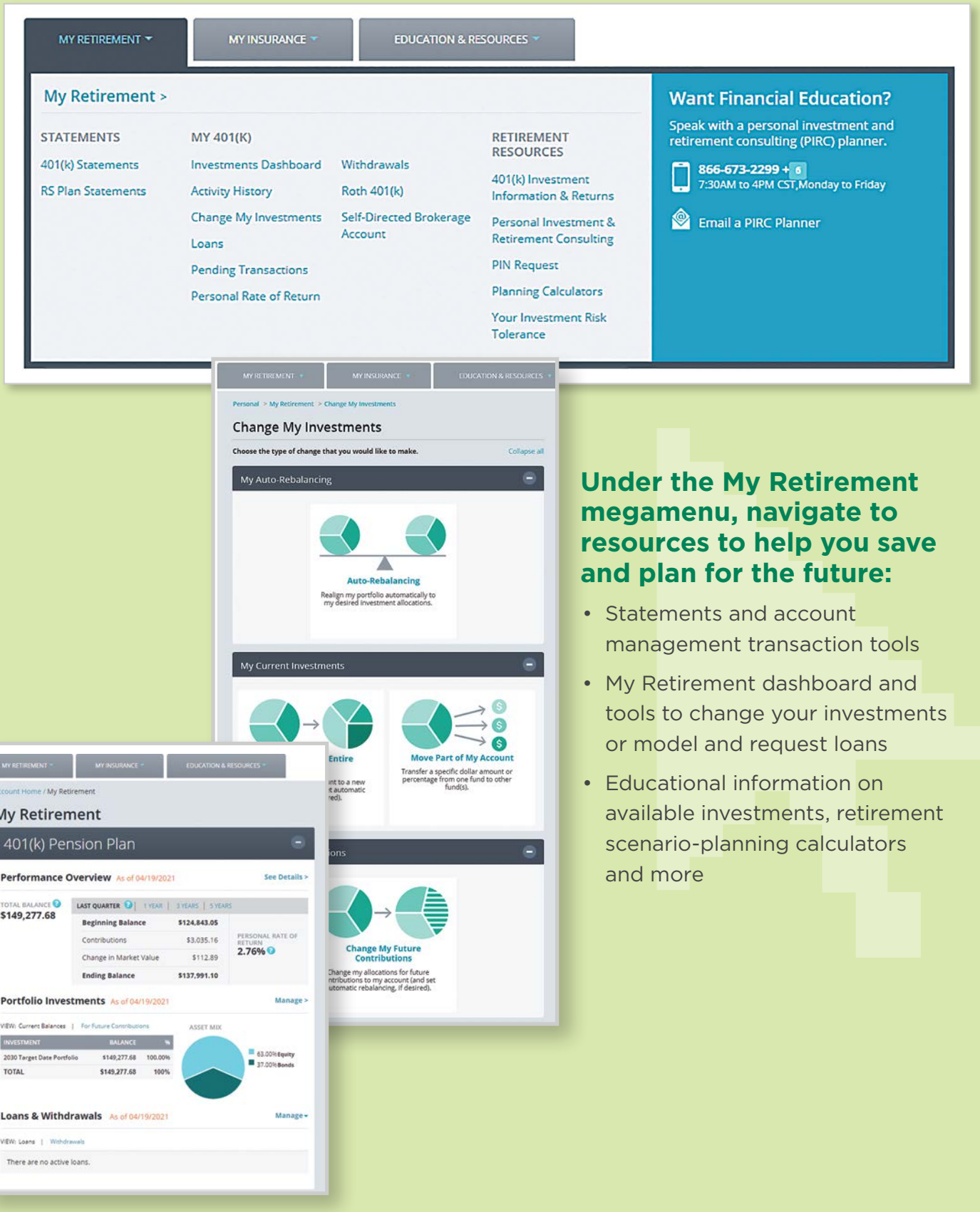
Benefits information at your fingertips

You can access:

- Current benefits
- Retirement account information
- Health ID cards
- Find care & costs
- Claims
- Educational resources
- Tools to manage your insurance and retirement benefits
- The latest news and updates

Note: The web pages shown in this brochure are intended as examples to illustrate the type of information available on the NRECA Employee Benefits website. Your actual benefits may vary depending on the specific benefit plans offered by your co-op.

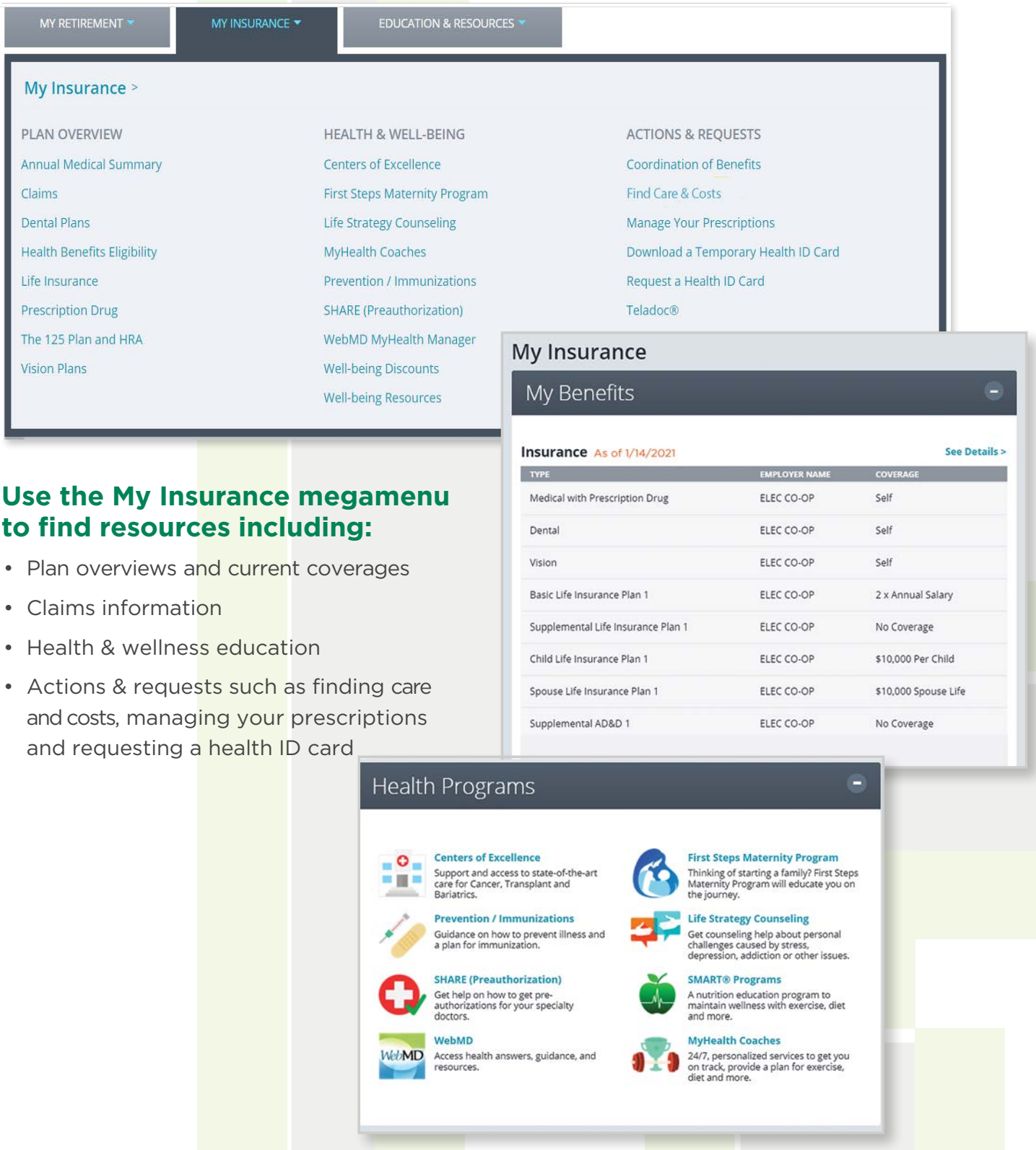
My Retirement



Under the My Retirement megamenu, navigate to resources to help you save and plan for the future:

- Statements and account management transaction tools
- My Retirement dashboard and tools to change your investments or model and request loans
- Educational information on available investments, retirement scenario-planning calculators and more

My Insurance



Use the My Insurance megamenu to find resources including:

- Plan overviews and current coverages
- Claims information
- Health & wellness education
- Actions & requests such as finding care and costs, managing your prescriptions and requesting a health ID card

Education & Resources

Explore the Education & Resources megamenu to find:

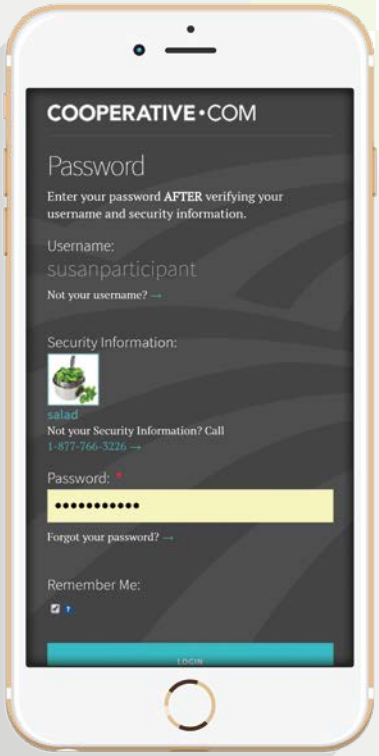
- Benefit plan documents
- Newsletters, articles and videos
- Interactive, scenario-planning calculators
- Contact information for NRECA

On the go? We've got you covered.

Whether it's viewing your retirement savings statements, changing your investments, finding a doctor or accessing a copy of your health ID card, the Employee Benefits website offers quick access on your mobile device.

STEP 1

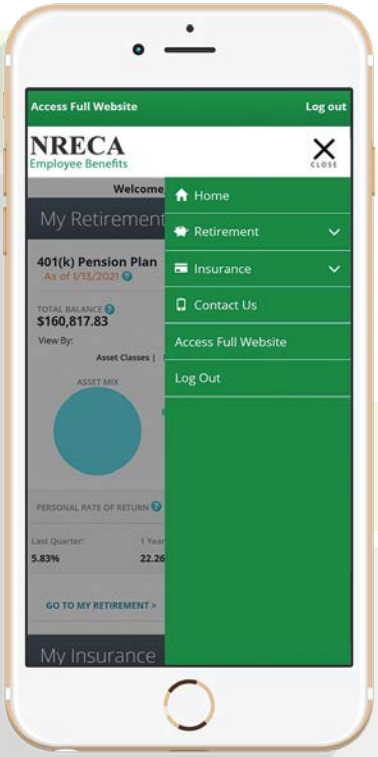
Get started by opening your mobile phone's web browser. Go to **cooperative.com** and click on "My Benefits." (This is a mobile website not available in the app store.)



STEP 2

Log in by entering your name and password.

New user?
Click "Login" and then "Need to Register?" on the following screen to continue.



STEP 3

Use the menu to quickly find the information you need. Or, choose "Access Full Website" for additional resources.

If you have questions, please contact the NRECA Member Contact Center at **866.673.2299** or **contactcenter@nreca.coop**. Representatives are available Monday through Friday, from 7 am to 7 pm, Central time.

NRECA
America's Electric Cooperatives

RMBR17087 12/2021

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this Plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or if you want more detail about your coverage and costs, you can get the complete terms in the Plan document(s) by contacting your Benefits Administrator, by calling 1-866-673-2299 or by visiting us at cooperative.com > My Benefits. For definitions of common terms, such as allowed amount,[1] balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-673-2299 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$50	Generally, you must pay all of the costs, including the allowed amount,[1] from providers up to the deductible amount before this Plan begins to pay. If you have other family members on the Plan, each family member must meet their own deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. For example, this Plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	Not Applicable.	This Plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This Plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This Plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered.	Not covered.	None
	Specialist visit	Not covered.	Not covered.	
	Preventive care[1]/screening/immunization	Not covered.	Not covered.	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered.	Not covered.	None
	Imaging (CT/PET scans, MRIs)	Not covered.	Not covered.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cooperative.com> My Benefits	Generic drugs (Tier 1)	Not covered.	Not covered.	None
	Preferred brand drugs (Tier 2)	Not covered.	Not covered.	
	Non-preferred brand drugs (Tier 3)	Not covered.	Not covered.	
	Specialty drugs (Tier 4)	Not covered.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.	Not covered.	None
	Physician/surgeon fees	Not covered.	Not covered.	
If you need immediate medical attention	Emergency room care	Not covered.	Not covered.	None
	Emergency medical transportation	Not covered.	Not covered.	
	Urgent care: Part of a hospital	Not covered.	Not covered.	
	Urgent care: Not part of a hospital	Not covered.	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	Not covered.	None
	Physician/surgeon fees	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered.	Not covered.	None
	Inpatient services	Not covered.	Not covered.	
If you are pregnant	Office visits	Not covered.	Not covered.	None
	Childbirth/delivery professional services	Not covered.	Not covered.	
	Childbirth/delivery facility services	Not covered.	Not covered.	
If you need help recovering or have other special health needs	Home health care	Not covered.	Not covered.	None
	Rehabilitation services	Not covered.	Not covered.	
	Habilitation services	Not covered.	Not covered.	
	Skilled nursing care	Not covered.	Not covered.	
	Durable medical equipment	Not covered.	Not covered.	
	Hospice services	Not covered.	Not covered.	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	None
	Children's glasses	Not covered.	Not covered.	None
	Children's dental check-up	No charge.	No charge.	Subject to allowed amount.[1] Limited to two visits per participant per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or Plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Plan document.)

- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.[2]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Plan at 1-866-673-2299. You may also contact your state insurance department, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your Plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that dental claim. Your Plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your Plan. For more information about your rights, this notice, or assistance, contact Cooperative Benefit Administrators, Inc. at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Plan provide Minimum Essential Coverage? **No**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan meet the Minimum Value Standards? **No**.
If your Plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-2299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-2299.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-673-2299.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-673-2299.

Other Information:

1 **Allowed Amount:** UCR - Referred to as Reasonable and Customary (R&C) Rates in the medical Plan materials, allowed amounts are the current, most common rates in a geographic area for a particular treatment or service. They are researched and reviewed by Cooperative Benefit Administrators, Inc. (CBA) on a regular basis.

2 **Coverage While Traveling Outside the United States:** In order for a service obtained outside the U.S. to be covered, the information provided to the Plan must include the following: the service must be a recognized service in the U.S.; all provider billings and/or records must be translated into English; bills must clearly show the patient's name, provider's name, date of service, diagnosis and a description of the services rendered; and the current money exchange rate needs to be provided with the bill showing the daily rate for the dates the services were rendered. The participant is required to pay for all services up front before submitting charges to the Plan.

To see examples of how this Plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this Plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the Plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby* (9 months of in-network pre-natal care and a hospital delivery)	
The Plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	100%
Other coinsurance	100%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

Managing Joe's Type 2 Diabetes* (a year of routine in-network care of a well-controlled condition)	
The Plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	100%
Other coinsurance	100%

This EXAMPLE event includes services like: Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,600
The total Joe would pay is	**$5,600**

Mia's Simple Fracture* (in-network emergency room visit and follow up care)	
The Plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	100%
Other coinsurance	100%

This EXAMPLE event includes services like: Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

* **Note**: This condition is not covered under the Dental Plan. The covered individual is responsible for 100%.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

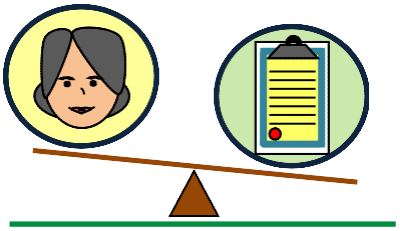
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

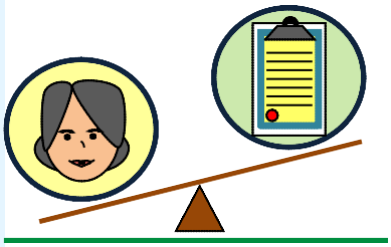
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

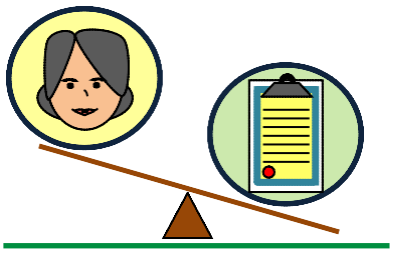
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

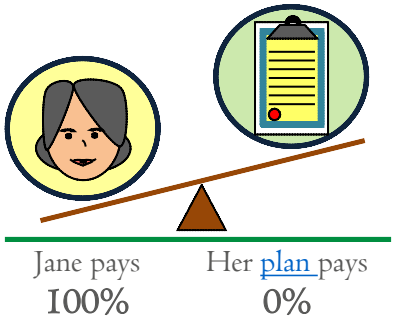
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

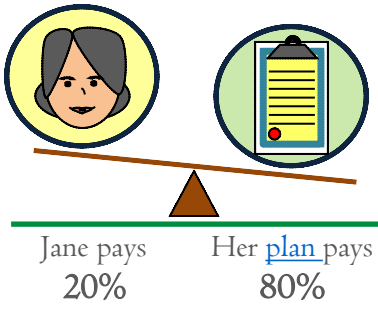
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



more costs



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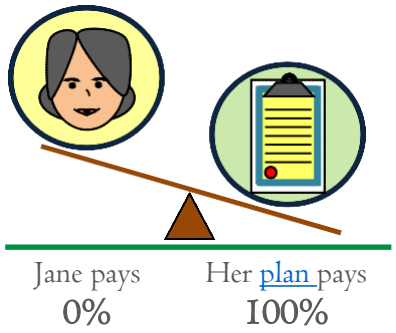


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this Plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or if you want more detail about your coverage and costs, you can get the complete terms in the Plan document(s) by contacting your Benefits Administrator, by calling 1-866-673-2299 or by visiting us at cooperative.com > My Benefits. For definitions of common terms, such as allowed amount[2], balance billing,[5] coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-673-2299 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $600/individual or $1,200/family; for out-of-network providers $1,200/individual or $2,400/family.	Generally, you must pay all of the costs, including the allowed amount,[2] from providers up to the deductible amount before this Plan begins to pay for covered services. If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care[1] services and physician office calls administered by network providers are not subject to the deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this Plan covers certain preventive services[1] without cost-sharing and before you meet your deductible. See a list of covered preventive services[1] at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	For network providers $2,600/individual or $5,200/family; for out-of-network providers $5,200/individual or $10,400/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. For network providers once you meet your network deductible ($600/individual or $1,200/family) and in-network coinsurance maximum ($2,000/individual or $4,000/family), you will continue to incur provider and prescription drug copays until you reach your network provider out-of-pocket limit. For out-of-network providers once you meet your out-of-network deductible ($1,200/individual or $2,400/family) and out-of-network coinsurance maximum ($4,000/individual or $8,000/family), you will continue to incur provider and prescription drug copays for out-of-network providers services.

What is not included in the out-of-pocket limit?	Premiums, balance billing[5] charges, out-of-network provider copayment, penalties for failure to obtain Preauthorization[3] for services and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cooperative.com> My Benefits or call 1-866-673-2299 for a list of network providers.	This Plan uses a provider network. You will pay less if you use a provider in the Plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays (balance billing[5]). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral. Preauthorization[3] and participation in the Center of Excellence (COE) is mandatory for both bariatric and transplant services.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/office visit, not subject to the deductible.	40% coinsurance	Subject to allowed amount.[2] If you consult with a Teladoc physician for a general medical condition, you pay $0 copayment /consultation.
	Specialist visit	$25/office visit, not subject to the deductible.	40% coinsurance	
	Preventive care[1]/screening/ Immunization	No charge.	40% coinsurance	Subject to allowed amount.[2] Age and gender limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your Plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2]
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization[3] is required for all non-emergency, outpatient imaging.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cooperative.com> My Benefits	Generic drugs (Tier 1)	Retail, $15 Mail-order, $0	Retail, $15 Mail-order, $0	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order & Exclusive Choice pharmacies). Subject to allowed amount[2] and prior authorization[3] is required for compound drugs greater than $300, specialty drugs or nonformulary drugs. Generic drugs are available at no cost through the Exclusive Choice network (including mail order).
	Preferred brand drugs (Tier 2)	Retail, $30 Mail-order, $60	Retail, $30 Mail-order, $60	
	Non-preferred brand drugs (Tier 3)	Retail, $50 Mail-order, $100	Retail, $50 Mail-order, $100	
	Specialty drugs (Tier 4)	Generic: 30% (max $100) Preferred Brand: 30% (max $300) Non-Preferred Brand: 30% (max $500) copay/prescription	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to allowed amount.[2]
If you need immediate medical attention	Emergency room care	$0 copayment, subject to $600 deductible and 20% coinsurance.	$0 copayment, subject to $600 deductible and 20% coinsurance.	Subject to allowed amount,[2] copayment or coinsurance and deductible (if applicable). **For outpatient Emergency room care visits that are not an actual**
	Emergency medical transportation	20% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care: Part of a hospital	$0 copayment, subject to $600 deductible and 20% coinsurance.	$0 copayment, subject to $600 deductible and 20% coinsurance.	**medical emergency at an out-of-network provider will be subject to the out-of-network deductible and coinsurance.** **Note:** Urgent care is paid as an office visit, unless it is part of a hospital urgent care center.
	Urgent care: Not part of a hospital	$25/office visit, not subject to the deductible.	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Subject to allowed amount.[2]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/office visit, not subject to the deductible.	40% coinsurance	Subject to allowed amount.[2] Teladoc is paid at 100% after you meet your office copay. Preauthorization[3] is required for inpatient hospital stays. Partial hospitalization benefits are considered at the inpatient services benefit level.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$25/office visit, not subject to the deductible.	40% coinsurance	Cost sharing does not apply to certain preventive services.[1] Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Childbirth/delivery professional service	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization.[3] Limited to 100 visits/ year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required after visit limitation has been reached. Restorative speech therapy and chiropractic services are limited to 25 visits each. Acupuncture, physical, occupational, and massage therapy are limited to a combined 25 visits.
	Habilitation services	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization.[3]
	Skilled nursing care	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization[3] and limited to 90-day limit.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization[3] is required (if the dollar amount is equal to or greater than the following amounts) for rentals $500, prosthesis $1,000 and purchases $1,500.
	Hospice services	20% coinsurance	20% coinsurance	Subject to allowed amount.[2] Lifetime maximum for hospice services is $50,000.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	No coverage for this service.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or Plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Eye exam
- Glasses
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.[4]
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Plan at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your Plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your Plan. For more information about your rights, this notice, or assistance, contact Cooperative Benefit Administrators, Inc. at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan meet the Minimum Value Standards? Yes.
If your Plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-2299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-2299.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-673-2299.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-673-2299.

Other Information:

1 **Preventive Services, Preventive Care:** Under Section 2713 of the Affordable Care Act, the Plan must provide coverage for a range of preventive services and may not impose Cost sharing (such as copayments, deductibles, or co-insurance) on participants receiving these services. The required preventive services come from recommendations made by four expert medical and scientific bodies – the U.S. Preventive services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services. Only preventive services recommended by one of these four groups are covered without Cost sharing.

2 **Allowed Amount:** UCR - Referred to as Reasonable and Customary (R&C) Rates in the medical Plan materials, allowed amounts are the current, most common rates in a geographic area for a particular treatment or service. They are researched and reviewed by Cooperative Benefit Administrators, Inc. (CBA) on a regular basis.

3 **Preauthorize, Prior Authorization, or Prior Approval:**

- **Medical Plan Services and Supplies**. Failure to receive preauthorization for medical necessity will result in a 20% reduction in charges considered covered by the medical Plan. If such services or supplies are later determined not to be medically necessary, the services or supplies will be denied and not eligible for coverage under the medical Plan. You will be responsible for requesting preauthorization and the expenses for failure to obtain preauthorization. Exception: If you access the Choice Plus network, the provider is responsible for your preauthorization of an in-patient hospital admission and the expenses for failure to obtain preauthorization.
- **Prescription Drugs and Supplies**. Compound drugs greater than $300 and certain drugs and drug classes require Prior Authorization by CBA or CVS Caremark. Refer to your medical Plan summary plan description for more information or contact CBA at 1-866-673-2299.

4 **Coverage While Traveling Outside the United States:** In order for a service obtained outside the U.S. to be covered, the information provided to the Plan must include the following: the service must be a recognized service in the U.S.; all provider billings and/or records must be translated into English; bills must clearly show the patient's name, provider's name, date of service, diagnosis and a description of the services rendered; and the current money exchange rate needs to be provided with the bill showing the daily rate for the dates the services were rendered. The participant is required to pay for all services up front before submitting charges to the Plan.

5 **Surprise billing and the No Surprises Act**: There are certain balance billing protections to protect consumers from getting a balance bill calculated at the out-of-network rate for out-of-network emergency services or when consumers have a scheduled procedure at an in-network hospital or surgery facility and are seen by an out-of-network provider. Note that some balance billing protections are waivable. Click here for more information.

*To see examples of how this **Plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this Plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the Plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The Plan's overall deductible*	$600
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

*Cost Sharing****	
Deductibles*	$600
Copayments	$25
Coinsurance	$1,975
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,600**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The Plan's overall deductible	$600
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

*Cost Sharing****	
Deductibles	$600
Copayments	$250
Coinsurance	$950
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The Plan's overall deductible	$600
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

*Cost Sharing****	
Deductibles	$600
Copayments**	$75
Coinsurance	$425
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

***Note:** This charge does **NOT** include facility charges for the newborn baby. Charges for the newborn baby would be subject to an individual deductible.
****Note:** This Plan has other copayments for emergency room care included in this coverage example. Review the charts in this SBC to determine how much you pay for covered emergency room care.
*****Note**: These cost sharing examples are based on generic prescription drugs.
[The Plan would be responsible for the other costs of these EXAMPLE covered services.]

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

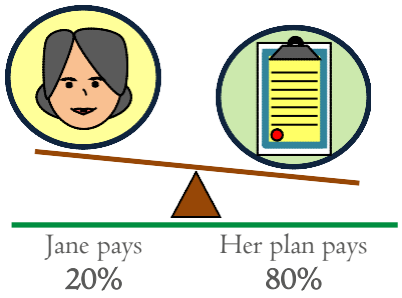
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

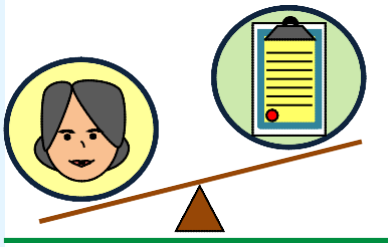
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

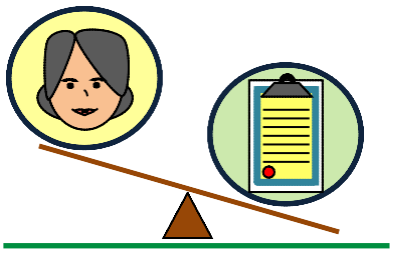
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

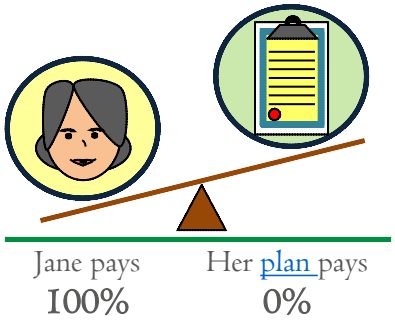
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

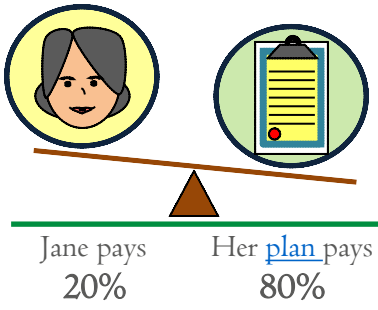
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

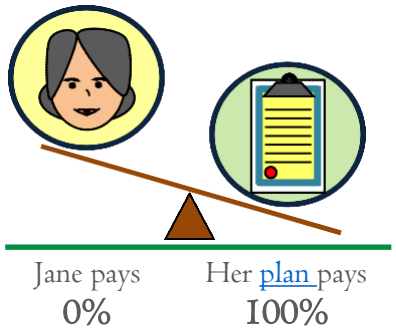
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

NRECA GROUP BENEFITS PROGRAM
SUMMARY OF MATERIAL MODIFICATIONS
For
NRECA High Deductible Medical Plan

EFFECTIVE: October 1, 2022

System Name: Jackson Electric Cooperative Inc.
RUS/Subgroup Number: 44102

This Summary of Material Modifications (SMM) describes changes, effective on the date listed above, to the National Rural Electric Cooperative Association (NRECA) High Deductible Medical Plan (Medical Plan).

This SMM is a supplement to the Medical Plan's Summary Plan Description (SPD), also known as the Benefits Booklet. Read this SMM and keep it with your SPD until you receive an updated copy of the SPD. See your benefits administrator if you have questions about these changes.

The prescription drug lists that make up the Medical Plan's formulary are subject to change from time to time by CVS Caremark. In the lists below, brand name products are in UPPERCASE, branded generic products are in *UPPERCASE* and *lowercase italics*, and generic products are in *lowercase italics*.

The updated drug lists mentioned in this SMM are available at **cooperative.com > My Benefits > My Insurance > Prescription Drug > Checking Coverage**. Or call NRECA's Member Contact Center at 866.673.2299 to request a copy.

Chapter 6: Prescription Drug Benefits

These prescription drugs were added to the "Prior Authorization" subsection under "How the Benefit Works:"

- *Disposable Insulin Pumps and Supplies*
- GRALISE
- HORIZANT
- LYRICA
- LYRICA CR
- NUZYRA
- OSMOLEX ER
- QBREXZA
- SIVEXTRO
- SUCRAID
- XHANCE

These prescription drugs were added to the "Specialty Drugs Subject to Quantity Limits" table under "How the Benefit Works:"

- CAMZYOS
- RADICAVA
- TYVASO DPI
- ZTALMY

These prescription drugs were added to the "Non-specialty Drugs Subject to Quantity Limits" table under "How the Benefit Works:":

- ADLYXIN
- BYDUREON
- BYDUREON BCISE
- BYETTA
- OZEMPIC
- RYBELSUS
- TANZEUM
- TRULICITY
- VICTOZA

These prescription drugs were added to the "Specific Exclusions" subsection under "What the Plan Covers:"

- APLENZIN
- ARESTIN
- PRUDOXIN
- QNASL

- AUVI-Q
- CAMBIA
- DENAVIR
- EDLUAR
- FENORTHO
- FORFIVO XL
- *ketoprofen*
- NALFON
- OMNARIS
- QNASL CHILDREN
- RAYOS
- SITAVIG
- SPRIX
- TREXIMET
- XERESE
- ZIPSOR
- ZORVOLEX
- ZYFLO (brand, generic & extended release)

Appendix C: Performance Drug List-Standard Control

These prescription drugs were added:

- ASTAGRAF XL
- CELLCEPT
- ENVARSUS XR
- MYFORTIC
- PROGRAF
- PROGRAF GRANULE
- RAPAMUNE
- ZORTRESS

These prescription drugs were removed. They were added to the Medical Plan's list of non-preferred brand name prescription drugs (Tier 3):

- LANOXIN TABLET 0.0625MG
- TRIDESILON CREAM 0.05%

Appendix D: Medications Requiring Prior Authorization for Medical Necessity

These prescription drugs were added:

- *betamethasone dipropionate ointment 0.05%*
- *clobetasol emollient foam 0.05%*
- *lansoprazole odt*
- *Tovet aerosol 0.05%*

Appendix E: High Deductible Health Plan (HDHP) Preventive Therapy Drug List

These prescription drugs were added:

- MOUNJARO
- NORLIQVA
- ZTALMY

These prescription drugs were removed:

- NULYTELY

All other rules, provisions, definitions and benefit amounts in the Medical Plan SPD remain the same. No further changes have been made to your Medical Plan's SPD.

Plan Sponsor: National Rural Electric Cooperative Association
4301 Wilson Boulevard, Arlington, VA 22203-1860
Plan Sponsor's Employer Identification Number: 53-0116145
Plan Number: 501

NRECA GROUP BENEFITS PROGRAM
SUMMARY OF MATERIAL MODIFICATIONS
For
NRECA Medical PPO Plan

EFFECTIVE: October 1, 2022

System Name: Jackson Electric Cooperative Inc.
RUS/Subgroup Number: 44102

This Summary of Material Modifications (SMM) describes changes, effective on the date listed above, to the National Rural Electric Cooperative Association (NRECA) Medical PPO Plan (Medical Plan).

This SMM is a supplement to the Medical Plan's Summary Plan Description (SPD), also known as the Benefits Booklet. Read this SMM and keep it with your SPD until you receive an updated copy of the SPD. See your benefits administrator if you have questions about these changes.

The prescription drug lists that make up the Medical Plan's formulary are subject to change from time to time by CVS Caremark. In the lists below, brand name products are in UPPERCASE, branded generic products are in *UPPERCASE* and *lowercase italics*, and generic products are in *lowercase italics*.

The updated drug lists mentioned in this SMM are available at **cooperative.com > My Benefits > My Insurance > Prescription Drug > Checking Coverage**. Or call NRECA's Member Contact Center at 866.673.2299 to request a copy.

Chapter 6: Prescription Drug Benefits

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- HORIZANT
- LYRICA
- LYRICA CR
- NUZYRA
- OSMOLEX ER
- QBREXZA
- SIVEXTRO
- SUCRAID
- XHANCE

These prescription drugs were added to the "Specialty Drugs Subject to Quantity Limits" table under "How the Benefit Works:"

- CAMZYOS
- RADICAVA
- TYVASO DPI
- ZTALMY

These prescription drugs were added to the "Non-specialty Drugs Subject to Quantity Limits" table under "How the Benefit Works:":

- ADLYXIN
- BYDUREON
- BYDUREON BCISE
- BYETTA
- OZEMPIC
- RYBELSUS
- TANZEUM
- TRULICITY
- VICTOZA

These prescription drugs were added to the "Specific Exclusions" subsection under "What the Plan Covers:"

- APLENZIN
- ARESTIN
- PRUDOXIN
- QNASL

- AUVI-Q
- CAMBIA
- DENAVIR
- EDLUAR
- FENORTHO
- FORFIVO XL
- *ketoprofen*
- NALFON
- OMNARIS
- QNASL CHILDREN
- RAYOS
- SITAVIG
- SPRIX
- TREXIMET
- XERESE
- ZIPSOR
- ZORVOLEX
- ZYFLO (brand, generic & extended release)

Appendix C: Performance Drug List-Standard Control

These prescription drugs were added:

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- RAPAMUNE
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Appendix D: Medications Requiring Prior Authorization for Medical Necessity

These prescription drugs were added:

- *betamethasone dipropionate ointment 0.05%*
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- *lansoprazole odt*
- *Tovet aerosol 0.05%*

All other rules, provisions, definitions and benefit amounts in the Medical Plan SPD remain the same. No further changes have been made to your Medical Plan's SPD.

Plan Sponsor: National Rural Electric Cooperative Association
4301 Wilson Boulevard, Arlington, VA 22203-1860
Plan Sponsor's Employer Identification Number: 53-0116145
Plan Number: 501

Retirement Security Plan

SUMMARY PLAN DESCRIPTION

as adopted by

JACKSON ELECTRIC CO-OP INC

44-102-001 (001)

Effective Date: 07/01/2022

NRECA
America's Electric Cooperatives

Introduction

This document is a Summary Plan Description (SPD) of the Retirement Security Plan (the “RS Plan” or “the Plan”) sponsored by NRECA. The purpose of this SPD is to summarize the key provisions of the RS Plan. Each participant in the RS Plan is responsible for reading this SPD and related materials completely and for complying with all rules and Plan provisions.

The federal laws governing the operation of retirement plans are complex. This SPD is only a summary of the most important provisions of the Plan. It does not discuss some of the more technical aspects of the Plan's operation that may affect you, your right to participate, or the amount of benefits available to you. The Plan is operated according to the provisions of the Plan document and amendments.

If the terms of this SPD conflict with the terms of the RS Plan document, the Plan document will govern in all cases. In addition, the language in the Plan document gives the Insurance and Financial Services Committee and its delegates (as defined in the section titled *Administrative and Contact Information*) discretionary authority to determine eligibility for benefits or to interpret the terms of the Plan.

If you have questions or you do not understand any part of this SPD, contact your local benefits administrator or the plan administrator. The plan administrator’s name and address can be found in the section titled *Administrative and Contact Information*.

Table of Contents

Administrative and Contact Information

Benefits Administrator

Your benefits administrator, who has on-site plan administration responsibilities for your employer, is your primary point of contact for questions concerning the operation and administration of the RS Plan.

Contact the benefits administrator of your RS Plan at:

JACKSON ELECTRIC CO-OP INC
P.O. BOX 1189,
EDNA, TX 779571189

Employer Identification Number: 74-0708876

Plan Sponsor

The plan sponsor is a designated party that sets up a retirement plan, such as the RS Plan, for the benefit of adopting employers and their eligible employees.

The plan sponsor of the RS Plan is:

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

Employer Identification Number: 53-0116145

Plan Administrator

The plan administrator is responsible for administration and operation of the RS Plan and acts in the interest of the Plan's participants. The plan administrator is designated as the agent for legal matters related to the RS Plan and works with your employer to ensure that the Plan meets all government regulations. Any action against or in connection with the Plan, NRECA, or any fiduciary or Named Fiduciary of the Plan must be filed exclusively in the United States District Court for the Eastern District of Virginia. Legal process may be served on the plan administrator at the following address.

The plan administrator of the RS Plan is:

Senior Vice-President
Insurance and Financial Services
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Arlington, VA 22203-1860
703.907.5743

Employer Identification Number: 54-2072724

Plan Trustee

In addition to a plan administrator, the RS Plan has a trustee that has been designated to hold and invest Plan assets, at the direction of investment managers, for the benefit of participants and their beneficiaries.

The trustee of the RS Plan is:

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

Insurance & Financial Services Committee

The named fiduciary of the RS Plan is the Insurance and Financial Services Committee (the I&FS Committee), whose members are appointed by the president of the NRECA board of directors. This committee has the central fiduciary responsibility for the Plan and has the discretion to select Plan providers, including the administrator, investment managers, and trustee. 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. The I&FS Committee has the exclusive discretion to interpret the terms of the Plan and to determine eligibility for benefits.

Plan Number

The Plan number assigned by the plan sponsor is 333.

The Pension Benefit Guaranty Corporation (PBGC)

The PBGC is an organization that insures the pensions of certain groups of employees. Benefits under the RS Plan are insured by the PBGC. The insurance provided by the PBGC may not cover 100% of the benefit you have earned because the insurance coverage is limited to certain guaranteed levels determined by law. Information about PBGC coverage of benefits and benefit limits can be found on the PBGC website at the address listed below.

PBGC insurance is provided in situations when a plan is terminated by the sponsoring employer and there are insufficient assets to pay the benefits that have been accrued by the employees who participated in an employer's plan or when the sponsoring employer is in bankruptcy or not financially able to fund the benefit using plan assets. Even if certain benefit levels are not guaranteed, you still may receive some non-guaranteed benefits from the PBGC depending on how much money your plan has and how much the PBGC collects from employers. You may request further information regarding the PBGC by contacting the plan administrator or through the PBGC directly at:

PBGC, Technical Assistance Division
445 12th Street SW
Washington, DC 20024-2101

202.326.4000

Additional information is available through the PBGC's website at pbgc.gov.

NRECA, as the RS Plan sponsor, is the only body authorized to terminate the RS Plan; however, your employer may cease participation in the RS Plan with appropriate advance notice to the plan administrator and employees. For information about these events, see the section titled *Amendment and Termination of Your Plan*.

General Plan Information

In cooperation with NRECA, your employer has adopted the RS Plan to provide retirement benefits to employees and their beneficiaries. The RS Plan is what is known as a defined benefit pension plan; it is qualified under all applicable sections of the Internal Revenue Code of 1986 (the Code) and Treasury Regulations. The RS Plan is a multiple employer plan (as defined in Section 413(c) of the Code) that operates on a calendar year basis during the twelve-month period beginning on January 1 and ending on December 31.

The RS Plan is tax qualified, which means that the benefits are not taxable to you when you earn them. You are responsible for income tax on the taxable portion of your pension benefit when the money is distributed, but your benefit may also be eligible for special tax treatment when distributed.

Your RS Plan benefit plays an important role in your financial planning for retirement. The benefit you earn is based on a formula that is not tied to financial market performance. To provide this benefit, your employer deposits contributions into a trust fund. These contributions must be sufficient to fund the expected RS Plan benefit for all eligible employees before their expected retirement dates. Since the RS Plan benefit is based on a formula, the trust fund's investment gains or losses do not affect the benefit that employees receive.

Your employer will make contributions to the Plan in the amount required to fund your RS Plan benefit. You are not required to make contributions to the Plan. These contributions fund the pension benefit that will be paid to you or your beneficiary upon retirement, termination, or death.

Your traditional RS Plan benefit is expressed as an annuity payable at your normal retirement date for your lifetime (or, if married, for your joint lifetime with your spouse). Other annuity and cash payment options are available depending on your employer's elections.

This SPD reflects the provisions and benefit formula **currently** in effect for your Plan. For a full record of the Plan provisions and employer elections in effect during your entire benefit service, keep a copy of each SPD you receive during your service with participating employer(s). Your final benefit will be calculated based on all the benefit provisions in effect during your specific periods of employment, including any amendments to those benefits.

The benefits available under the RS Plan are designed to supplement any benefits available to you under Social Security and any other retirement plans in which you may participate. The Plan should be considered as one source of retirement security, along with your personal savings and investments.

A more thorough discussion of how the RS Plan is maintained and operated is provided in the sections to follow. If you have questions about your RS Plan benefit, please contact your benefits administrator. See the section titled *Administrative and Contact Information* for details.

Summary of Plan Benefits

This chart reflects the Plan elections and benefit formula chosen by your employer and in effect as of the *Employer Plan Amendment Date* below. Prior SPDs from your current and prior employers may reflect earlier employer elections. Refer to this *Summary of Plan Benefits* for the specific Plan provisions and employer elections described throughout this SPD.

Effective date of Plan	10/01/1989
Employer Plan amendment date	07/01/2022
Employer Identification Number	74-0708876
Plan number	001
Plan type	Defined benefit pension plan
Current benefit design	Traditional (Final Average Earnings) Formula
Eligible class of employees	All employees
Excluded class of employees	None
Eligibility waiting period	1 year (first of the month on or next following)
Normal retirement age	Age 65
Benefits accrue until actual retirement date	Yes
Compensation used to calculate benefits	Base Salary
Quasi-retirement	Yes
Current benefit formula	1.8% of a participant's final average effective salary, times years of benefit service. See the section titled *How Are My Benefits Calculated?* for more information.
Employee required contributions	0%
Single Cash Payment	Yes
Survivor benefit	Standard; or, in limited circumstances, the survivor benefit equivalent
Transfers from other participating employers	N/A

Important Definitions

Throughout this SPD, certain terms are used frequently to describe your benefit and explain how it is calculated. Those terms and concepts are defined below so that you can refer to them as you read through this SPD.

Accrued benefit

For benefits you earn under the Plan's traditional benefit formula, your monthly accrued benefit as of a specific date is the amount you would receive each month if you stopped working on that date and waited until your normal retirement date to receive benefit payments. Depending on your employment history, you may own only the vested part of your accrued benefit.

Actuarial equivalent

Actuarial equivalent means a benefit of equivalent present value to a benefit stated under the Plan on a specific starting date. For example, your accrued benefit could be paid as one of the available forms of annuity that is actuarially equivalent to your accrued benefit on the date paid. Your accrued benefit could also be converted to a single cash payment that is actuarially equivalent to your accrued benefit.

Benefit rate

Your benefit rate (also called your benefit level) is a percentage specified by your employer of your final average effective salary (see FAES, defined below). Your benefit rate may apply to your future benefits, your past benefits, or both, as elected by your employer.

Benefit service

Service with a participating employer that is used to determine your accrued benefit and your eligibility for early retirement benefits under the traditional benefit formula and the amount of your annual pay credits under the cash balance benefit formula.

Cash balance benefit design

Also called a cash balance benefit formula, the RS Plan's cash balance benefit design states benefits earned as a single sum in a notional account. Your notional account balance is used to track your benefit as annual pay credits and interest credits accumulate over time. See the *Summary of Plan Benefits* chart for this Plan's current benefit formula election.

Effective salary

For each calendar year, your effective salary is the amount of your pay that is used to determine your accrued retirement benefit under the Plan's traditional benefit formula. The section of this SPD titled *Summary of Plan Benefits* describes your Plan's effective salary definition and the section titled *How are My Benefits Calculated?* lists the pay components included in effective salary.

Eligibility service

Eligibility service means your service with a participating employer that is used to determine when you become eligible to participate in the Plan.

Final average effective salary (FAES)

Under the Plan's traditional benefit formula, your FAES is either the average of your highest five effective salaries or, if you have fewer than five years of participation, the average of all of your effective salaries. The section titled *How Are My Benefits Calculated?* describes FAES in detail, including how it is used to calculate your benefit.

Normal retirement age (NRA)

Normal retirement age, or NRA, is the age chosen by your employer and shown in the *Summary of Plan Benefits* section of this SPD. Your NRA occurs on your birthday coincident with or immediately preceding your normal retirement date (NRD), defined below. Under the Plan's traditional formula, you are eligible for unreduced benefits when you reach your NRA.

Normal retirement date (NRD)

Your normal retirement date, or NRD, is the first of the month coincident with or next following the day you reach age 65.

Salary

Your salary means what you earn as an employee of JACKSON ELECTRIC CO-OP INC. Salary includes amounts that are actually paid to you, except where certain deferred or non-taxable types of compensation are included as part of your salary for purposes of the RS Plan, as required by the Internal Revenue Code. Your effective salary, defined above, is calculated using the pay components that are listed in the section titled *How Are My Benefits Calculated?*

Traditional benefit design

Also called a traditional benefit formula, the RS Plan's traditional benefit design provides an annuity benefit using a formula that includes your years of benefit service, the benefit level elected by your employer, and the average of your highest five effective salaries (also called FAES, which is defined in the section titled *How Are My Benefits Calculated?)*. See the *Summary of Plan Benefits* chart for this Plan's current benefit formula election.

Vesting

Vesting means the percentage of your retirement benefit that you own.

Vesting Service

Your service with a participating employer that is used to determine the nonforfeitable portion of your accrued benefit.

Vesting Service is determined as described in the section titled *Vesting and Benefit Service*.

Eligibility and Participation

This section contains general information on how you qualify for participation in the RS Plan and when you will begin earning benefits.

Eligibility

Eligible class of employees

To be eligible to participate in the RS Plan, you must be in the following class of employees:

All employees of your employer who have met the age and service requirements.

If you have questions about the eligible class(es) of employees, please see your benefits administrator.

Excluded class of employees

Your employer does not exclude any class of employees from participation in the Plan.

Age and Service Requirements

To become a participant in the Plan, you must meet certain minimum service requirements. There are no minimum age requirements to participate in this Plan. This means that you must be a member of the group of eligible employees described above and you must work for a minimum length of time. You become a participant on the first day of the month coincident with or next following the date you meet the minimum service requirements. The eligibility requirements are based on either hours of service or one year of eligibility service (called the 1,000 hour rule). Your employer's specific service requirements are described later in this section.

Your employer will keep track of your service and will enter you into the Plan on the first of the month coincident with or next following the date you complete either the required number of months with the minimum hours of service (if applicable to your Plan) or a computation period with at least 1,000 hours of service.

Hours of Service

Hours of service are any hours for which you are paid your salary. This includes paid vacation, sick leave, holidays, jury duty and military service. You are also credited with hours of eligibility service (not to exceed 501 hours) for any uncompensated leave of absence, as long as you return to work at the end of such leave.

The 1,000 Hour Rule

Under the 1,000 hour rule, eligibility service is calculated during a computation period defined as either:

- Your first 12 consecutive months of employment, beginning on the date you first complete an hour of service; or
- A subsequent calendar year (if you do not perform at least 1,000 hours of service during your first 12 consecutive months of employment).

Therefore, under this rule, if you do not work at least 1,000 hours in your first 12 months of employment, the next 12-month period used to determine your eligibility is the calendar year (January 1 through December 31) after the year in which you first began to work for your employer. It is not necessary to be employed each and every day of the eligibility computation period in order to satisfy the 1,000 hour requirement.

***For example**, if you begin work on May 10, 2022, and by May 9, 2023 you have not performed at least 1,000 hours of service, the measurement year changes to the calendar year from January 1, 2023 to December 31, 2023. If you perform at least 1,000 hours of service during 2023, you have one year of eligibility service on December 31, 2023 and become eligible to participate in the Plan on January 1, 2024.*

Your Plan's Requirements

You will meet the minimum service requirements on the first day of the month coincident with or next following the date you have completed one year of eligibility service.

A year of eligibility service is a 12-month period during which you perform at least 1,000 hours of service. The initial 12-month period begins on the date you perform your first hour of service.

***For example,** if you are hired on May 10, 2022 and you perform at least 1,000 hours of service by May 9, 2023, you become eligible to participate in the Plan on June 1, 2023.*

Employee Contributions

Your employer does not require any employee contributions to participate in this Plan.

Additional Eligibility Issues

Reemployment for prior participants

If you are a participant in the Plan, terminate your employment, and are later rehired by an employer that participates in the Plan, you will become a participant either on the day you are rehired or when you begin making employee contributions, if applicable.

Reemployment for previously non-participating employees

If you satisfy the 1,000 hour rule requirement but do not become a participant in the Plan, terminate employment, and are later rehired, you may be eligible to participate in the Plan on the first day of the month following the date you are rehired.

Employment with related employers

Employment with the following related employers counts toward eligibility service in this Plan:

- An employer that is a member of NRECA but does not participate in the pension programs sponsored by NRECA;
- An employer that is an affiliate of an NRECA member employer that participates in the Plan;
- An employer that was not a member of NRECA and later became a member of NRECA;
- Any of the above entities of which an employee is a leased employee, if leased employees within the meaning of Section 414(n) of the Code are eligible to participate in the entity's plan.

Employment as part of an excluded class of employees

If you are in an excluded class of employees and later become part of an eligible class of employees, your employment as a member of the excluded group will count towards the service requirement for participation in this Plan.

Part-time employees

Eligibility service for part-time employees is credited in the same manner as service for full-time employees. If your employer has elected an eligibility period of one, three, or six months and you work part time, you may not meet the eligibility requirements on a monthly basis but may still be eligible to participate in the Plan if you perform more than 1,000 hours of service in a

year. Your employer will calculate your hours of service and will offer participation at the appropriate time.

Breaks in service

If, during your initial eligibility period, there is a calendar year in which you are credited with fewer than 501 hours of service, you will be deemed to have incurred a break in service. If you again perform service for a participating employer, then the day you begin working will be treated as the first day of a new eligibility computation period. Any service you had prior to the year in which you were credited with fewer than 501 hours of service will be disregarded for purposes of meeting the service requirement for eligibility.

The break-in-service rule applies only during the initial eligibility period.

Vesting and Benefit Service

This section contains general information about how you earn vesting service and benefit service through your continued employment. If you have any questions about your own service, contact your benefits administrator.

Vesting Service

The term “vested” means the percentage of your retirement benefit that you own. Each year that you are employed, you earn a year of vesting service. When you leave your job, you will be entitled to the portion of your accrued benefit that is vested.

An hour of service for vesting purposes is the same as an hour of service for eligibility purposes (see the section titled *Eligibility and Participation* for the definition of an hour of service).

You will be credited with one year of vesting service for the Plan in any calendar year that you are paid for at least one hour of service, beginning with your hire date.

Vesting schedule

If you completed one or more hours of service on or after January 1, 1989, you will be vested in your RS Plan benefit based on the following schedule:

Years of Vesting Service[1]	Vesting
One year of service	10%
Two years of service	20%
Three years of service	30%
Four years of service	40%
Five or more years of service	100%

To illustrate how this schedule works, assume your monthly benefit is $1,000 at the time you leave your job. Depending on how many years of service you have, your vested accrued benefit would be:

Years of Vesting Service	Vesting	Vested Accrued Benefit
One year of service	10%	$100/month
Two years of service	20%	$200/month
Three years of service	30%	$300/month
Four years of service	40%	$400/month
Five or more years of service	100%	$1,000/month

1 If you previously earned cash balance benefits under this or another employer’s RS Plan, all benefits (both cash balance and traditional) follow this Plan’s vesting schedule until you reach three years of vesting service, at which time you become 100% vested. This is true even if you were previously paid your entire cash balance benefit and are now earning only traditional benefits.

Age 55 vesting rule

If you are actively participating in the Plan (i.e., you are being credited with benefit service) at age 55 or older, then you will be 100% vested in the Plan even if you do not have five or more years of service, except as noted below.

You will not become 100% vested at age 55 or older if:

- Your employer's Plan requires employee contributions and you stop making the required contributions before age 55 (and do not initiate participation again after age 55);
- Your employer's Plan is frozen before you turn age 55 and your employer never resumes participation; or
- You become part of an excluded class of employees prior to age 55 and you never resume participation.

Vesting and your Normal Retirement Age (NRA)

If you are employed by a participating employer on your NRA, then you will be become 100% vested even if you do not have five or more years of benefit service.

Vesting of employee contributions

If you are required to make employee contributions during any period as a participant in this Plan, all benefits derived from your own contributions are always 100% vested.

Vesting and employment with related employers

Employment with the following related employers counts toward vesting service in this Plan:

- An employer that is a member of NRECA but does not participate in the pension programs sponsored by NRECA;
- An employer that is an affiliate of an NRECA member employer that participates in the Plan;
- An employer that was not a member of NRECA and later became a member of NRECA;
- A predecessor employer (another company acquired by or merged with your employer), if elected by your current employer; and
- Any of the above entities of which an employee is a leased employee, if leased employees within the meaning of Section 414(n) of the Code are eligible to participate in an employer's plan.

Vesting as a part-time employee

Upon meeting the eligibility requirements for participation in the Plan, vesting service is credited for part-time employees in the same manner as for full-time employees.

Vesting and employment as part of an excluded class of employees

If you are in an excluded class of employees and subsequently transfer to an eligible class of employees, your employment as a member of the excluded group will count toward the vesting requirements in this Plan.

Vesting of transferred benefits earned under a cash balance benefit formula

If you were not fully vested and transferred from another participating employer with benefits accumulated under that plan's cash balance benefit formula, this Plan's vesting schedule will apply until you reach three years of vesting service, at which time both your accumulated notional account balance and your accrued benefit under the traditional benefit formula will become 100% vested.

Benefit Service

Your years of benefit service are a key factor in how your Plan benefit is calculated. A year of benefit service equals 12 months of Plan participation during which you earn 2,280 hours of service, subject to the following special rules:

- If you became a participant (or if you withdrew or resumed participation) on a date other than January 1, you will be credited with a partial year of benefit service.
- You will earn benefit service only for those months in which you were an active participant. You will be credited with a full month (i.e., 190 hours) of benefit service as long as you earn an hour of service for which you are directly or indirectly compensated for the performance of duties during that month.
- If you retire on or after your NRA (as defined in the Plan) and are actively participating in the Plan when you retire, you will receive a one-time credit of benefit service through the end of the calendar year in which you retire, regardless of your date of retirement. This credit applies only to your first retirement after your NRA.
- If you participated in a plan that was merged or consolidated with the RS Plan, any years credited for benefit service under that plan are counted toward your years of benefit service, unless doing so would result in a duplication of benefits for the same period of service.
- If your employer elects a buyback, then additional years of benefit service may be credited towards your benefit (see the section of this SPD titled *How are My Benefits Calculated?* for more about buybacks). Certain eligibility periods (including the current eligibility period) may be excluded.
- If there are years in which you decline to make employee contributions (if required by your employer), then those years are not counted toward your years of benefit service.
- If you were not working due to disability at some point during your benefit service, this period may count toward your benefit service (see the section titled *Leaves of Absence* for details).

Benefit service as a part-time employee

Upon meeting the eligibility requirements for participation in the Plan, part-time employees are credited with benefit service in the same manner as full-time employees.

Benefit service as a part of an excluded class of employees

You will not receive credit for benefit service while you are a member of an excluded class of employees. To receive credit for benefit service while you are a member of an excluded class of employees, your employer must amend its Plan to provide benefit service credit for such years. If the Plan is not amended to provide such service credit, your final retirement benefit will not include credit for that period.

Top Heavy Plans

Each plan year, the plan administrator will determine whether your Plan is top heavy. A plan is top heavy if more than 60% of the accrued benefits are attributable to key employees. The term “key employee” generally refers to owners of the company and individuals who are corporate officers. If the Plan becomes top heavy, additional benefits for non-key employees may be required. If this occurs, you will be informed. The top heavy minimum contribution will be provided to non-key employees through the RS Plan. Otherwise, the top heavy minimum benefit will be provided through the 401(k) Pension Plan if your employer also participates in that plan.

The law requires specific vesting schedules to be applied to top heavy plans. Here is a comparison of the Plan’s regular and top heavy vesting schedules. If this Plan is top heavy for any year, your vesting percentage would be the greater percentage from either schedule, based

on your years of service. In years when the Plan is not top heavy, the regular vesting schedule, shown in the section titled *Vesting Service*, applies.

Regular Vesting Schedule	
Years of Vesting Service	Vesting
One	10%
Two	20%
Three	30%
Four	40%
Five or more	100%

Top Heavy Vesting Schedule	
Years of Vesting Service	Vesting
One	10%
Two	20%
Three	100%

How Are My Benefits Calculated?

This section contains general information on how your Plan benefit is calculated. It does not address all possible situations that may affect your benefit.

Your traditional RS Plan benefit is calculated based on a formula that uses your years of benefit service and your final average effective salary (FAES).

Other factors can also affect your benefit. For example, you may have worked for other employers that participate in the Plan prior to working for your current employer, you may have transferred between different subgroups within the same employer, or you may have had a period of military service or disability. Your employer could also change or limit the forms of distribution of your future benefit under the Plan.

In addition, the RS Plan provisions or your employer's elections (including the benefit formula chosen by your employer) could be amended, which may affect your past, present, and future benefits; however, no amendment can reduce the benefit that you earned prior to the amendment.

This SPD reflects the provisions currently in effect for your Plan. For a full record of the Plan provisions and employer elections in effect during your benefit service, keep a copy of each SPD you receive during your service with participating employer(s). Your final benefit will be calculated based on all the benefit plans in effect during the specific periods of your employment, including any amendments to those benefits.

Definitions

The following definitions and concepts (presented alphabetically) will help you to understand how your retirement benefit formula is calculated.

Benefit rate

Your Plan's current benefit rate is 1.8% of your FAES. More than one benefit rate may be used to calculate your benefit, such as when your employer has previously changed the benefit rate or when another employer (for which you previously worked) also participates in the RS Plan. The rate shown above is the rate for current benefit determinations as of the date that this SPD was published. Examples provided later in this section demonstrate how the calculation can vary in differing situations.

Benefit reductions

Your employer may choose to reduce your future RS Plan benefit accruals. Any benefit you earned prior to the effective date of the benefit reduction will not be reduced. If your employer elects to reduce your future benefit accruals, you will receive an ERISA 204(h) notice explaining the effect of the benefit reduction on your future accruals.

Buyback

A buyback is a type of amendment that will either:

- Apply a new benefit level (or new tiered benefit levels) to some or all benefit service before the effective date of the amendment;
- Grant additional benefit service for periods of employment before the effective date of the amendment; or
- Both of the above.

Please note that your employer is not obligated to adopt a buyback plan amendment; rather, it is a business decision made by your employer's board of directors.

Several rules affect the years of service eligible to benefit from a buyback. The most important ones are:

- You must be actively employed and participating in the Plan on the date of the amendment to the Plan that provides the buyback;
- You must have repaid any distributions you received from the Plan before the buyback takes place in order to receive benefit credit for those years. You cannot repay a distribution you received on or after your NRD;
- No credit is given for any period during which you declined to make required employee contributions, if applicable;
- The buyback is not applied while you are receiving benefit service through the disability waiver (see the section of this SPD titled *Leaves of Absence)*. However, if the Plan is amended after you return to active employment from a period of disability, then the benefit buyback will be applied for the period of your disability;
- If you are a new employee and have benefit service at a prior employer, the buyback will only be applied to your prior benefit service if your current employer specifies in the amendment that credit will be given; and
- If you are a new employee and do not have any prior benefit service, the buyback would only apply to the future portion of the amendment, if applicable.

Cost of living adjustments

Your Plan benefit will not be adjusted for increases in cost of living unless you elect the Individual Cost of Living Adjustment (Individual COLA) option described in the section titled *Forms of Distribution*.

Effective salary

Your employer has elected **base salary** as the effective salary definition used to determine the retirement benefit you will receive from the Plan. The base salary used to determine benefits under the Plan is the annual base rate of pay in effect on November 15 of the year prior to the year benefits are determined. Base salary is defined as your regular compensation, including:

- Wages from your employer subject to income tax withholding;
- Any amount deferred under a qualified salary reduction arrangement under Sections 125, 401(k) and 457(b) of the Internal Revenue Code; and
- Elective amounts that are not includible in your gross income by reason of Section 132(f)(4) of the Code;

but excluding:

- Any extra, overtime, or bonus compensation;
- Reimbursements or other expense allowances provided under an accountable plan;
- Moving expenses;
- A retainer or fee under a contract;
- Pension, deferred compensation, or retirement allowances; and
- Any amount deferred under a nonqualified defined benefit deferred compensation plan.

For 2022, compensation in excess of $305,000 may not be used to calculate benefits under Federal regulations. The IRS adjusts this figure periodically to reflect changes in the cost of living.

Final average effective salary

Your FAES is either the average of your highest five effective salaries during your participation in the Plan or, if you have been employed and a participant for fewer than five years, the average of your effective salaries for all years of participation.

Required employee contributions

You are not currently required to make after-tax employee contributions to participate in your Plan.

Example of an Accrued Benefit Calculation

This section shows the accrued benefit calculation for a hypothetical employee whose high five effective salaries were based on periods of Plan participation.

To calculate the accrued benefit for a participant, it is necessary to know not only the participant's employment and salary history, but also the historical pension benefit Plan provisions and the elections adopted by the employer(s) for which he or she worked.

These examples are based on hypothetical employment history and are presented for illustrative purposes only. When you receive your benefit, it will be based on your actual employment history and applicable Plan provisions.

Sample employee information and Plan provisions

Date of Hire:	December 18, 2011
Date of Participation:	January 1, 2013
Date of Termination:	December 31, 2021

2013 base salary:	*$65,000
2014 base salary:	*$70,000
2015 base salary:	*$70,000
2016 base salary:	$72,000
2017 base salary:	$75,000
2018 base salary:	$77,000
2019 base salary:	$78,000
2020 base salary:	*$69,000
2021 base salary:	$78,000

The hypothetical December 31, 2021 FAES equals $380,000/5, or $76,000, which is the average of 2021, 2019, 2018, 2017, and 2016 salaries.

**These salaries are not used to calculate FAES because they are not among the five highest salaries needed for the calculation. See the* Definitions *section above for specific details about which years are included in your FAES.*

Adoption agreement effective prior to January 1, 2016:	
Benefit level:	1.0%
Normal Retirement Age:	65
COLA:	none
Adoption agreement effective January 1, 2016:	
Benefit level:	1.7% *(future service only)*

Normal Retirement Age:	62
COLA:	none

Sample benefit calculation

The benefit calculation assumes that the hypothetical participant retires at age 62 and there was an upgrade of NRA for past benefits as of January 1, 2016:

- January 1, 2013 to December 31, 2015:
  $76,000 x 1.0% x 3 (years) = $2,280, payable at age 62, no COLA
- January 1, 2016 to December 31, 2021:
  $76,000 x 1.7% x 6 (years) = $7,752, payable at age 62, no COLA

Thus, the participant's total accrued benefit, payable annually as of December 31, 2021 equals **$10,032**, payable at age 62, without COLA. The actual amount payable will vary based upon the form of payment elected by the participant.

Sample benefit calculation with buyback

In addition to the provisions shown above, if a buyback (defined as an increased formula for a period of prior service) was implemented on January 1, 2020, then this hypothetical participant would instead receive the accrued benefit illustrated below. However, if the recalculated benefit under the buyback provision was smaller than the original benefit, the participant would receive the original benefit. This example assumes there was also an upgrade of COLA for past benefits as of January 1, 2020.

Adoption agreement effective January 1, 2020:		
Benefit level:	*(past and future service, for periods of participation service only)*	1.5%
Normal Retirement Age:		62
COLA:		Applies

- January 1, 2013 to December 31, 2019:
  $76,000 x 1.5% x 7 (years) = $7,980, payable at age 62, with COLA
- January 1, 2020 to December 31, 2021
  $76,000 x 1.5% x 2 (years) = $2,280, payable at age 62, with COLA

Thus, the participant's total accrued benefit, payable annually as of December 31, 2021 equals **$10,260**, payable at age 62, with COLA, provided that the participant was an employee when the COLA provision was adopted.

Annual Benefit Statement

Each year that you are a participant in the RS Plan, you will receive a statement of your benefits, provided you are either an active employee or are still earning benefits under the Plan. The statement will be as of January 1. The information provided in the statement does not reflect any Plan provision changes that may be made by your employer after the date of the statement.

The estimated future benefits shown on your statement will be based on the years of benefit service, your salary history, and your employer’s benefit formula as of the statement date. The statement includes your annual annuity benefit, which is the estimated amount you would receive per year if you stopped working as of the statement date and waited until your NRD to receive your benefits. It also includes:

- Projected annual benefits as of possible future retirement ages and dates, reflecting the default form of payment described later in this SPD; and

- If permitted under your employer's Plan provisions, the single sum cash value of the portion of your benefit eligible to be paid in such form, as of the date of the statement.

Reemployment

This section describes how your benefits are determined if you work for an employer that participates in the RS Plan, terminate employment, and are later employed by the same or another participating employer. Your benefits depend upon the length of your break in service, whether you received benefit payments from your previous employer's Plan, and the form of benefit payment you received, if applicable.

Eligibility Information

When you transfer from one participating employer to another, you begin earning benefits under the new employer's Plan once you meet its eligibility requirements. If you already met the minimum age and service requirement at the time of your reemployment (as described in the section titled *Eligibility and Participation*), then you will become a participant on the date you are rehired. If you are still receiving benefit service from your previous employer when you are rehired, then you will become a participant on the first day of the month after your benefit service from the previous employer ends, provided you've met your new employer's waiting period.

Future Benefits If You Did Not Receive a Prior Payment

If you did not receive a benefit payment from your prior employer's plan after termination, your benefit will be calculated under the 18-month rule as follows:

- If you are reemployed **within 18 months** of your termination by the same or another employer that also participates in the RS Plan, then your final benefit will be calculated based on all your years of service and your FAES.
- If you are reemployed **after 18 months** has passed from your prior termination, then your final benefit will be the sum of the benefits you earned under the plan of your former employer(s) and the benefits you earn under the provisions of this Plan. This means that the benefits earned under your prior employer's plan are added to benefits from this Plan.

Service with your current employer and your prior employer may count toward the vesting service that determines your final benefit. See the section titled *Vesting Service* in this document for details about this Plan's vesting rules.

When You Received a Prior Benefit Payment

If, after your first termination, you began receiving an annuity (or, if permitted by your employer, a combined annuity and single cash payment), your benefit payments will continue after your reemployment. You cannot repay your prior benefit payments and benefit service is not credited for your prior employment. Any benefit you receive after your second termination or retirement will be calculated without regard to your prior period of employment. On the other hand, if you received your benefit as a single cash payment before reaching your NRA (and the payment wasn't part of a voluntary early retirement program elected by your employer), you can repay your benefit if you are rehired by the same or another participating employer. You cannot repay a single cash payment received after your NRA.

If you are eligible to do so but choose not to repay your prior benefit payment upon reemployment, benefit service will not be re-credited for your prior employment. Any future benefit you receive will be based solely on your benefit service and FAES earned after reemployment.

Repaying your single cash payment enables you to receive your full benefit upon your eventual retirement. How your future benefit is calculated depends upon the elapsed time between your

first departure and your rehire date, as described below. When you leave again, your benefit will be either 1) the sum of your restored benefit plus what you earn under the Plan provisions in place during your second employment period; or 2) the benefit based on all periods of service.

To restore your benefit, you must be participating in the RS Plan following reemployment and you must repay the full single cash payment amount with interest. If your single cash payment consisted of benefits from both the traditional and cash balance formulas, you cannot pay back just one portion and not the other. You must pay back the entire amount. You have five years from the later of 1) your rehire date with the same (or a different) participating employer; or 2) the date your employer adopts the RS Plan to repay your benefit.

Repaying Your Previous Benefit Payment

If you received your entire benefit from your prior employer's plan in the form of a single cash payment, you have the option to repay that payment (unless it was received after your NRA, in which case there is no repayment option).

If you decide to repay your benefit, you must do so within five years from the date you are reemployed, or the date your employer adopts the RS Plan, whichever is later. Your repayment schedule will include principal and interest due. The interest rate is based on either 120% of the Federal Mid-term Rate or 5%, whichever is lower. The repayment schedule is not an amortization schedule. Because the Federal Mid-term Rate changes annually, your schedule will provide your payments due only through January 1 of the next year.

If you deposited the benefit payment from your prior employer's plan into an Individual Retirement Account (IRA), then you may be able to use those funds for your repayment, or you may use another source of funds. It is recommended that you seek the advice of a qualified tax professional when deciding whether and how to repay your benefit.

Repayment of traditional benefits

If you repay your prior plan benefit (plus interest, as described above), your future traditional Plan benefit will be calculated based on the 18-month rule as follows:

- If you were reemployed **within 18 months** of your prior termination of employment, your final benefit will be calculated based on all of your cumulative benefit service (under both the former employer(s) plan and this Plan) and your FAES.
- If you were reemployed **more than 18 months** after your prior termination of employment, your prior benefit will be reinstated upon repayment, but your FAES will not be applied to the prior benefit. Instead, the prior benefit will be frozen. Your frozen benefit will be based solely on your benefit service and FAES as of your prior termination date. When you receive your benefit, it will be the sum of the frozen benefit from your prior employment and the benefit earned after your reemployment. While certain Plan amendments made by your employer can affect (and upgrade) your frozen benefit, in general the dollar amount of the frozen portion of your benefit is not affected by these amendments. However, if a buyback is made covering the period of service under your frozen benefit, you will receive the greater of the frozen amount or the buyback benefit.

Leaves of Absence

This section contains general information about how compensated and uncompensated leaves of absence affect your participation in the RS Plan.

If you are on a leave of absence (such as vacation, holiday, sickness, or jury duty) for which you are receiving any type of compensation, your leave of absence will have no effect on your participation in the Plan.

Generally, if you are on a leave of absence for which you are not receiving any type of compensation, you will be withdrawn from participation in the Plan for that period and will not receive benefit service during your absence.

Military Leave

Military leave is any absence from employment because you are called to active duty, including active duty for training, full-time National Guard duty and inactive training. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives individuals who must perform military service certain reemployment and benefit rights as outlined below. See your benefits administrator for information about Plan participation during and after a period of military leave and to obtain information and instructions applicable to your individual circumstances.

Returning to work after military leave

To be entitled to reemployment benefits following completion of uniformed service, you must produce either your DD214 or a certificate of release. Your discharge papers should indicate your discharge was honorable, general, under honorable conditions or uncharacterized. In addition, prior to your leave of absence, you must notify your employer of your intent to return to work following the leave.

If your period of service is 30 days or less, you generally must report to work no later than the beginning of your first scheduled work period after completing your military service, allowing for safe travel home and an eight-hour rest period.

If your period of service is 31 through 180 calendar days, you must apply for reemployment (in writing or orally) no later than 14 days after completing your military service.

If your period of service is 181 calendar days or more, you must apply for reemployment (in writing or orally) no later than 90 calendar days after completing your military service.

If you do not apply for reemployment with your former employer within the timeframes noted above, then you will be treated as having terminated employment on the last day worked before you left for uniformed service. Special rules apply if you incur or aggravate an illness or injury during the period of service.

Benefit service for periods of military leave

If you meet the reemployment requirements after your military leave, your benefits under the RS Plan will be restored as if you were never out on military leave.

Disability Leave

The RS Plan has a special feature that permits you to continue to earn benefit service for certain periods of time when you are unable to work due to a disability; however, this feature does not guarantee any employment rights for disabled individuals. If your employment is

terminated, you will no longer earn additional years of benefit service credit. At that time, you will be eligible to receive the Plan benefit you have earned up until your termination.

There will be an elimination period during which you are required to wait before you receive disability income. While you are receiving compensation from your employer during this period, you are considered an active employee. Generally, the elimination period is either three months or six months, depending on your employer's disability plan. If you do not receive compensation during the elimination period, you will be withdrawn from the Plan. However, if you are eventually approved for disability, you will be retroactively enrolled into the Plan to the withdrawal date and any outstanding costs must be submitted. If you are on an uncompensated leave of absence and are not approved for disability, you will not be eligible to participate in the Plan until you return from your uncompensated leave and begin to receive compensation.

Total disability

Total disability means that the following three conditions are met:

1. Your active employment ceased due to sickness or accidental bodily injury and, as of the last day you stopped working, you are completely unable to perform any duties pertaining to the occupation for which you were employed;
2. You qualify for disability benefits under the provisions of the NRECA Long-term Disability Plan, regardless of whether your employer participates in that Plan; and
3. You and your employer have continued to make all required contributions, as applicable, for the six-month period commencing with the first day of the month coincident with or following the date your active employment ceased.

If your active employment stops as the result of total disability, you will continue to receive vesting service and benefit service until your participation is discontinued because you cease to meet the definition of total disability. You will cease to meet this definition at the time any of the following occurs:

- You attain your NRA, as defined in the Plan;
- You elect early retirement;
- You return to work;
- Your employment terminates (voluntarily or involuntarily);
- Your death;
- Your employer freezes benefit accruals under the RS Plan; or
- The Plan is terminated.

You will continue to receive vesting service and benefit service if you return to work under a rehabilitative provision in your employer's long-term disability plan. If you are on disability and you reach your NRA, your benefit accruals will cease.

When you return to active employment, you will begin to participate in the Plan on the first day of the month coincident with or next following the date you returned to work.

Compensation during disability leave

If you meet the three conditions and are determined to be totally disabled (as defined above), then for purposes of this Plan, you will be considered a disabled, inactive employee and your benefit accruals will continue; however, employee and employer contributions (as applicable based on your Plan's benefit formula) will be waived. Your Plan benefits will be based on your effective salary on the date your active employment ceased, except if your active employment ceased after December 31, 1982 but before July 1, 1990. If your employment ceased within that period, your benefits will be based on an effective salary calculated using the three-year

average of the effective salary in the calendar year in which your active employment ceased and the two consecutive calendar years immediately preceding that year.

For example, *if your active employment ceased on January 1, 1990, the compensation used for calculating your benefits while you are disabled is the average of your effective salaries for 1988, 1989, and 1990.*

Plan amendments during disability leave

If your employer amends the Plan during the first 26 weeks of your disability, the amendment may or may not affect your benefit. During the time you are disabled, your benefit accruals will generally continue (and their cost will be waived) provided that your employer does not amend the Plan to stop crediting future benefits. Refer to the definition of *Benefit Reductions* in the section titled *How Are My Benefits Calculated?* for information about what happens if your employer stops or reduces future Plan benefits.

If you were disabled (as defined in the *Total disability* section above) at the time your employer adopted changes to the Plan's benefit formula, then during the full period of your disability, your benefits will continue to accrue under the benefit formula in effect prior to your disability.

Quasi-retirement during disability leave

If you are on disability and you reach your NRA, your benefit accruals will cease. At this time, you may elect to retire or you may be eligible to quasi-retire (defined in the *Payment Events* section) on all or a portion of your benefit, subject to Plan provisions and your employer's elections.

For more details and a definition of quasi-retirement, see the section of this SPD titled *Payment Events*. Refer to the *Summary of Plan Benefits* for your employer's specific election with respect to the quasi-retirement option.

If you are under 59 1/2 and elect to have any permitted benefits paid directly to you, a 10% premature distribution penalty on the taxable portion of your distribution may apply. A quasi-retirement distribution, if permitted, will not be subject to taxation currently to the extent it is paid in the form of a single cash payment (if permitted) and to the extent you transfer that single cash payment to the 401(k) Plan or to other tax-qualified retirement plans.

Important Note: If you take a distribution from the RS Plan prior to retirement, this may reduce any current or future long-term disability benefits to which you may be entitled. To avoid a reduction in your long-term disability benefits, you may elect to receive a distribution from this Plan as a single cash payment (if permitted under your employer's Plan) and then roll over that distribution to a 401(k) plan in which you are a participant, another employer's qualified retirement plan, or an IRA. However, if you begin to withdraw the funds derived from this rollover, your disability income benefits may still be reduced.

Payment Events

This section contains general information about how various events may affect your benefit payment.

Although the RS Plan is designed to pay you a benefit at your NRD, you are permitted to receive a distribution from the Plan under certain other circumstances, including if you terminate your employment, retire earlier or later than your NRD, quasi-retire (if permitted based on Plan provisions and your employer's elections), or if the Plan is terminated.

Your beneficiaries may receive a distribution from the Plan in the event of your death if you have not started to receive your benefit. Benefits may also be paid if a Qualified Domestic Relations Order (QDRO) requires part of your benefit to be paid to an alternate payee (usually an ex-spouse).

This section describes these payment events. For a detailed discussion of the various forms of payment you may choose for your benefit, review the section titled *Forms of Distribution*. Refer to the *Summary of Plan Benefits* for a list of the Plan provisions and your employer's specific elections as referenced throughout this SPD.

Termination of Employment

You are entitled to receive any vested benefits you have earned from this Plan if you either voluntarily or involuntarily terminate your employment with your employer before you are eligible for retirement.

If you terminate employment, you are entitled to receive only the vested percentage of your benefit. The unvested portion will be forfeited (see the section titled *Vesting Service* for more information about vesting schedules).

You can elect to receive your vested benefit as soon as your employment terminates or delay receiving your benefit until a later date (but generally not later than your NRD, and subject to the required minimum distribution rules in the Internal Revenue Code). See the section titled *Forms of Distribution* for more details on delaying your benefit payment.

If you take your benefit as an annuity, your monthly benefit will be actuarially reduced from your NRD to your annuity start date based on your age at the time your payments begin, as described in the section titled *Early Retirement*.

If all or a portion of your benefit is available to be taken in the form of a single cash payment (subject to Plan provisions and your employer's elections) and you take all or a portion of your benefit in a single cash payment, then your payment equals the present value of that portion of your accrued benefit on the date of payment.

Early Retirement

You can start to receive your benefit as soon as your employment terminates or at a later date that is on or before your NRD.

If you take your retirement benefit as an annuity, your payments will be reduced. Looking backwards from your NRD to the benefit start date you select, the reductions are:

- 1/15 for each of the five years immediately preceding your NRD; and
- 1/30 for each additional year by which your benefit start date precedes your NRD.

Further, your annuity benefit will be actuarially reduced, based on mortality tables and interest factors, for each additional year by which your benefit start date precedes your 55th birthday.

Quasi-retirement

Quasi-retirement is an optional feature under this Plan that your employer may elect to offer. It permits you to elect to receive your benefit while you are still employed but after you have reached your NRA. In addition, if you are still employed as of the first day of the month coincident with or following the day you reach age 70 1/2, you may elect to quasi-retire a second time. See the section of this document titled *Summary of Plan Benefits* for your employer's election with respect to quasi-retirement.

If permitted, your quasi-retirement benefit will be calculated based on the date you select (which must be on or after your NRA) and the portion of your benefit that is eligible for distribution. Subject to Plan provisions, you will continue to earn benefit credit for as long as you continue to work after your quasi-retirement date. When you do retire, you will receive a benefit for the time you worked after you quasi-retired, plus any benefit accrued that was not payable at the date you elected to quasi-retire. Your final benefit accrual will include benefit credit for the entire calendar year in which you actually retire, provided you have not previously received this one-time credit.

If you are under 59 1/2 and receive either a single cash payment paid directly to you (if permitted under your employer's Plan elections) or a monthly annuity, a 10% premature distribution penalty on the taxable portion of your distribution may apply. Please see the section in this document titled *General Tax Information* for more details. If permitted under your employer's Plan, any quasi-retirement distribution you receive will not be subject to taxation currently if the distribution is eligible and you transfer it to any 401(k) plan in which you are a participant or to an IRA.

Retirement

Under the terms of this Plan, you are entitled to receive normal retirement benefits if you retire (i.e., stop working) at your NRA.

Your Plan specifies that you may retire on any day coincident with or following the date you reach age **65**.

You can also choose to continue to work after your NRA and receive delayed retirement benefits from this Plan. However, in general, if you have reached your NRA and then, in any subsequent month or during a four- or five-week payroll period, you do not work at least 40 hours, the Plan will treat you as if you had retired.

Generally, the value of your normal retirement benefit is greater on your NRD than at a later date. Before you decide to delay your retirement while you continue in employment, you should be aware of the specific effect this decision can have on the value of your benefit.

If you plan to receive your benefit in the form of an annuity and you delay receipt of that annuity, there will be no make-up payments once you do retire. The payments that you would have received if you had not continued to work may not be recaptured.

If you plan to receive all or a portion of your benefit as a single cash payment (subject to Plan provisions and your employer's elections) and you decide to delay your retirement, the total dollars you will receive when you do retire may be smaller. This occurs because the single cash payment amount is calculated to be an amount sufficient to fund an annuity starting at your retirement age and lasting for your life expectancy. If you work for additional years and then retire, you will consequently be older at the later date, with a shorter life expectancy. The amount necessary to provide a benefit to you for the rest of your life is lower because the benefit will be provided over fewer years. Depending on the terms of your Plan, in some cases,

the additional years of benefit service credit and pay increases may offset the reduction that results from a shorter life expectancy.

Another factor that will affect your payment is the interest rate. The interest rate used to calculate a single cash payment fluctuates and is determined based on interest rates in the second month preceding the year of payment. Generally, a lower interest rate produces a higher single cash payment.

If you are planning to retire, you can contact NRECA's Personal Investment & Retirement Consulting (PIRC) team at 866.673.2299 (option 6) to assist you with information about your retirement alternatives. In addition, it is recommended that you seek the advice of a qualified tax professional before making a decision about your distribution.

Death

Standard survivor benefit under the Plan

In the event of your death, your beneficiary will receive:

- If you are **married**, a Qualified Pre-retirement Spouse Annuity, based on 50% of the amount you could have received as a Joint and 50% Spouse Annuity if you had terminated employment on the date of your death; or
- If you are **unmarried**, a 10-Year Certain Annuity based on the amount you could have received as a 10-Year Certain and Life Annuity if you had terminated employment on the date of your death.

If you die **before your NRA** and death benefit payments to your beneficiary begin before your NRA, the death benefit described above may be reduced as explained in the preceding section titled *Early Retirement*.

If you are receiving benefit service and die **on or after** reaching the date when you would have been eligible to retire with unreduced benefits (generally, your NRA) but before starting to receive your Plan benefit, then your surviving spouse or beneficiary will instead receive a survivor benefit equivalent to the present value of the vested accrued benefit you would have received had you terminated employment on the day of your death.

If you instead terminate employment after reaching the date when you are eligible for unreduced benefits, then your beneficiary remains eligible to receive the survivor benefit described in the preceding paragraph during the 90-day benefit election period listed on the distribution option form **unless** the 90-day election period lapses and you die having not made an election on time and in good order, in which case your beneficiary will receive:

- If you are **married**, a Qualified Pre-retirement Spouse Annuity based on 50% of the amount you could have received as a Joint and 50% Spouse Annuity if you had terminated employment on the date of your death; or
- If you are **unmarried**, a 10-Year Certain Annuity, based on the amount you could have received as a 10-Year Certain and Life Annuity if you had terminated employment on the date of your death.

Note that if you previously earned benefits under a cash balance benefit formula, your notional account balance will also be paid under the rules of this Plan's standard death benefit. After your death, your notional account balance will be converted into an annuity benefit payable in the form of a Joint and 50% Spouse Annuity, and 50% of that benefit will be paid to your survivor for that individual's lifetime. Other forms of annuity maybe available to your beneficiary. Alternatively, your beneficiary may elect to receive his or her benefit as a single cash payment if permitted under Plan provisions and your employer's elections.

See the section titled *General Beneficiary Information* for guidelines about naming your beneficiary.

Married participants

If you are married at the time of your death and **have already** begun to receive your Plan benefit in a form that provides a death benefit to your spouse, the Plan will provide your surviving spouse with a benefit beginning on the first of the month after your death. The benefit will be determined based on the payment election you made at the time you began receiving benefits.

If you are married at the time of your death and **have not** started to receive your Plan benefit, the Plan will provide your surviving spouse with a benefit beginning on the later of the date of your death or the date you would have reached your NRD. Your surviving spouse may elect to begin payments sooner than your NRD, but those payments may be subject to actuarial reductions as described in the section titled *Early Retirement*.

The benefit will be in the form of a Life Only Annuity, as described in the section titled *Forms of Distribution.* Your surviving spouse may alternatively elect to receive the benefit in the form of a Life Only Cash Refund Annuity or as a single cash payment (if permitted under Plan provisions and your employer's elections). The individual cost of living adjustment may also be added to annuity forms of benefit. See the *Summary of Plan Benefits* section of this SPD for your employer's elections with respect to this Plan's permitted payment options.

If the amount of your surviving spouse's benefit is less than $50, your spouse may elect to receive a payment of $50 per month until he or she remarries, dies, or reaches age 62 (whichever comes first). At that time, any remaining benefit will be determined as described in the section titled *Standard Survivor Benefit Under the Plan*, based on the date the $50 benefit payment commenced.

If you and your spouse die simultaneously, or if your surviving spouse dies within 10 days of your death and you have not started to receive your Plan benefit, your benefits will be paid to your beneficiary as if you died without a spouse.

Unmarried participants

If you are unmarried at the time of your death and you die **after payment of your Plan benefit has started**, then any benefits that may be payable after your death will be determined based on the selections you made on your original distribution option form.

If you are unmarried at the time of your death and have **not begun** to receive your Plan benefit as described in the section titled *Standard Survivor Benefit under the Plan:*

- If your beneficiary's life expectancy is 120 months or less at the time of your death, then he or she will receive the benefit as an equivalent 5-Year Certain Annuity. Where permitted by Plan provisions and your employer's elections, all or a portion of your benefit may be paid as a single cash payment.
- If your beneficiary's life expectancy is more than 120 months at the time of your death, then he or she will receive a 10-Year Certain Annuity or the equivalent as a single cash payment, if permitted under Plan provisions and your employer's elections; however, a single cash payment must be elected no more than 12 months after your death.

General Beneficiary Information

When you enroll in the Plan, you are asked to designate a beneficiary.

If you are not married, you may designate any individual or trust as beneficiary to receive payment from the Plan if you die before you begin to receive your benefit. Unless you marry, your beneficiary will not change until you designate a new beneficiary.

If you are married, federal law requires that your spouse automatically becomes the mandatory beneficiary of your Plan benefit. This is true even if you had previously designated someone else as beneficiary; thus, any beneficiary designations you may have made before you were married will be revoked. You may designate someone other than your spouse as beneficiary only if your spouse agrees and the consent is in writing and is witnessed by a notary public. Your benefits administrator can provide you with the proper forms for this purpose.

The Plan will make payment upon your death to the person named as beneficiary on the latest beneficiary designation you made on the *Beneficiary Designation/Waiver of Qualified Pre-retirement Survivor Annuity Form.* To designate a beneficiary, complete this form and submit it to your benefits administrator, who will enter your election(s) in NRECA's system.

If you do not designate a proper beneficiary or if you designate no beneficiary, payments will be made to the first surviving person in the following order:

1. Your spouse;
2. Your children;
3. Your parents;
4. Your brothers and sisters;
5. The executors or administrators of the last surviving participant or contingent annuitant.

In the event you divorce, you should update your beneficiary information as soon as possible. Even if you divorce, remarry, or rewrite your will, your former spouse may be entitled to benefits after your death unless you update your beneficiary designations.

We suggest that you review your beneficiary election annually at the time of your employer's annual enrollment to ensure it reflects your most current designation.

Minor beneficiary designations

The RS Plan will not make a distribution to a minor beneficiary. If you wish to name a minor child as a beneficiary of your RS Plan benefits, we recommend that you establish the proper legal vehicle, such as a guardianship or conservatorship, as required by the laws of your state. Confirm your state law requirements before you designate a minor as your beneficiary.

Assignment of Benefits

Qualified Domestic Relations Orders

A domestic relations order is a court order that provides for the payment of child support, alimony, or otherwise allocates a portion of your benefits to an alternate payee. An alternate payee is your spouse, former spouse, child, or other dependent recognized in a domestic relations order as having a right to receive all or a portion of your RS Plan benefit. If the court order allocates a portion of your benefits to an alternate payee, the domestic relations order must be submitted to the plan administrator for review. If the domestic relations order meets statutory requirements, it is considered a QDRO and the plan administrator will be obligated by law to comply with its terms.

To meet the requirements, the order must contain the following information:

- Name, address, date of birth, and social security number of both the participant and the alternate payee;
- Correct name of the Plan(s) from which a payment will be made;

- Amount or percentage of your benefit to be paid by the Plan(s), or the manner that the amount or percentage is to be determined; and
- Timing of the payment.

A QDRO cannot require a type or form of benefit that the RS Plan does not otherwise provide. It cannot require the RS Plan to provide increased benefits and cannot require that benefits otherwise payable to an alternate payee under an earlier QDRO be paid to anyone else. An alternate payee may elect any payment option that the Plan provides, except a Joint and Spouse Annuity. A distribution made under a QDRO may be made as soon as possible, as long as an immediate distribution is clearly stated in the QDRO. If your RS Plan benefits become subject to a QDRO, then you, your attorney or your spouse's attorney should contact either your benefits administrator or NRECA for further instructions, QDRO procedures and sample QDRO documents.

We strongly suggest that you submit an updated beneficiary designation as soon as possible if your RS Plan benefits become subject to a QDRO.

Additional assignment information

You may not use this Plan or any other qualified plan as collateral for a loan.

As a general rule, your benefits may not be garnished, subject to certain exceptions (such as if the IRS places a levy on your retirement benefit).

Power of Attorney

The laws of your state govern any power of attorney that you execute for retirement plan payment purposes. Most states have a checklist document describing the steps you must follow in order to give your power of attorney authority over retirement benefits. It is a good idea to specifically reference your retirement plan benefits in your power of attorney if it is otherwise part of the state law. Once a legal power of attorney has been granted, that person may act on your behalf in the fashion you indicate, until it is revoked or you die.

Forms of Distribution

This section will help you to understand the various forms of payment available under the Plan. **It is recommended that you seek the advice of a qualified tax professional before making a decision about your distribution.**

Forms of Payment

Benefits are paid from the RS Plan in one of the following forms**:

- Joint and Spouse Annuity
- Survivorship Annuity
- Joint and Spouse, Life Only, or Survivorship Cash Refund Annuity*
- Single Cash Payment*
- Life Only Annuity
- 10-Year Certain and Life Annuity
- Combined Cash/Annuity*

*Forms of distribution that include a single cash payment are subject to Plan provisions and your employer's current elections, which are shown in the section of this SPD titled *Summary of Plan Benefits*.

**You can add the Individual Cost of Living Adjustment (Individual COLA) Option to any annuity form of payment listed. Refer to the section titled *Individual Cost of Living Adjustment (Individual COLA) Option* for details.

To receive your benefit, you must choose how you would like to receive it (and whether to add the Individual COLA option) on applicable forms provided to you by the plan administrator. If you do not make your elections in writing, your benefits will be paid to you based on the Plan's default form of payment outlined below.

Default Form of Payment If You Are Married

Unless you make another choice in writing, if you are married, your Plan benefit will be paid as a 50% Joint and Spouse Annuity. An annuity is a periodic payment, providing equal monthly payments for your life, and under certain annuity options, for the lifetime of your beneficiary. Accordingly, the 50% Joint and Spouse Annuity will pay you a monthly payment for as long as you live. If you are survived by a spouse, to whom you were married at the time your benefits began, your spouse will receive a monthly payment for the remainder of his or her life equal to 50% of the monthly amount you were receiving at the time of your death.

You may waive the 50% Joint and Spouse Annuity only if your spouse irrevocably consents in writing to the waiver. Your spouse's signature must be witnessed by a notary public. You may revoke any waiver prior to the time benefit payments begin. **Because your spouse participates in these elections, it is very important to inform the plan administrator immediately of any change in your marital status.**

Default Form of Payment if You Are Unmarried

If you are unmarried, your benefit will be paid as a Life Only Annuity, unless you make another choice in writing. This annuity provides a monthly payment to you for as long as you live. All payments stop when you die.

Other Forms of Payment

Whether you are married or not, you may elect any other form of payment offered under the Plan, as described below, subject to certain restrictions.

Alternate Annuity Payments

In addition to the default annuity options described above, you may choose from these other annuity options:

Joint and (100%, 75%, or 50%) Spouse Annuity provides equal monthly payments for your life. After your death, your spouse will receive a percentage (100%, 75%, or 50%) of this amount for life.

Life Only Annuity provides equal monthly payments for your life and terminates at your death.

10-Year Certain and Life Annuity provides equal monthly payments to you for life and in the event you die before the completion of 120 monthly payments (10 years), the balance is payable in monthly payments to an initial beneficiary (called a contingent annuitant). Your contingent annuitant can also elect a single cash payment if the monthly benefit amount is less than $200. If both you and your contingent annuitant die before the completion of 120 monthly payments, the balance is paid in a single cash payment to an alternate beneficiary.

Survivorship Annuity provides equal monthly payments for your life and then after your death, your contingent annuitant, who is someone other than your spouse, will receive a percentage (100%, 75%, or 50%) of your monthly payments for his or her life.

Cash refund option: Joint and Spouse, Life Only or Survivorship

With the cash refund option, if both you and your spouse or contingent annuitant die and the value of your single cash payment at retirement exceeds the total amount of monthly payments actually received by you and your spouse or contingent annuitant, you can elect to have the difference paid as a single cash payment to an alternate beneficiary. This option may be available for all or a portion of your benefit, subject to Plan provisions and your employer's elections, as shown in the *Summary of Plan Benefits* section of this SPD.

If permitted by your employer, you may elect the cash refund option unless the single cash payment value of your benefit is $5,000 or less or your benefits are calculated under the terms of certain predecessor pension plans.

Single cash payment

A single cash payment is a distribution of your vested annuity benefit in one payment. This payment option may be permitted by your employer for all or a portion of your accrued benefit. Check the section of this SPD titled *Summary of Plan Benefits* for availability under this Plan. If permitted, a single cash payment may or may not be a lump sum distribution. A lump sum distribution is defined as a distribution of your entire benefit under all similar plans (e.g., all defined benefits plans) in one year at the time of one of the following four events: termination of employment, death, disability, or attainment of age 59 1/2. If you were born in 1936 or before, your distribution may be eligible for special income tax averaging. It is recommended that you seek the advice of a qualified tax professional before making decisions about Plan distributions and to obtain information about the rules for pension and annuity income.

Cash/annuity combined payment

If single cash payments are permitted under Plan provisions and your employer's elections (see the *Summary of Plan Benefits* section at the beginning of this SPD), you may request that a portion of your benefit be paid in cash and the remaining balance paid as an annuity. The

benefit may be split between the cash and annuity portions in 10% increments, and the amount payable as an annuity must have a minimum cash value of $5,000.

Individual Cost of Living Adjustment (Individual COLA) Option

When you elect your RS Plan benefit, you can also add the Individual COLA option to any of the annuity options listed in the *Forms of Payment* section, including those with the cash refund feature.

Combined with one of the existing annuity options, the Individual COLA option adds inflation protection for your RS plan benefit. Individual COLA allows you (and your surviving beneficiary) to receive annual cost of living adjustments after receiving your first annuity payment.

If you elect Individual COLA, your annuity payments will be automatically adjusted annually based on the consumer price index (CPI-U) measurements that are issued by the Bureau of Labor Statistics of the U.S. Department of Labor. The adjustments:

- Begin one year after your first payment date and then occur on each payment anniversary thereafter;
- Are equal to the average monthly percentage change in the CPI-U for the one-year period beginning October 1 and ending September 30 of the calendar year preceding each payment anniversary;
- Are capped each year at a maximum of 10%; and
- Are paid for by you, rather than your employer, through a lower starting monthly benefit (as compared to a similar type benefit without the added Individual COLA inflation protection).

When you are eligible to receive a distribution, you'll be able to elect the Individual COLA option using the distribution option form. Details appear in the section of this SPD titled *Making Your Election*.

Making Your Election

If you are eligible to receive a distribution for any reason, a distribution option form and guide will be sent to you. These documents contain an explanation of the terms and conditions of the default forms of payment under the Plan as well as a general description of material features of the optional payment types available under the Plan. It is recommended that you seek the advice of a qualified tax professional before making financial decisions related to distributions. In addition, the NRECA PIRC team is available to discuss payment options. To contact a PIRC representative, please call 866.673.2299 (option 6).

The option form and guide will be sent to you at least 30 days but not more than 90 days (the 30/90 day election period) before payments begin. You may change or revoke your election at any time before payments begin. Once you begin receiving benefits in the form you have elected, the election is irrevocable; neither you nor your spouse (if applicable) may change that election.

When you plan to receive your benefit, it is best to make your election and sign your option forms promptly. If you fail to return your option forms in a timely manner, then the default forms of payment or the Plan's survivor benefit may apply, depending on the circumstances. For details, see the sections titled *Death* and *Delaying Your Benefit Payment.*

Making elections as a married participant

You may elect to waive the 50% Joint and Spouse Annuity (with the consent of your spouse) and choose another form of payment during the 30/90 day election period. However, if you want to begin benefit payments before the end of the 30/90 day election period, you may elect to

waive the 30-day period. If you waive the 30-day period, payments may begin no sooner than the end of the seven day period beginning the day after you sign the option form.

Making elections as an unmarried participant

You may elect to waive the Plan's default annuity form of payment and choose another form of payment during the 30/90 day election period. If you prefer to begin receiving benefit payments sooner than 30 days, you may elect to waive the 30-day period. If you waive the 30-day minimum, payments may begin no sooner than the end of the seven day period beginning the day after you sign the option form.

Making elections upon termination and subsequent reemployment

If your employment is terminated (i.e., you have a distributable event as described in the section titled *Payment Events*), you elect to receive your payment by signing your option form, and you are later reemployed, then you may still be eligible to receive your distribution (whether or not you become a participant in the RS Plan upon reemployment) provided you return your option forms in a timely manner. If you have not elected to receive benefits and the 90-day election period has elapsed, you must wait until a distributable event at your new employer before receiving benefits.

Cash payment and treatment of employee contributions

If you made required (after-tax) employee contributions to the Plan, they will be used to provide a portion of your retirement benefit. Alternatively, if Plan provisions and your employer's elections permit distributions in the form of a single cash payment (see the *Summary of Plan Benefits* section of this SPD) and you elect this option, your employee contributions will be distributed to you in a separate check.

How the Value of Your Benefit Affects Your Payment Choices

If the present value of your benefit does not exceed $1,000 following your termination of employment and no amount has been distributed as an annuity, then your entire benefit will automatically be paid to you as a single cash payment. If you are married, your spouse does not need to consent to the single cash payment distribution.

If the present value of your benefit is more than $1,000 and does not exceed $5,000 following your termination of employment and no amount has been previously distributed as an annuity, then your entire benefit will be distributed as a single cash payment. If you are married, your spouse does not have to consent to a single cash payment, but you must notify the plan administrator that you want your payment. If you do not notify the plan administrator, thus delaying your benefit payment, then your benefit will not be distributed until a specified time described below.

If the present value of your benefit is greater than $5,000, then you may elect any form of payment permitted under the Plan with applicable spousal consent if you are married. See the sections of this SPD titled *Forms of Payment* and *Summary of Plan Benefits* for more about the available forms of payment under the Plan and the payment options permitted by your employer.

In addition, if you (or your beneficiary) are entitled to receive benefits in the form of an annuity and the monthly payments as a Life Only annuity would be under $200, then the annuity recipient may elect to receive a single cash payment for the current value of the annuity payments.

Delaying Your Benefit Payment

As noted above, you generally have the right to delay receiving your termination or retirement benefit. You may do this by indicating your choice on your benefit option form. Alternatively, if you do not sign and return your benefit option form before 90 days have elapsed from the later of either the event date or the request date on the option form, then the form will no longer be valid. You may request a new benefit option form and make an election at any time, except if you are re-employed at another participating employer. However, the amount of the distribution will be based on your age and current actuarial factors at the time you request payment.

If the value of your benefit is more than $1,000 and you terminate employment or retire before your NRD, then you may defer receipt of your distribution until any date which is not later than your NRD. If the value of your benefit is more than $1,000 and you retire on or after your NRD, then you may elect to defer receipt of your distribution until the January 1 following your retirement. Such election must be made on your distribution option forms.

Deferring benefits until your NRD

If you terminated employment but have not begun to receive your distribution by the time you reach your NRD, you will be sent another option form to elect your benefit payment. **If you do not return this option form before 90 days have elapsed from the later of the date you reached your NRD or the request date on the option form, NRECA will begin to pay you the applicable default form of benefit.**

In general, if you reach your NRD and do not work at least 40 hours in either a month or during a four- or five-week payroll period, the Plan will view you as being retired, and you must begin receiving your Plan benefit.

For these reasons, if you delay your benefit payment after terminating employment, be sure to maintain a current address with NRECA. Contact your benefits administrator promptly to update any personal information for benefit purposes, including your primary address, mailing address, marital status or legal name.

General Tax Information

If permitted under Plan provisions and your employer's elections (as described in the *Summary of Plan Benefits*), or if required because of your benefit amount (as described in the section titled *How the Value of Your Benefit Affects Your Payment Choices*), you receive a single cash payment from the RS Plan, the taxable portion of the benefit could be subject to 20% tax withholding if you do not roll over that taxable portion to another qualified plan in which you participate (such as the 401(k) Pension Plan) or to an IRA.

If you receive a direct single cash payment from the RS Plan, 20% of the taxable portion of the payment will be withheld for income tax. You may subsequently elect to roll over your payment to a qualified plan or an IRA, but you must complete the rollover within 60 days of the day you received the payment. When you receive a direct single cash payment, you will receive only 80% of your total distribution. If you would like to roll over an amount equal to 100% of your benefit, you may add money from other sources (e.g., savings) to your distribution to make up the 20% that was withheld.

The 20% tax withholding does not apply to a direct rollover. Subject to Plan provisions and your employer’s elections, a distribution of a single cash payment may be made directly from the RS Plan to an IRA or to another qualified plan, including the 401(k) Pension Plan, if you participate (a direct rollover). 100% of any single cash payment, including any after-tax employee contributions (if applicable) will be transferred to the plan or IRA you specify.

Eligible rollover distributions may contain both the taxable and non-taxable (after-tax employee contributions) portions of your payment. Distributions from the RS Plan that are eligible rollover distributions (and are affected by the 20% tax withholding) are:

- Direct single cash payments to the participant, and
- Direct single cash payments to a beneficiary or to an alternate payee under a QDRO.

Distributions that are not eligible for rollover (and therefore not subject to the 20% tax withholding) are:

- Any payment in a series of substantially equal periodic payments made over the life expectancy of the participant or the joint life expectancies of the participant and beneficiary. This includes all RS Plan annuity distribution options, including the Spouse Annuity, if a married participant dies before beginning to receive benefits.
- Any payment in a series of substantially equal periodic payments over a period of 10 years or more. This includes the default form of distribution to the beneficiary of an unmarried participant who dies before beginning to receive benefits.

If you are under age 59 1/2, your payment may be subject to both income tax and an additional 10% penalty on the taxable portion of your distribution(s), unless an exception to the 10% penalty applies.

Exceptions to the 10% penalty

In general, if you receive your distribution as a series of substantially equal periodic payments (an annuity), there is an exception to the application of the 10% penalty.

If your payment is the result of your separation from service in or after the year you turn age 55, an exception to the 10% penalty applies.

An exception also applies if your payment is the result of quasi-retirement (if permitted by Plan provisions and your employer's elections) and you are at least age 59 1/2.

Additional exceptions may apply, depending on your employer’s plan provisions, your beneficiary or disability status, and the form of distribution that you choose.

Overpayments

An overpayment occurs when you (or your contingent annuitant, your beneficiary, or an alternate payee) are paid more than you (or he or she) are entitled to under the terms of the Plan. If an overpayment of retirement benefits is made from the Plan to any of these parties, the Plan is entitled to correct the overpayment by offset of future distributions until the overpayment amount is exhausted or request that it be returned. The Plan may utilize any means that are necessary to ensure that the error (overpayment) is corrected and the Plan is made whole.

You, your contingent annuitant, your beneficiaries, or an alternate payee are obligated to repay, immediately upon request by the Plan, any overpayments (plus interest from the date of the distribution through the date of the request or repayment if later).

The Plan is entitled to offset the overpayment against any ongoing annuity payments to you, your contingent annuitant, beneficiary, or an alternate payee, as applicable.

Where no offset against an ongoing annuity is otherwise possible, the recipient may repay the excess he or she received. If the Plan does not receive repayment, the plan administrator may take affirmative steps to collect the overpayment, plus interest, through any means at its disposal, up to and including reversal of rollovers, collections activity, or legal action, in which case the Plan will be entitled to collection of the overpayment in full, plus attorneys’ fees and costs.

Procedure for Claiming Benefits

This section describes how you present a claim for your benefits.

Pursuant to federal authority related to the Novel Coronavirus Outbreak, the time to file or perfect benefit claims and to appeal a denied claim has been extended. Notwithstanding any other provisions in this section, the Plan will disregard the COVID-19 "Outbreak Period" for purposes of determining the deadline to file or perfect a benefit claim and to appeal an adverse benefit determination. The Outbreak Period begins March 1, 2020 and ends 60 days after the end date of the COVID-19 National Emergency. As of the date of this SPD, the National Emergency has not yet expired.

Benefits will be paid to participants and beneficiaries without a formal claim when a recognized distribution event occurs. As a general rule, a claim for a benefit occurs when there is a dispute with regards to the amount of a payment. All claims for Plan benefits will be subject to a full and fair review. You may appoint a duly authorized representative to assist you at any time, if you provide written notice of such authorization. All communications under this procedure must be sent to:

Retirement Security Plan
c/o Plan Administrator
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Mail Stop IFS 7-300
Arlington, VA 22203-1860

Submitting a Claim

If you feel you are entitled to a benefit you haven't received or you believe the amount of the benefit is wrong, you should submit your request for a claim review to the plan administrator in writing. You should explain the problem and include any information or documents you feel will assist in the review. Initial claims determinations are made by the plan administrator.

After the extended COVID-19 claim and appeal period ends, you (or your beneficiary) have three years to submit a claim, as measured from the earlier of the date that you knew (or had reason to know) that:

- The benefit paid to you was incorrect; or
- Your claim for benefits would have been denied.

If you do not submit your claim within this three-year timeframe, your claim review will be denied.

Claim Determination

The plan administrator will, in most circumstances, provide a decision about your claim within 90 days of receipt. If circumstances require an extension, you will receive written notice prior to the expiration of the initial 90-day period, along with:

- An explanation of the reason(s) for the extension; and
- The date when you will be notified of decision about the claim.

The plan administrator has discretion to determine whether an extension is necessary.

Claim Denial

If your claim is wholly or partially denied as a result of the claim determination process, the plan administrator will notify you in writing of this denial within the time periods described above.

The written explanation will contain the following information:

- The specific reason or reasons for the denial;
- The specific reference to the Plan provisions on which the denial is based;
- A description of any additional information or material necessary to perfect your claim and an explanation of why such material or information is necessary; and
- A description of what steps are necessary to submit your claim for review.

If you are not notified of a claim denial as discussed above, the claim will be deemed denied on the 90th day after receipt. The plan administrator determines whether a claim has been submitted or received and, if so, the date on which it was sent or received.

If you wish to challenge the claim determination, you must proceed with the procedure described in the section titled *Claim Review (Appeal)*.

Claim Review (Appeal)

If your claim has been denied, either in writing or because the 90th day following receipt of your claim has passed, you may submit your claim for review. The I&FS Committee (or their duly authorized delegate other than the individual or entity who performed the initial claim determination) reviews claim appeals. The request for review must be in writing. The procedure is:

- File the request for review no later than 90 days after you receive written notification that your claim has been denied or, if there is no written decision, the 90th day following the date the Plan received your claim. If you or your representative fail to submit a written request for appeal in a timely fashion to the address listed in this procedure, this will bar review of your claim denial by the I&FS Committee, as well as any judicial review.
- Include documents related to the denial of your claim and send any issues and comments in writing. The information you send will supplement the administrative record and should contain all the information you wish to be considered during the review, including relevant documents, records, and correspondence. In preparing your appeal, you may request a copy of pertinent documents (including claims records) that the plan administrator used to make the initial decision.
- Your claim for review must be given a full and fair review. The I&FS Committee will evaluate claim review requests at its regularly scheduled meeting. Or, review will occur by telephone if required to meet the applicable time periods, and this telephone review shall be as effective as if the review was conducted in person. If the review period is not within normal scheduled meeting times or a meeting cannot be held without undue cost and inconvenience, the review period will automatically be extended to 120 days. Claimants and their authorized representative may request an in-person review by the I&FS Committee at their regularly scheduled meeting, provided that the I&FS Committee has the sole and exclusive authority to approve or deny such request, in its discretion.
- The I&FS Committee's decision on appeal will be in writing and will set forth the specific reason(s) for the denial and the specific Plan provisions on which a denial is based. The I&FS Committee's decision on appeal is final.
- Once the I&FS Committee or its delegate renders a final decision in writing, if you want the decision reviewed by a court, that review can only occur after this claims review procedure is complete and you have exhausted your administrative remedies. You must apply for judicial review of the I&FS Committee's decision within one year of the decision date and your review request must be filed exclusively in the United States District Court for the Eastern District of Virginia. A claimant's (or their representative's) failure to seek judicial review in the required venue and within one year of the date the I&FS Committee rendered its final

decision bars judicial review of the claim, including the plan administrator's or the I&FS Committee's determinations.

Statement of ERISA Rights

This section explains your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

As a participant in the Plan described in this Summary Plan Description, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to the rights and protections outlined below.

Receive Information About Your Plan and Benefits

You are entitled to examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

You are entitled to obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may require a reasonable fee for providing you with a copy.

You are entitled to receive an annual funding notice. The plan administrator is required by law to furnish each participant with a copy of this annual funding notice.

You are entitled to obtain a statement telling you whether you have a right to receive a pension at Normal Retirement Age, and if so, what your benefits would be at Normal Retirement Age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

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 their beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $171 per day, not to exceed $1,713 (2022 limit, indexed annually), until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the

qualified status of a domestic relations order, you may file suit in a 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 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, 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.

Amendment and Termination of Your Plan

Your employer has the right to amend or terminate its participation in the RS Plan. This section discusses the rights and responsibilities of your employer if the board of directors elects to either amend or terminate its participation in the RS Plan.

If the Plan is amended, no amendment will permit any part of the Plan assets to be used for any purpose other than to provide benefits for participants or their beneficiaries. No amendment will cause any reduction in your vested accrued benefit or cause Plan assets to be returned to your employer.

Your employer may either withdraw from participation in the RS Plan or continue to operate the Plan, but without further benefit accruals. In order to distribute benefits after Plan withdrawal, your employer must formally terminate their plan using a special process that follows rules described in IRS and PBGC regulations. If the Plan is continued, your benefit will be payable to you when you retire or terminate your employment, or when another distributable event occurs. Your employer will provide further information and instructions in the event of a Plan termination.

401(k) Pension Plan

SUMMARY PLAN DESCRIPTION

as adopted by

JACKSON ELECTRIC CO-OP INC

44-102-001

Effective Date: July 01, 2022

NRECA
America's Electric Cooperatives

Introduction

This document is a Summary Plan Description (SPD) of the 401(k) Pension Plan ("401(k) Plan" or "Plan") sponsored by NRECA. The purpose of this SPD is to summarize the key provisions of the 401(k) Plan. Each participant in the 401(k) Plan is responsible for reading this SPD and related materials completely and for complying with all rules and Plan provisions.

The Federal laws governing the operation of retirement plans are complex. This document is only a summary of the most important provisions of the Plan. It does not discuss some of the more technical aspects of the Plan's operation that may affect you, your right to participate or the amount of benefits available to you. The Plan is operated according to the provisions of the Plan and amendments.

If the terms of this SPD conflict with the terms of the 401(k) Plan document, the Plan document will govern in all cases. In addition, the language in the Plan document gives the I&FS Committee and its delegates (as defined in the section titled *Administrative and Contact Information*) discretionary authority to determine eligibility for benefits or to interpret the terms of the Plan.

If you have questions or you do not understand any part of this SPD, contact your local benefits administrator (BA) or the plan administrator. The plan administrator's name and address can be found in the section titled *Administrative and Contact Information*.

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Administrative and Contact Information

Benefits Administrator

Your co-op's BA is the person who has on-site plan administrator responsibilities for your employer. Your BA is your primary point of contact for any questions concerning the operation and administration of the 401(k) Plan. However, it is recommended that you seek the advice of a qualified tax or financial professional before making decisions about your 401(k) Plan, particularly decisions about Plan distributions.

The BA of your 401(k) Plan is:

Benefits Administrator
JACKSON ELECTRIC CO-OP INC
P.O. BOX 1189,
EDNA, TX 779571189

Employer Identification Number: 74-0708876

Plan Sponsor

The plan sponsor is a designated party that sets up a retirement plan, such as the 401(k) Plan, for the benefit of the adopting employers and their eligible employees.

The plan sponsor of the 401(k) Plan is:

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

Employer Identification Number: 53-0116145

NRECA, as the 401(k) Pension Plan sponsor, is the only body authorized to voluntarily terminate the 401(k) Plan; however, your employer may cease participation in the Plan with appropriate advance notice to the plan administrator and employees. For more about these events, see the section titled *Amendment and Termination of Your Plan*.

Plan Administrator

The plan administrator is responsible for the administration and operation of the 401(k) Plan and acts in the interest of the Plan's participants. The plan administrator is designated as the agent for legal matters related to the 401(k) Plan and works with your co-op to ensure that the Plan meets all government regulations. Any action against or in connection with the Plan, NRECA, or any fiduciary or Named Fiduciary of the Plan must be filed exclusively in the United States District Court for the Eastern District of Virginia. Legal process may be served on the plan administrator at the following address.

The plan administrator of the 401(k) Plan is:

Senior Vice-President
Insurance and Financial Services
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Arlington, VA 22203-1860
703.907.5743

Employer Identification Number: 54-2072724

Plan Trustee

The assets of the 401(k) Plan are held in trust by a trustee that has been designated to invest Plan assets, at the direction of investment managers, for the benefit of participants and their beneficiaries.

The trustee of the 401(k) Plan is:

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

Insurance & Financial Services Committee

The named fiduciary of the 401(k) Plan is the Insurance and Financial Services Committee (the I&FS Committee), whose members are appointed by the president of the NRECA board of directors. This committee has the central fiduciary responsibility for the plan and is vested with the discretion to select providers for the plan, including the administrator, investment managers and trustee. The I&FS Committee delegates authority to various entities and individuals to carry out required plan operations and then actively monitors its delegates in order to help ensure compliance with complex federal laws and regulations governing employee benefit plans. The I&FS Committee has the exclusive discretion to interpret the terms of the plan and to determine eligibility for benefits.

Plan Number

The Plan number assigned by the Plan Sponsor is 444.

General Plan Information

Your employer, in cooperation with NRECA, has established the 401(k) Plan at your co-op to provide a retirement plan for the benefit of its employees and their beneficiaries. The 401(k) Plan is what is known as a defined contribution plan; it is qualified under all applicable sections of the Internal Revenue Code of 1986 (the Code) and Treasury Regulations. The 401(k) Plan operates on a calendar year basis during the 12-month period beginning on January 1 and ending on December 31.

General Plan Contributions

The Plan is a money purchase pension plan with a special salary deferral feature that allows you to contribute to your account on a pre-tax basis. This means that you will be able to make contributions before federal and, where applicable, state taxes are withheld. This will enable you to save more for retirement with minimal impact on your take-home pay. Contributions to the Plan will begin after you meet the eligibility requirements for participation. The contributions accumulate with investment earnings until you or your beneficiaries are eligible to withdraw your benefit (upon retirement, disability, termination or death).

The benefit available to you at retirement depends on the amount(s) contributed to the Plan and on the investment results obtained over the term of your investment. There is no guarantee as to the amount of your benefit available at retirement. When you receive your distribution(s), you may be liable for income tax on the taxable portion of your account.

The benefits available under the 401(k) Plan are designed to supplement any benefits available to you under Social Security and any other retirement plans in which you may participate. The Plan should be considered as one source of retirement security along with your other personal savings and investments.

Roth Contributions

You are also able to make after-tax Roth elective contributions. Your Roth salary deferrals are taxed at the time you make the contribution. Roth contributions and the earnings attributable to them are not taxed when they are distributed to you if certain requirements are met. See the section titled *Payment Options* for more information about Roth distributions.

Employer Contributions

Your employer will contribute to the Plan on your behalf after you meet the eligibility requirements for employer contributions. As with your own salary deferrals, your employer contributions will be held in an account under your name until you are eligible to withdraw your benefit. You do not pay income tax on these contributions when they are made, but you may be liable for income tax on the taxable portion of your account when the money is distributed to you.

Voluntary Employee Contributions

In addition to your pre-tax salary deferrals and Roth elective contributions, you may make additional after-tax contributions to the Plan, known as voluntary employee contributions. Since these contributions are made on an after-tax basis, they are not taxed when they are distributed to you. Generally, however, earnings on voluntary employee contributions are taxed upon distribution. Your employer will not make a corresponding matching or base contribution for your voluntary contributions.

For More Information

A more thorough discussion of how your account is maintained and operated is provided in the sections to follow. If you have questions specific to your 401(k) Plan account or about the Plan in general, please contact your BA. See the section titled *Administrative and Contact Information* for details.

Summary of Plan Benefits

Effective date of plan	08/01/1993
Employer Plan amendment date	07/01/2022
Employer Identification Number (EIN)	74-0708876
Plan number	002
Eligible class of employees	All Employees
Excluded class of employees	Part-time, Temporary/Seasonal Employees who have not completed a year of eligibility service
Eligibility waiting period for employee contributions	1 month (First of the month on or next following)
Eligibility waiting period for employer contributions	1 month (First of the month on or next following)
Normal Retirement Date (NRD)	Age 62
Plan type	401(k) Plan
Compensation used for employer contributions	Full salary
Compensation used for employee elective contributions	Full salary
Compensation used for voluntary employee contributions	Full salary
Safe Harbor Plan design	No
Employer base contribution	1% of compensation
Employee required contribution for base contribution	1% of compensation

After-tax voluntary employee contributions allowed	Yes
Roth contributions	Yes
In-service withdrawals (later of Age 59 1/2 or NRD)	Yes
Hardship withdrawals	Yes
Loan provision	Yes
Number of loans available	Four
Loan fees	$100 per loan
Contributions during initial disability period	No
Investment of contributions	Employee designates
Frequency of investment changes	Daily
Self-Directed Brokerage Account (SDBA)	Yes

Eligibility, Participation and Vesting

This section contains general information about how you qualify to participate in the 401(k) Plan and when you can begin making and receiving contributions.

Eligibility

Eligible class of employees

To be eligible to participate in the 401(k) Plan, you must be in the following class of employees:

All employees of your employer who have met the age and service requirements

If you have questions about the eligible class(es) of employees, please see your BA.

Excluded class of employees

Your employer excludes certain classifications from participation in the Plan. All employees in the following job classifications are not eligible to participate in the Plan:

- Part-time, Temporary and Seasonal Employees who have not completed one year of eligibility service

Age and Service Requirements

To become a participant in the Plan, you must meet certain minimum service requirements. There are no minimum age requirements to participate in the Plan. This means that you must be a member of the group of eligible employees described above and you must work for a minimum length of time.

You become a participant on the first day of the month coincident with or next following the date on which you meet the minimum service requirements. The service requirements are based on either hours of service or one year of eligibility service (called the 1,000 hour rule). Your employer's specific service requirements are described later in this section.

Your employer will keep track of your service and will enter you into the Plan on the first of the month coincident with or next following the date you complete either the minimum hours of service (if applicable to your Plan) or 1,000 hours of service.

Hours of service

Hours of service are any hours for which you were paid your salary. This includes paid vacation, sick leave, holidays, jury duty and military service. You are also credited with hours of service for any uncompensated leave of absence, as long as you return to work at the end of such leave.

The 1,000 hour rule

Under the 1,000 hour rule, service is calculated during a computation period defined as either:

- Your first 12 consecutive months of employment, beginning on the date you complete an hour of service, or
- A subsequent calendar year (if you do not perform at least 1,000 hours of service during your first 12 consecutive months of employment).

Therefore, under this rule, if you do not work at least 1,000 hours in your first 12 months of employment, the next 12-month period used to determine your eligibility is the calendar year (January 1 through December 31) after the year in which you first began to work for your employer. It is not necessary to be employed each and every day of the eligibility computation period in order to satisfy the 1,000 hour requirement.

***For example**, if you began work on May 10, 2022 and you did not perform at least 1,000 hours of service by May 9, 2023, the measurement year changes to the calendar year from January 1, 2023 to December 31, 2023. If you perform at least 1,000 hours of service during 2023, you will have one year of eligibility service on December 31, 2023 and would be eligible to participate in the Plan on January 1, 2024.*

Employer contributions and employee contributions

You will meet the minimum service requirements on the first day of the month coincident with or next following the date you have performed at least 84 hours of service in one full calendar month.

***For example**, if you were hired on May 10, 2022, performed at least 84 hours of service between May 10, 2022 and May 30, 2022 and then performed at least 84 hours of service between June 1, 2022 and June 30, 2022, you would be eligible to participate in the Plan on July 1, 2022, because you must perform 84 hours of service during one full calendar month to be eligible to participate.*

On the other hand, you may be eligible to participate in the Plan if you meet the 1,000 hour requirement. The 1,000 hour requirement applies only if:

- You do not perform at least 84 hours of service in at least one full calendar month, and
- You perform at least 1,000 hours of service in the 12-month period beginning on the date you perform your first hour of service or in a subsequent calendar year.

***For example,** if you were hired on May 10, 2022 and you did not perform at least 84 hours of service in any full calendar month, but performed at least 1,000 hours of service by May 9, 2023, you would be eligible to participate in the Plan on June 1, 2023.*

Additional Eligibility Issues

Reemployment

For prior participants

If you are a participant in the Plan, terminate your employment, and are later rehired by an employer that participates in the Plan, you will become a participant either on the day you are rehired or when you begin making employee contributions, if applicable.

For previously non-participating employees

If you satisfied the 1,000 hour rule requirement but did not become a participant in the Plan, then terminate employment and are later rehired by an employer that participates in the Plan, you may be eligible to participate in the Plan on the first day of the month following the date you are rehired.

Employment with related employers

Employment with the following related employers counts toward eligibility service in this Plan:

- An employer that is a member of NRECA and does not participate in the NRECA pension programs;
- An employer that is an affiliate of an NRECA member employer that participates in the Plan;
- An employer that was not a member of NRECA and later became a member of NRECA;
- Any of the above entities of which an employee is a leased employee, if leased employees within the meaning of Section 414(n) of the Code are eligible to participate in an employer's plan.

Employment as part of an excluded class of employees

If you are in an excluded class of employees and later become part of an eligible class of employees, your employment as a member of the excluded group will count towards the service requirement for participation in this Plan.

Part-time, seasonal or temporary employees

Eligibility service for part-time, seasonal or temporary employees is credited in the same manner as service for full-time employees. If your employer has elected an eligibility period of one, three or six months and you work part time, you may not meet eligibility requirements on a monthly basis, but may still be eligible to participate in the Plan if you perform more than 1,000 hours of service in a year. Your employer will calculate your hours of service and will offer participation at the appropriate time.

Breaks in service

If, during your initial eligibility period, there is a calendar year in which you are credited with fewer than 501 hours of service, you will be deemed to have incurred a break in service. If you again perform service for a participating employer, then the day you begin working will be treated as the first day of a new eligibility computation period. Any service you had prior to the year in which you were credited with fewer than 501 hours of service will be disregarded for the purposes of meeting the service requirement for eligibility.

This break in service rule applies only during the initial eligibility period.

Vesting

The term “vested” refers to the percentage of your 401(k) account that you own. You are always 100% vested in your 401(k) Plan account; however, your account is subject to investment gains and losses, and there is no guarantee of what your account balance will be at any future date.

Contributions To Your Account

This section explains how contributions to your account are calculated using the Plan's salary definition and the contribution formula elected by your employer.

Compensation (Salary)

Your compensation, or salary, refers to the amount you earn in wages as an employee of JACKSON ELECTRIC CO-OP INC during a plan year. This figure is used to determine permitted 401(k) Plan contributions. Salary includes amounts that are actually paid to you, except where certain deferred compensation amounts are included in your salary as required by the IRS. For 2022, compensation in excess of $305,000 may not be used to calculate benefits under Federal regulations. The IRS reviews this figure annually and adjusts it periodically to reflect changes in the cost of living.

Your employer has elected **full salary** as the amount used to determine the permitted contribution as allowed under the Plan for the following contribution types:

- Employer contributions;
- Pre-tax employee contributions;
- After-tax voluntary employee contributions.

Your **full salary** is defined as your regular compensation, including:

- Wages from your employer subject to income tax withholding;
- Any amount deferred under a qualified salary reduction arrangement under Sections 125, 401(k) and 457(b) of the Code;
- Elective amounts that are not includible in your gross income by reason of Section 132(f)(4) of the Code;
- Differential wage payments, defined under Section 3401 of the Code; and
- Wages paid by the later of two and a half months after your termination of employment or the end of the calendar year of your termination;

but excluding:

- Reimbursements or other expense allowances provided under an accountable plan;
- Fringe benefits;
- Moving expenses;
- Welfare benefits;
- Pension, deferred compensation or retirement allowances; and
- Any amount deferred under a nonqualified defined benefit deferred compensation plan.

Contribution Types

Employer Base Contributions (employee contribution required)

Your employer makes an ***Employer Base Contribution*** equal to 1% of your salary. However, in order to receive the Employer Base Contribution, you must first make a Required Employee Contribution in the amount of 1% of your salary. If you do not make the Required Employee Contribution, you will not receive the Employer Base Contribution. Amounts you contribute in excess of the required employee contribution do not affect the employer base contribution.

For example*, if your salary is $25,000 per year and you contribute 1% of your salary or $250.00, your employer would contribute $250.00 or 1% of your salary.*

Voluntary employee contributions

You may make after-tax voluntary employee contributions, in addition to your other elective contributions, up to the limits imposed by the Code. Your employer does not make any employer contribution based on the amount you contribute in voluntary employee contributions.

True-up contributions

True-up contributions are employer contributions that were not fully contributed to a participant's account during the Plan year or period of participation, which must be funded to ensure that the participant receives the full employer contribution amount. True-up contributions must be made no later than the employer's annual federal tax return filing deadline (including extensions).

Roth Elective Contributions

Because your employer has adopted the Roth 401(k) option under the 401(k) Plan, you may also elect to make Roth after-tax contributions in addition to traditional pre-tax contributions.

Contribution limits apply to your **combined** Roth 401(k) after-tax and traditional 401(k) pre-tax deferrals. In 2022, participants can contribute a total of $20,500 in Roth and traditional pre-tax deferrals to their 401(k) Plan(s). The limit is $27,000 if you are age 50 or older during the year of contribution. The IRS adjusts these figures periodically to reflect changes in the cost of living.

The investment options and allocation percentages you choose for your future traditional 401(k) contributions will also apply to your Roth elective contributions. If your employer provides a matching contribution, your Roth 401(k) contributions and traditional 401(k) contributions will be matched in the same manner. Contributions, withdrawals, earnings and losses will be separately tracked by NRECA as record keeper.

Contributions After Your Normal Retirement Date

Contributions to your account will continue as long as you are an eligible participant, regardless of your age.

Contributions From Other Sources

The 401(k) Plan will accept an eligible rollover distribution as a contribution to this Plan.

You may roll over an account from a former employer as long as the plan of your former employer is a qualified plan that has operated in compliance with all of the federal laws governing retirement plans. A rollover may come from your former employer’s retirement plan that is qualified under sections 401(a), 403(a) or 403(b) of the Code or from a governmental 457(b) plan. In addition, you may roll over the taxable portion of an IRA, but not contributions that would not be otherwise taxable to you if distributed from your IRA. **It is recommended that you seek the advice of a qualified tax or financial professional before making a decision about rollovers.**

You may roll over a distribution from a qualified retirement plan into this Plan any time after you start to work, including before you meet the eligibility requirements for participation. There are three ways to roll your money into this Plan:

- A **direct rollover** from your former employer’s plan to this Plan. A direct rollover occurs when your former plan forwards your distribution directly to this Plan. After-tax employee contributions can also be directly rolled over.
- A rollover from a **traditional IRA**. After-tax employee contributions from a traditional IRA or Roth IRA account cannot be rolled over into this Plan.

- An **indirect rollover**. If you receive a distribution from your former employer's plan or an IRA, as opposed to a direct rollover to this Plan from either your former employer's plan or your IRA, you may deposit the taxable portion of your distribution in this Plan, provided you do so within 60 days of receiving the money from your former plan. You must deposit the check from your former employer's plan or your IRA, not your personal check.

This Plan permits only **direct** rollovers from a former employer's Roth 401(k). Your employer is not required to offer the Roth option in this Plan in order for you to roll over your Roth 401(k) balance from a former employer's plan. You may not roll over a Roth IRA distribution into this Plan.

Rollovers do not count towards your annual contribution limit. See the section titled *Contribution Limits* for details about the contribution limits in this Plan.

If you are also a participant in the Retirement Security (RS) Plan and you terminate your employment, you may roll over your RS Plan benefit into this Plan.

In addition, if your 401(k) Plan account balance is at least $5,000 and you terminate your employment, if you leave your account balance in the 401(k) Plan you are permitted to roll over a distribution from an eligible retirement plan.

Contribution Limits

This section summarizes the contribution limits specified by the Treasury Regulations and the Code. Several tests must be performed to make sure the deposits to your Plan account do not exceed these limits, which are periodically adjusted for inflation, usually annually.

All Employees

Salary deferrals

Under Section 402(g) of the Code, the maximum 401(k) contribution (pre-tax and Roth) that a participant can make is $20,500 (the 2022 limit, indexed annually).

You can also make an additional catch-up contribution of $6,500 (2022 limit, indexed annually) if at any time during the plan year you are at least 50 years old.

If you participate in more than one 401(k) plan during the plan year, all of your pre-tax and Roth contributions (if applicable) to all plans will be aggregated towards the limit.

Annual contribution limit

Under Section 415(c) of the Code, all employer and employee contributions made to your retirement plan accounts during a calendar year are limited to the lesser of 100% of your salary or $61,000 (2022 limit, indexed annually). Employee required contributions to the Retirement Security (RS) Plan (or any other defined benefit plan) and contributions to any other defined contribution plan also apply toward this annual limit. Your annual contribution limit is the sum of:

- Current year contributions made by you or your employer to this Plan;
- Current year contributions to any other defined contribution plan in which you are a participant; and
- Your contributions to a defined benefit pension plan.

Your annual contribution limit is affected only by current year contributions made on your behalf by you or your employer to this Plan, to any other defined contribution plan and to a defined benefit pension plan. A rollover will not affect your annual contribution limit.

Highly Compensated Employees

You are a highly compensated employee for 2022 if you earned more than $130,000 during 2021 or if you own at least 5% of your employer's business during the current or prior year. This amount is adjusted annually for inflation, if needed. Under the nondiscrimination rules of Section 401(k) and Section 401(m) of the Code, highly compensated employees may not contribute more than a certain percentage of the amount contributed by non-highly compensated employees.

To determine if this has occurred, your Plan will be tested annually using methods described by the IRS. If the highly compensated group’s actual deferral percentage is greater than the maximum percentage allowed under IRS rules, the excess contributions must be refunded to highly compensated employee(s). If you are a highly compensated employee and you must receive a refund, you will be notified.

Top Heavy Plans

Your plan administrator is responsible for determining whether your Plan is top heavy for each Plan year. A plan is considered top heavy if more than 60% of the account balances are attributable to key employees. The term “key employee” generally refers to owners of the company and individuals who are corporate officers. If the Plan becomes top heavy, certain

requirements may apply (such as additional benefits for non-key employees). If this occurs and your employer participates in both the RS and 401(k) Plans, the top heavy minimum contribution will be provided to non-key employees through the RS Plan. You will be notified if this takes place.

The law requires specific vesting schedules to be applied to top heavy plans. Since all contributions under your Plan are always 100% vested, the top heavy vesting requirements are automatically satisfied.

Leaves Of Absence

This section contains general information about compensated and uncompensated leaves of absence and how they affect your participation in the 401(k) Plan.

If you take a leave of absence (such as vacation, holiday, sickness or jury duty) for which you are receiving any type of compensation, your leave of absence will have no effect on your participation in the Plan.

Generally, if you are on a leave of absence for which you are not receiving any type of compensation, you will be withdrawn from participation in the Plan for that leave period. Special rules apply to unpaid leaves of absence for purposes of uniformed service.

Military Leave

Military leave is any absence from employment because you are called to active duty, including active duty for training, full-time National Guard duty and inactive training. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives individuals who must perform military service certain reemployment and benefit rights as outlined below. See your BA for information on plan participation during and after a period of military leave and to obtain information and instructions applicable to your individual circumstances.

Contributions during military leave

There is no effect on your 401(k) Plan benefits if you use paid leave. If your employer pays you differential pay, you can make up contributions for the difference between what your employer paid you while you were on military leave and what your salary would have been if you had not been on leave. If you take an unpaid leave of absence, contributions to your 401(k) Plan account will be suspended. Upon your return to employment, you and your employer are able to make up any contributions missed during this absence, if applicable.

Starting from your date of reemployment, the deadline for you to make up the elective deferrals or after-tax contributions is three times the period of uniformed service that gave rise to the USERRA rights, generally no more than five years. For example, if you served in the military for one year, you would have three years (three times the service period) in which to make up the deferrals or contributions. If your employment is terminated for any reason, voluntarily or involuntarily, the make-up period will end at the date of your termination.

Loans during military leave

If your employer's Plan permits loans and you have an outstanding loan during your military leave of absence, you may request a loan repayment grace period. This grace period can begin on the date you begin performing uniformed service. You will not be required to make loan repayments during the grace period, but interest will continue to accrue during your military leave of absence. When you return to work, a new repayment date will be determined using the repayment date under the original term of the loan plus the period of uniformed service. You must repay your loan no later than this new repayment date.

Distributions during military leave

Generally, military service is considered a leave of absence and not a termination of employment. Distributions cannot be made unless you terminate employment. If you terminate employment, receive a distribution and are then subsequently reemployed with the same employer, you may be able to roll your distribution back over to the 401(k) Plan, provided that all applicable rollover rules are satisfied. See the section of this SPD titled *Contributions From Other Sources* for a discussion of rollover rules.

Returning to work after military leave

To be entitled to reemployment following your completion of uniformed service, you must produce either your DD214 or a certificate of release. Your discharge papers should indicate that your discharge was honorable, general, under honorable conditions or uncharacterized. In addition, prior to your leave of absence, you must notify your employer of your intent to return to work following the leave.

If your period of service is 30 calendar days or less, you must report to work no later than the beginning of your first scheduled work period after completing your military service, allowing for safe travel home and an eight-hour rest period.

If your period of service is 31 through 180 calendar days, you must submit an application for reemployment (written or oral) no later than 14 calendar days after completing your military service.

If your period of service is 181 calendar days or more, you must submit an application for reemployment (written or oral) no later than 90 calendar days after completing your military service.

If you do not submit an application for reemployment with your former employer within the timeframes noted above, then you will be treated as having terminated employment on the last day worked before you left for uniformed service. Special rules apply if you incur or aggravate an illness or injury during the period of service.

Disability Leave

If your active employment stops as a result of your disability as defined under the NRECA Long-term Disability Plan, you are subject to certain contribution and withdrawal conditions under the 401(k) Plan.

Contributions while disabled

Generally, as long as you are receiving compensation through your employer, you can make salary deferrals to your 401(k) Plan. Salary deferrals must stop when you begin to receive long-term disability income.

Your employer will not make any contributions if you are disabled.

Contributions during periods of rehabilitation

If you return to work on rehabilitative status, as approved by Cooperative Benefit Administrators, your employer and your physician, employer and employee contributions will be made during your period of rehabilitative status based on the compensation earned through your employer, subject to required or matching contributions, if applicable.

Loans while disabled

For information about loans during disability, see the section titled *Loans* located in the *Payment Events* chapter of this SPD.

Disability withdrawals

If you should become disabled, you will be entitled to receive all or a portion of your Plan account balance. Please see the section titled *Payment Events* for details on disability withdrawals.

Investments

This section contains general information about the rules that govern the investment of your 401(k) Plan account.

The 401(k) Plan is a retirement plan as described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA) and the regulations issued thereunder. Accordingly, any fiduciary within the meaning of Section 3(14) or 3(21) of ERISA shall not be liable for any loss or by reason of any loss or by reason of any breach, that results from a participant exercising control over investment of his or her account. This includes any investments made using the established procedures and based on instructions from you, via telephone, internet or other approved method, that are believed to be genuine, to the extent that you exercise control over the assets in your account as described in Section 404(c) of ERISA.

This Plan is an individual account plan. This means that all employer and employee contributions are maintained in separate accounts for each participant. Each account is credited with its share of contributions and investment gains and losses.

Your employer is responsible for submitting employee contributions to the Plan as soon as the contributions can be separated from their general assets. These contributions are credited to your account on the evening of the third business day after NRECA receives actual payment for the investment and all information required to process the deposit. Your employer and employee contributions to the Plan are invested in one or more of the available investment funds, as specified by you.

Investment Options

Once you enroll in the Plan, you may choose to invest your contributions and any contributions made by your employer (if applicable to your plan) in any of the available investment funds.

The Plan offers a variety of investment options. Investment and disclosure information, including detailed profiles of all investment options, can be found online at cooperative.com/401kInvestments and in the *Participant Fees Annual Disclosure Statement*, which is located on cooperative.com at *My Benefits > Education & Resources > Retirement Plan Documents.* These resources provide important information to help you compare and choose between the investment options in your Plan. They provide the name of the designated investment manager for each investment option, general information about operation of the Plan, expense information and a chart comparing the performance and other features of each investment option. In addition, the plan administrator will provide you with an update if, for example, investment options are added, removed or changed during the year.

To assist you, NRECA provides investment education and retirement planning on behalf of participants in the 401(k) Plan. Assistance is available from NRECA's Personal Investment & Retirement Consulting (PIRC) team, either by phone at 866.673.2299 (option 6), by email pirc@nreca.coop or in writing at:

NRECA PIRC; IFS 8-306
4301 Wilson Blvd
Arlington, VA 22203-1860

However, NRECA does not provide investment, legal or tax advice. It is recommended that you consult with your own legal, tax, or investment advisers before making specific decisions.

Investment performance: variable return investments

Each of the Plan's current investment options is a variable return investment, meaning it does not have a fixed or stated return. The table in the *Participant Fees Annual Disclosure Notice*

shows how these options have performed over time and allows you to compare them with an appropriate benchmark for the same time periods. An investment's past performance is not necessarily an indication of how it will perform in the future. Your investment in these options could lose money.

Commodity pool operator disclosure notice

The Commodity Exchange Act regulates financial futures, including futures contracts used by stock and bond funds for hedging purposes. Under the Commodity Futures Trading Commission (CFTC) regulations, any investment fund that invests in futures contracts is potentially classified as a commodity pool, and any person operating such a commodity pool could be required to register and be regulated as a commodity pool operator by the CFTC. However, statutory exclusions are available for certain entities.

Periodically, the NRECA Insurance & Financial Services Committee may pursue trades of futures or options on futures on behalf of the 401(k) Plan. Because the committee, as named fiduciary of the plan, has claimed an exclusion from the definition of a commodity pool operator under the Act, the committee is not subject to registration or regulation as a pool operator under the Act. This information is disclosed above is a requirement of the statutory exclusion pursuant to 17 CFR § 4.5(c)(2).

Valuation

All 401(k) Plan investment options are priced daily for each day in which the New York Stock Exchange (NYSE) is open for business. Each fund's share price is calculated at the close of business (usually 4 pm ET) on days when the NYSE is open. Valuations may not be performed on any business trading day that shares cannot be valued due to the inability of NRECA personnel to service the Plan because of circumstances beyond their control, such as severe weather or an Act of God, even if the NYSE is open for business.

Voting rights

The designated investment managers will exercise any voting or other rights associated with ownership of the investments held in your Plan account.

Expenses

The Plan is self-administered and does not charge participants or beneficiaries separately for administration services, including recordkeeping, legal and accounting services. Instead, the Plan charges expenses to your account through the annual operating expenses of each investment option as described in your *Participant Fees Annual Disclosure Notice.* The expense ratios therein are the total annual operating expenses for each investment option, which reduce the return of each option. There are no shareholder-type fees or Plan-level expenses other than the individual fees described in the disclosure and elsewhere in this document.

The cumulative effect of total annual operating expenses can substantially reduce the growth of your retirement savings. Visit the Department of Labor's website at www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-retirement-plan-fees for an example showing the long-term effects of fees and expenses. This site also discusses the many factors to consider when choosing your investment options, including whether a given choice, along with your other investments, will help you achieve your retirement goals.

Qualified Default Investment Alternative

If you do not choose investment fund(s) when you enroll in the Plan, any contributions to your account will automatically be invested in the 401(k) Plan's Qualified Default Investment

Alternative (QDIA). The QDIA for the 401(k) Plan is the Target Date Portfolio (TDP) investment funds, a group of funds that invest in a mix of different asset classes. These funds serve as the default investment option for the 401(k) Plan in order to comply with federal regulations designed to foster retirement income security.

If you do not choose your own investment options from your Plan's line-up, contributions to your account will be invested in the TDP specific to your year of birth using the assumption that you will retire at age 65. If your assumed retirement date falls between the target year of two TDPs, then additions to your account will be divided equally between the two TDPs closest to your assumed retirement age of 65. NRECA will continue to direct your 401(k) Plan account investments to the TDP(s) selected for you until you make an investment election of your own. You may choose to leave your investments in the TDPs selected for you, or at any time you can make your own selection from the investment options available in your Plan's fund lineup.

Each year you will receive a notice that describes the Plan's QDIA investment options (in which you may be invested) and explains how to change your current account balance and future contribution allocations. Consult the detailed information about each of the TDP investment options at cooperative.com/401kInvestments or contact PIRC as described above before making decisions about how to invest.

Giving Investment Instructions

You can invest your contributions and any employer contributions (if your employer has elected to contribute and you are eligible to receive them) in any of the available investment funds. Your investment allocation may be in one fund or split among multiple funds; however, you may not allocate less than 1% of your entire contribution to any one fund.

To direct your Plan investments, including changing your existing account balance, choosing an allocation for future contributions or rebalancing your account, log in to cooperative.com or call NRECA at 866.673.2299 (option 5, then 1). Your elections will go into effect either the same day, or, if after 4 pm ET, on the next business trading day.

Limits on fund exchanges

Your instructions for an exchange will be implemented after 4 pm ET on any day the NYSE is open for business. However, due to market timing restrictions, if you sell shares from one fund (excluding the stable income/cash investment option), you will be prevented from moving existing money back into that fund for 30 days. This policy applies only to fund-to-fund exchanges, with certain exceptions that include new investments made from regular payroll contributions and mistakes made by you while requesting a transaction. These exceptions are described in detail in the QDIA notice sent to you annually and described above.

Share Value and the Dollar Value of Your Account

Contributions are used to purchase shares in the investment funds of your choice based on the share values in effect when the trustee receives the contributions. The share value is determined on a daily basis and reflects the value of each investment fund at the current market value.

Increases or decreases in the market value of a fund are reflected in the share price. By multiplying the number of shares in your account by the share price, you can determine the dollar value of your account.

For example, if the price per share in a particular fund is $5 per share on June 30, 2022 and your account has 500 shares in this fund (450 shares plus an additional 50 purchased), the value of your account on June 30, 2022 is $2,500 ($5 x 500 shares).

Date	# of shares in account	Plus shares purchased (contribution)	Equals total # of shares in account	Times daily $ price per share	Equals account value
June 30, 2022	450	+ 50	= 500	x $5	= $2,500

Account Statements

You will receive a statement of your account balance at the end of each calendar quarter. The statement will show the value of your account at the start of the quarter, your contributions and investment results, withdrawals and fees and the value of your account at the end of the quarter.

Self-Directed Brokerage Account

Your employer has chosen to offer the Self-Directed Brokerage Account (SDBA) as an additional investment option within your Plan. You can set up an account, direct a portion of your Plan assets to the SDBA, and then use the account balance to buy and sell individual stocks, bonds and mutual funds.

NRECA offers the SDBA choice in conjunction with TD Ameritrade, Inc. When you open an SDBA account, TD Ameritrade routes the orders you place with them to be executed and then maintains records for the self-directed portion of your account.

When you open an SDBA you serve as your own investment manager. All investments are made at your own direction and risk. Securities purchased through the SDBA, including mutual funds, are not bank deposits and are not insured by the FDIC or guaranteed by TD Ameritrade. All investments are subject to investment risk, including possible loss of the principal amount invested, and there is no guarantee of any future performance. Neither NRECA nor TD Ameritrade can give you advice concerning your investment selections or the potential tax implications surrounding them.

Complete information on the SDBA investment option is available on cooperative.com at *My Benefits > My Retirement > Self Directed Brokerage Account.*

SDBA eligibility requirements

To open an SDBA account, your total 401(k) Plan account balance must be at least $5,000 when your SDBA enrollment application is received. You may transfer up to 50% of the value of your 401(k) Plan account, excluding outstanding loans, to the SDBA. The minimum initial transfer is $1,000 and the minimum subsequent transfer is $250. You must maintain a $500 account balance in the 401(k) Plan's core funds. If the assets in your traditional funds fall below $500, you will not be allowed to make any further transfers into your SDBA until the minimum balance is restored to at least $500. You may make a maximum of one transfer either in or out of the brokerage account on any trading day.

SDBA fees

The Plan currently imposes a charge against your individual account for opening and maintaining an SDBA. This does not include any fees and commissions you separately incur as a result of selecting investments through the SDBA. Your quarterly 401(k) Plan account statement provides information on the Plan's SDBA-related expenses that you incur individually in the prior quarter.

In addition, TD Ameritrade may impose separate fees and commissions for each investment you select through the SDBA, in addition to any ongoing fees for the particular investment. The types of charges you incur depend on the investments you select within the account and can include transaction fees, front and back end sales loads, contingent deferred sales charges, 12b-1 fees, redemption fees, exchange fees, brokerage fees, management fees and shareholder servicing fees.

A fee schedule is available on cooperative.com at *My Benefits* > *My Retirement* > *Self Directed Brokerage Account* > *SDBA Commissions and Service Fees*. However, participants and beneficiaries should call TD Ameritrade at 866.766.4015 to ask about commissions and fees, including any undisclosed fees associated with the purchase or sale of a particular security through the SDBA, before purchasing or selling that security.

SDBA withdrawals and distributions

Assets in your SDBA must be transferred back to your 401(k) Plan account before such amounts are available for loans, withdrawals and/or distributions.

In the event of your termination, retirement, or quasi-retirement, your SDBA will automatically be liquidated unless you elect to defer payment of your 401(k) Plan account (even if you choose annuity payments). Note that if you do not request a distribution of your benefits when you separate from service, then you are deemed to have elected to defer distribution, as described in the *Payment Options* chapter of this document under *Making Your Election*. If the distribution of your 401(k) Plan account is deferred, you must continue to meet the minimum balance requirement of $500 in order for your SDBA to not be liquidated. In the event of your death, your SDBA will be liquidated and will be included in the distribution of your Plan account to your beneficiary.

If TD Ameritrade ever needs to liquidate securities without your instructions, it would follow this selling order:

- No-load, no-fee mutual funds;
- No-load mutual funds;
- Load mutual funds;
- Equities;
- Fixed-income securities.

Your SDBA and Qualified Domestic Relations Order Withdrawals

In the case of a Qualified Domestic Relations Order, if your 401(k) Plan account balance is not sufficient to cover the settlement, NRECA will first ask you to transfer assets from your SDBA to your 401(k) Plan account so that NRECA can comply with the court order. If you do not transfer the assets, NRECA will instruct TD Ameritrade to make the transfer.

Your SDBA and required minimum distributions (RMDs)

If you need to take an RMD, NRECA will authorize TD Ameritrade to liquidate and close your SDBA. Proceeds will be transferred to your 401(k) Plan account and your distribution will be processed. See the section titled *Payment Events* for more information on RMDs.

Payment Events

This section contains general information about how various events may affect your benefit payment.

You may receive a payment from the Plan if you terminate your employment, retire or die. In addition, you may also receive a benefit following certain corporate transactions or if the Plan is terminated.

Your beneficiaries may receive a payment from the Plan in the event of your death. Benefits also may be paid if a Qualified Domestic Relations Order (QDRO) exists that requires a part of your benefit be paid to an alternate payee (usually the participant's ex-spouse).

Under certain circumstances you may request a cash withdrawal from your account while you are still employed by your employer. If elected by your employer, these circumstances may include: financial hardship, disability, withdrawal of voluntary employee contributions and quasi-retirement. Other sections of this SPD describe these withdrawal types in further detail, if your employer has elected to offer them in this Plan.

For details about the forms of payment you may elect with regard to your Plan benefit, see the section of this SPD titled *Payment Options*.

Termination of Employment

You are entitled to receive your total account balance from this Plan if you either voluntarily or involuntarily terminate your employment with your employer.

Normal Retirement

Your Normal Retirement Date under this Plan is the first day of the month coinciding with or next following the day you reach age 62.

Required Minimum Distributions

IRS rules state that you must begin to receive at least a minimum benefit (called a required minimum distribution or RMD) from your 401(k) Plan account when you reach your required beginning date (RBD). If you were born on or before June 30, 1949, your RBD is April 1 of the year following the year you turn 70 1/2 or the year in which you retire, whichever is later. If you were born after June 30, 1949, your RBD is April 1 of the year following the year you turn 72 or the year in which you retire, whichever is later. If you reach your RBD, do not provide distribution instructions to NRECA, and are not already receiving benefit payments from your Plan account, your RMD for the year will automatically be sent to you.

Death

In the event of your death, your designated beneficiary(ies) will receive your undistributed Plan account balance. See the section titled *General Beneficiary Information* for details about the rules for designating your beneficiary.

The form of death benefit that your beneficiary (or beneficiaries) will receive depends upon both your marital status and whether you had begun to receive your Plan benefit at the time of your death.

Married participants

If you had not begun receiving your Plan benefit prior to your death, your spouse will receive a monthly annuity (called a pre-retirement survivor annuity) for his or her life, unless your spouse

had previously waived this form of payment in writing. If the value of your account is greater than $5,000 at the time of your death, then your spouse may also be eligible to receive the benefit in another form, including a single cash payment or annual installments.

If you die after starting to receive your Plan benefit, your spouse will receive a monthly payment for the remainder of his or her life equal to 100% of the monthly amount you were receiving at the time of your death, unless your spouse had previously consented to your choice of another form of payment, in which case your spouse's options will depend on the form of payment you chose. Your spouse will be notified of the available payment options as needed.

Unmarried participants

If you are unmarried and die before beginning to receive your Plan benefit, your beneficiary will receive a life-only annuity (monthly payments that continue as long as your beneficiary is alive but stop immediately upon his or her death) unless he or she elects to receive the benefit in either a single cash payment or in annual installments.

Additional death benefit information

If you elect to terminate or retire, submit your distribution election and then die before your actual termination or retirement date, the Plan's death benefit will be paid (not the form of benefit you elected in writing). In addition, if you should die without having made your elections via a signed option form, the Plan's applicable form of death benefit will be paid. See the earlier information about the death benefits provided under this Plan.

Disability

If you become disabled, you are entitled to receive all or a portion of your Plan account balance. You may request a distribution no earlier than 26 weeks after you stop working due to your disability status. If you are married, you may withdraw your benefits only as a Joint and Spouse Annuity, unless your spouse consents, in writing, to an alternate form of payment.

If you previously quasi-retired in the Retirement Security (RS) Plan and transferred your accrued benefit from the RS Plan to your 401(k) Plan account, withdrawal of the RS Plan portion of your account will cause a reduction in your long-term disability benefit. However, you may withdraw all of the money attributable to contributions to your 401(k) Plan account without any reduction to your long-term disability benefit. It is recommended that you seek the advice of a qualified tax or financial professional before making a decision about Plan distributions.

Potential tax consequences of disability withdrawals

If your disability withdrawal is made before you are 59 1/2 years old, a 10% tax penalty may be assessed on the taxable portion of the withdrawal unless an exception applies. Exceptions are explained in the packet of withdrawal information that you receive when requesting a distribution. Also, if the distribution is not rolled over into an IRA, the taxable portion is subject to a 20% mandatory tax withholding.

Hardship Withdrawals

A hardship withdrawal is permitted from this Plan only if your hardship meets the IRS safe harbor criteria described below and if the amount of the distribution is within allowable limits. Hardship withdrawals are subject to applicable federal and state taxes, and if you are under age 59 1/2, the distribution is generally subject to a 10% early withdrawal penalty. You will be required to submit documentation to support your request. For more details about hardship withdrawal requirements, see your BA.

Roth 401(k) assets are available for hardship withdrawals. Funds will be taken from traditional 401(k) contributions first, then from your Roth 401(k) contributions. Hardship withdrawals of Roth 401(k) contributions may also be taxable to the participant.

Safe Harbor criteria for hardship withdrawals

According to regulations established by the IRS, a hardship withdrawal must be necessary to satisfy an immediate and heavy financial need. The facts and circumstances specific to your request will be considered in determining whether the hardship withdrawal meets the IRS requirements. Hardship withdrawal requests may be approved for the following reasons:

Medical expenses as described in Section 213(d) of the Code incurred by you, your spouse, and/or your dependents, or expenses necessary to obtain such medical care.

Costs directly related to the purchase of your principal residence. A distribution for mortgage payments is not permitted.

Tuition and educational fees for post-secondary education for you, your spouse, children and/or your dependents, including tuition, related educational fees and room and board expenses for the next 12 months.

Payments necessary to prevent your eviction from or foreclosure of your primary residence. Documentation must include an official notice that eviction or foreclosure is immediate. A late notice with the threat of eviction or foreclosure does not satisfy the Safe Harbor criteria.

Costs directly related to burial or funeral expenses for your deceased parents, spouse, children or dependents.

Costs for repair of damages to your principal residence that would qualify for the casualty deduction under Section 165 of the Code, determined without regard to the Code's limitation for tax years 2018 through 2025.

Expenses and losses (including loss of income) you incur due to a disaster declared by the Federal Emergency Management Agency (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, provided your principal residence or place of employment at the time of the disaster was located within the area designated by FEMA as eligible for individual assistance with respect to the disaster.

Hardship withdrawal requirements and application

As noted above, the distribution may not exceed the amount necessary to satisfy your financial need and must be at least $1,000. The amount requested can include any amount necessary to pay any federal, state or local income taxes or penalties. You can withdraw only the portion of your account that is attributable to elective contributions. You cannot withdraw any account contributions made by your employer or any of the earnings in your account.

You must take all distributions and loans that are available from any plan of your employer before you are eligible for a hardship withdrawal from this Plan. This includes withdrawals of voluntary employee contributions, if your Plan permits these contributions.

Coronavirus Related Distributions

If your employer permitted Coronavirus distributions during the 2020 calendar year and you received such a distribution, you may repay the distribution to your Plan account within three years from the distribution date. Your repayment will be treated as a direct rollover into the Plan. If you choose to make multiple repayments, such repayments cannot exceed one per year for the applicable three-year period.

Loans

The Plan allows you to borrow against your account. Loans from the Plan must carry a market rate of interest and they must have adequate security. If you borrow from your account, you must sign a promissory note. A regular repayment schedule will be established and your account balance will be the collateral for any loan from the Plan. Also, you will have to pay an administrative fee in advance to cover the expenses of handling your loan.

The Plan treats loans as another investment in your account. The total value of your account is not reduced because you have borrowed from it; however, there is less money in your investment funds because you have withdrawn some for the loan. In other words, the loan remains an asset of your account. If you receive a total distribution from your Plan account prior to paying off the loan, the amount of your distribution will exclude the portion of the loan that you have not paid back.

Eligible borrowers

An employee who has met the Plan's participation requirements and has an account balance sufficient to receive at least the minimum loan amount is considered an eligible borrower. If you roll over money from another plan into this Plan, you may not receive a loan until you become a participant in this Plan. Dependents and beneficiaries of employees are not eligible borrowers.

If you were an eligible borrower and your active employment ends as a result of total or permanent disability as determined under the Plan, you may still apply for a loan.

Internal Revenue Code rules

***Minimum loan amount*:** The minimum loan from the Plan is $1,000.

***Maximum loan amount*:** The maximum loan permitted is the lesser of $50,000 or 50% of the value of your Plan account as of the day you apply for the loan. If you have had another Plan loan in the last 12-month period, the $50,000 limitation will be reduced by the highest outstanding loan balance on your account during the last 12 months prior to your new loan application minus the outstanding balance of all loans from the Plan on the date the loan is made.

***Interest rate*:** Interest rates for a loan must be comparable to that of any commercial lender making a similar loan. Your interest rate will be 1% higher than the prime rate in effect nationwide as published in financial journals as of the first business day of the quarter in which the loan is approved. The applicable quarters are the calendar quarters beginning January 1, April 1, July 1 and October 1.

***Loan term*:** The maximum time allowed for repayment of a loan is five years.

***Repayment schedule*:** The loan must be paid in substantially equal installments made not less frequently than quarterly. (Some exceptions are made for unpaid leaves of absence.)

Plan rules

***Applying for a loan*:** After you request a loan, a written application for a Plan loan will be generated in the form of a promissory note and loan agreement. This will provide evidence of your obligation to repay the borrowed amount and your understanding of, and agreement to, the terms and conditions under which the loan is granted.

***Number of outstanding loans*:** No more than four loans can be outstanding from your Plan account at one time, up to the maximum loan amount.

***Prepayment*:** You may pre-pay a Plan loan in full before the end of its term. Partial pre-payments are not permitted.

***Refinancing*:** You may not refinance an existing Plan loan.

***Spousal consent*:** You may not borrow from your Plan account without your spouse's written consent on the promissory note.

Loan administration

Loans are taken proportionately from each eligible investment fund in which your account is invested.

Loans from certain asset types

If your account balance includes Roth 401(k) assets, your Roth balance will be used to calculate the total amount available for a loan; however, no portion of the actual loan distribution will come from your Roth 401(k) balance.

Loan interest

The interest you pay on your loan goes back into your own account. Your payments of principal and interest are allocated to your account's investments in the same proportion that the money was withdrawn from your account when you made the loan. However, if you change your investment fund selections while you are repaying a loan, the payments will go to your most recent selections and not to the investment funds from which the money was withdrawn.

Interest on Plan loans is not tax-deductible.

Applying for a loan

You can find out if you are eligible for a loan or request a loan using cooperative.com. Go to *My Benefits* > *My Retirement* > *Loans*, and follow the instructions. Or call NRECA's automated voice response system at 866.673.2299 (option 5, then 1) and follow the voice prompts for loan administration. These resources are available 24 hours a day. You may also contact your BA in the event you do not have access to cooperative.com or if you have questions about loan administration.

The plan currently imposes an administrative fee against individual accounts for processing your loan application. This fee will be deducted from the loan proceeds and will be repaid into your account as part of your loan repayment amount. See the section titled *Summary of Plan Benefits* for fee amounts. Your quarterly 401(k) Plan account statement provides information about loan expenses you incur individually in the prior quarter.

Repaying your loan

Active employees: You will make loan repayments through payroll deductions, as agreed to in the promissory note. If, for some reason, you are unable to make payroll deductions, alternate arrangements for repayment must be made with your employer.

***General leaves of absence not related to disability*:** If you have a Plan loan and are on a leave of absence from employment, you can request a grace period for repayments equal to the length of your leave of absence, up to a maximum of 12 months. You will not be required to make loan repayments; however, interest on any outstanding principal and interest balance will continue to accrue. At the end of the grace period, the original terms and conditions of the loan will be reinstated.

***Military leaves of absence*:** If you have an outstanding loan, you may request a repayment grace period during your military leave of absence. This grace period can begin on the date you

begin performing uniformed service and extend to the end of your military leave of absence. You will not be required to make loan repayments during the grace period, but interest will continue to accrue. When you return to work, a new repayment date will be calculated using the repayment date under the original term of the loan plus the period of uniformed service. You must repay your loan no later than this new repayment date.

Disabled employees: If you have a Plan loan and are on disability leave of absence, but are not receiving compensation from your employer, then your loan repayments cannot be made through payroll deduction. In order to keep your loan from default, you are required to submit all loan repayments to your employer through another method.

Loan default

If you miss your Plan loan repayments for three successive months, a loan default will occur. A loan default will also occur if you fail to pay the balance by the loan maturity date. If you default on your loan, NRECA will report your loan default as a distribution on IRS Form 1099-R. Interest on the loan will continue to add up until the time you repay the outstanding balance or you become eligible for a distribution from the Plan. If you do not repay your defaulted loan in full by its maturity date, you will be unable to take another loan from the Plan in the future. Complete information on loan defaults is found in your promissory note.

Distribution events with an outstanding loan

When you have a distribution event (e.g., termination of employment, retirement or death) you have the following options for your outstanding Plan loan balance:

Option 1: Pay off your outstanding loan balance when you terminate employment. You will have 90 days after termination to pay the outstanding balance to avoid a default distribution.

Option 2: Receive your distribution, (less the balance total outstanding loan amount) and report the outstanding loan amount as ordinary income for the year you receive the distribution.

Option 3: If your new employer participates in the 401(k) Plan and offers the loan option, you may transfer your loan obligation to your new employer's Plan and continue to make payments through your new employer for the remaining term of the loan. When choosing this option, note that all outstanding loans from your prior employer may be transferred to your new employer, even if your new employer does not permit as many loans under its loan provision.

For example, *you have three outstanding loans and terminate your employment. You transfer to a new employer that offers the 401(k) Plan and has adopted the loan program, allowing two outstanding loans. You are permitted to transfer all of your loans to your new employer's Plan; however, you will not be eligible to request a new loan until the number of outstanding loans at your new employer falls to at least one fewer than that allowed under the new employer's Plan—in this example, until at least two of your loan obligations are paid off.*

Voluntary Employee Contribution Withdrawals

If you made voluntary employee contributions, you may withdraw them using the *Voluntary Employee Contribution Withdrawal Form*. These withdrawals may be made at any time. There is no minimum withdrawal amount and the maximum is limited to the total of your voluntary contribution balance. Your withdrawal may be made from both your contributions and associated earnings.

Voluntary contributions made before January 1, 1987 may be withdrawn tax-free. However, withdrawals of your voluntary contributions made after December 31, 1986 must include a

proportional share of taxable earnings on all employee contributions and are taxed as ordinary income.

Quasi-retirement

Your Plan permits quasi-retirement, which is an election to receive a distribution while you are still employed but after you have reached the later of age 59 1/2 or your Normal Retirement Date (see section above for your Normal Retirement Date). If you are still employed as of the first day of the month coinciding with or following the day you reach age 70 1/2, you may also elect to quasi-retire a second time.

General Beneficiary Information

When you enroll in the Plan, you are asked to designate a beneficiary.

If you are not married, you may designate any individual or trust as a beneficiary to receive payment from the Plan if you die before you receive your benefit. Unless you marry, your beneficiary will not change until you designate a new beneficiary.

If you are married, Federal law requires that your spouse automatically becomes the mandatory beneficiary of your Plan benefit. This is true even if you had previously designated someone else as beneficiary; thus, any beneficiary designations you may have made before you were married will be revoked. You may designate someone other than your spouse as a beneficiary only if your spouse agrees and the consent is in writing and is witnessed by a notary public. Your BA can provide you with the proper forms for this purpose.

The Plan will make payment upon your death to the person named as beneficiary on the latest beneficiary designation you made on the *Beneficiary Designation/Waiver of Qualified Pre-retirement Survivor Annuity Form*. To designate a beneficiary, complete this form and submit it to your BA, who will enter your election(s) in NRECA's system.

If you do not designate a proper beneficiary or if you designate no beneficiary, payments will be made to the first surviving person in the following order:

1. Your spouse;
2. Your children;
3. Your parents;
4. Your brothers and sisters;
5. The executors or administrators of your estate.

In the event you divorce, you should update your beneficiary information as soon as possible. Even if you divorce, remarry or rewrite your will, your former spouse may be entitled to benefits after your death unless you update your beneficiary designations.

We suggest that you review your beneficiary election annually at the time of your co-op's annual enrollment to ensure it reflects your most current designation.

Minor beneficiary designations

The Plan will not make a distribution to a minor beneficiary. If you wish to name a minor child as a beneficiary, we recommend that you establish the proper legal vehicle, such as a guardianship or conservatorship, as required by the laws of your state, so that the assets in your account can be paid as soon as possible to your child's designated guardian.

Assignment of Benefits

Qualified Domestic Relations Orders

A domestic relations order is a court order that provides for child support, alimony payments or marital property rights to an alternate payee. An alternate payee is your spouse, former spouse, child or other dependent, recognized in a domestic relations order as having a right to receive all or a portion of your 401(k) Plan benefit. If the court order allocates a portion of your benefits to an alternate payee, the domestic relations order must be submitted to the plan administrator for review. If the domestic relations order meets statutory requirements, it is considered a Qualified Domestic Relations Order (QDRO) and the plan administrator will be obligated by law to comply with its terms.

To meet the requirements, the order must contain the following information:

- Name, address, date of birth and social security number of both the participant and alternate payee;
- Correct name of the Plan from which a payment will be made;
- Amount or percentage of your benefit to be paid by the Plan or the manner that the amount or percentage is to be determined; and
- Timing of the payment.

A QDRO cannot require a type or form of benefit that the Plan does not otherwise provide. It cannot require the Plan to provide increased benefits and cannot require that benefits otherwise payable to an alternate payee under an earlier QDRO be paid to anyone else. An alternate payee may elect any payment option that the Plan allows, either immediately or at a later date, except a Joint and Spouse annuity or intermittent withdrawals (either unscheduled or as part of a series). If your account becomes subject to a QDRO, contact your BA and NRECA for further instructions and sample QDRO documents.

We strongly suggest that you submit an updated beneficiary designation as soon as possible if your account becomes subject to a QDRO.

Additional assignment information

You may not use this Plan or any other qualified plan as collateral for a loan.

As a general rule, your benefits may not be garnished, subject to certain exceptions (such as if the IRS places a levy on your retirement benefits).

Power of Attorney

The laws of your state govern any power of attorney that you execute for retirement plan payment purposes. Most states have a checklist document describing the steps you must follow in order to give your power of attorney authority over retirement benefits. It is a good idea to specifically reference your retirement plan benefits in your power of attorney if it is not otherwise part of state law. Once a legal power of attorney has been granted, that person may act on your behalf in the fashion you indicate, until it is revoked or you die.

Payment Options

This section explains the payment options permitted by the Plan. **Before making a decision about your distribution or choosing any of the options described here, it is recommended that you seek the advice of a qualified tax or financial professional.**

Forms of Payment

Benefits are paid from the 401(k) Plan in the following forms:

- Joint and (100%, 75%, 50%) Spouse Annuity without Cash Refund;
- Joint and (100%, 75%, 50%) Spouse Annuity with Cash Refund;
- Straight (Single) Life Annuity without Cash Refund;
- Straight (Single) Life Annuity with Cash Refund;
- Joint and (100%, 75%, 50%) Survivor Annuity without Cash Refund;
- Joint and (100%, 75%, 50%) Survivor Annuity with Cash Refund; and
- 10-Year Certain and Life Annuity.

Any of these annuities can be combined with the Individual Cost of Living Adjustment (Individual COLA) option. See the section titled *Individual Cost of Living Adjustment (Individual COLA) option* for details.

Other payment forms include:

- Intermittent withdrawals;
- Annual installments not to exceed 15 years; and
- Single cash payment.

Automatic Form of Payment if You Are Married

Your benefit will be paid as a Joint and 100% Spouse Annuity unless you make another choice in writing. A Joint and 100% Spouse Annuity provides you with a monthly payment for as long as you live. If you are survived by a spouse, your spouse will receive a monthly payment for the remainder of his or her life equal to 100% of the monthly amount you were receiving at the time of your death.

You may waive the Joint and 100% Spouse Annuity only if your spouse irrevocably consents in writing to the waiver. A notary public must witness your spouse's signature. You may revoke any waiver prior to the time benefit payments begin. **Because your spouse participates in these elections, it is important to inform the plan administrator immediately of any change in your marital status.**

Automatic Form of Payment if You Are Unmarried

Your benefit will be paid as a Straight (Single) Life Annuity, unless you make another choice in writing. This annuity provides a monthly payment to you for as long as you live. All payments stop when you die.

Other Forms of Payment

Whether you are married or unmarried, you may elect any other form of payment the Plan provides, subject to certain restrictions.

Annuity payments

An annuity is a periodic payment, usually monthly, providing equal payments for your life and, under certain annuity options, for the lifetime of your beneficiary. The amount of your annuity is

calculated using the value of your account balance at the time payments begin. The 401(k) Plan provides these annuity options:

Joint and (100%, 75%, 50%) Spouse Annuity without Cash Refund provides equal monthly payments for your life. After your death, your spouse will receive a percentage (100%, 75% or 50%) of this amount for life.

Joint and (100%, 75%, 50%) Spouse Annuity with Cash Refund provides equal monthly payments for your life. After your death, your spouse will receive a percentage (100%, 75% or 50%) of this amount for life. In addition, with this option, if there is any excess value to the annuity beyond the total amount of monthly payments actually received by you and your spouse, you can request that the excess value be paid as a single cash payment to an alternate beneficiary.

Straight (Single) Life Annuity without Cash Refund provides equal monthly payments for your life and terminates at your death.

Straight (Single) Life Annuity with Cash Refund provides equal monthly payments for your life and terminates at your death. After your death, if there is any excess value to the annuity beyond the total amount of monthly payments actually received by you, you can request that this be paid as a single cash payment to an alternate beneficiary.

Joint and (100%, 75%, 50%) Survivor Annuity without Cash Refund provides equal monthly payments for your life and then a percentage (100%, 75% or 50%) of those monthly payments to an alternate beneficiary (not your spouse) for their life.

Joint and (100%, 75%, 50%) Survivor Annuity with Cash Refund provides equal monthly payments for your life. After your death, your contingent annuitant will receive a percentage (100%, 75% or 50%) of this amount for life. In addition, with this option, if there is any excess value to the annuity beyond the total amount of monthly payments actually received by you and your contingent annuitant, you can request that this will be paid as a single cash payment to an alternate beneficiary.

10-Year Certain and Life Annuity provides equal monthly payments to you for life and in the event you die before the completion of 120 monthly payments (10 years), the balance is payable in monthly payments to your contingent annuitant. If both you and your contingent annuitant die before the completion of 120 monthly payments, then the balance is paid in a single cash payment to an alternate beneficiary.

Any of the foregoing annuity options may be taken as a partial annuity. A partial annuity provides you with a lifetime monthly payment using just part of your account balance, leaving you with additional options later. You may take a partial annuity upon your employment termination or quasi-retirement through the unscheduled intermittent withdrawal process.

Cash refund option

If you elect the cash refund option, if both you and your spouse (or contingent annuitant) die, and if the value of the single sum payment you would have received at retirement is more than the total amount of monthly payments that you and your spouse (or contingent annuitant) actually received, the difference will be paid as a single cash payment to your alternate beneficiary.

Individual Cost of Living Adjustment (Individual COLA) option

When you elect your 401(k) Plan benefit, you can also select the Individual COLA option along with any of the annuity options described in the *Annuity Payments* section of this SPD, including those with the cash refund feature.

Combined with one of the existing annuity options, the Individual COLA option provides inflation protection. The feature allows you (and your surviving beneficiary) to receive 100% annual cost-of-living adjustments after receiving your first annuity payment.

If you elect the Individual COLA option, your annuity payments will be automatically adjusted annually based on the consumer price index (CPI-U) measurements that are issued by the Bureau of Labor Statistics of the U.S. Department of Labor. The adjustments:

- Are based on the average monthly percentage change in the CPI-U for the one-year period ending three months before each payment anniversary;
- Begin one year after your first payment date and on each payment anniversary thereafter;
- Are based on contract terms set by the 401(k) Plan annuity provider; and
- Are paid for by you, rather than by your employer, through a lower starting monthly benefit (as compared to a similar type benefit without inflation protection).

If you are eligible to receive a distribution, you will be able to elect the Individual COLA option when you complete an option form. For details, refer to the section of this SPD titled *Making your Election*.

Intermittent withdrawals

If you terminate employment or retire and your account balance is greater than $1,000, you can request an unscheduled cash withdrawal. The minimum amount that may be withdrawn on an unscheduled basis is $1,000.

If your account balance remains above $5,000, you can request both an unscheduled cash withdrawal and a partial annuity. You may request a partial annuity as either a percentage of your account balance (in 10% increments) or as a dollar amount. If you wish to take a total distribution as a combined cash and annuity payment, you must elect this on your option form.

If your employer has elected the feature and you are eligible to quasi-retire (for basic plans, at the Normal Retirement Date; or, for 401(k) Plans, at the later of either your Normal Retirement Date or age 59 1/2), then you may also elect to receive up to four unscheduled withdrawals a year as well as a partial annuity.

In addition, if you terminate your employment or retire (but not quasi-retire), then you may elect to receive a series of equal withdrawals, paid either monthly, quarterly, semi-annually or annually, for at least 12 months and up to 9 years and 11 months. The minimum amount that may be withdrawn as a series of equal withdrawals is $500 per payment. At the time of your election, your account balance must be $5,000 or more.

Roth 401(k) contributions are available for withdrawal under the intermittent withdrawal provisions of the 401(k) Plan. If you have made both Roth and traditional 401(k) contributions, you may elect to take your intermittent withdrawals out of either source or both.

Installment payments

Installment payments are approximately equal annual payments made to you from your account for a specified number of years. You choose the number of years over which the payments will be made, up to a maximum of 15 installments (i.e., 15 years).

Single cash payments

A single cash payment is a distribution of your total account balance, valued as of the date the distribution is paid.

Making Your Election

If you are eligible to receive a distribution for any reason, information describing your distribution options will be sent to you, your beneficiary, or an alternate payee, depending on the reason for the distribution. If you do not request a distribution (except when your account balance is $1,000 or less), then you will be deemed to have elected to defer receiving your benefit until the next distributable event. If you later wish to request benefit payments, contact NRECA for an option form.

In addition, the NRECA Personal Investment & Retirement Consulting (PIRC) team is available to discuss your payment options. To contact a PIRC representative, please call 866.673.2299 (option 6).

Once you make a payment election, details about your distribution will be sent to you at least 30 days but not more than 90 days (the 30/90 day election period) before your payments are scheduled to begin. You may change or revoke your election at any time before payments begin. However, once you begin receiving benefits in the form you have elected, the election is irrevocable; neither you nor your spouse, if applicable, may change that election.

You may elect to waive the standard form of benefits (with the consent of your spouse, if you are married) and choose another form of payment during the 30/90 day election period. If you are married, the standard form of benefit is the 100% Joint and Spouse Annuity; if you are unmarried, the standard form of benefit is the Life Only Annuity. For more on the Plan's automatic form(s) of payment, see the sections on this topic earlier in this chapter.

If you want your benefit payments to begin before the end of the 30/90-day election period, then you may elect to waive the 30 day period. If you waive the 30 day period, payments may begin no sooner than the end of the seven day period beginning the day after you sign your option form.

Impact of Your Account Balance on Your Payment Choices

If your account balance is **less than $200** following your termination of employment (and no amount has previously been paid to you as an annuity or in installments) you will receive your entire account balance in a single cash payment. If you are married, your spouse does not need to consent to the single cash payment distribution.

If your account balance is **more than $200 but less than $1,000** following your termination of employment and no amount has been previously been paid to you as an annuity or in installments, then you will receive distribution option forms to make a payment election. If you are married, your spouse does not need to consent to your election. If you do not make a payment election within 90 days of the option form event date or request date (whichever is later), then you will receive your entire account balance in a single cash payment.

If your account balance is **more than $1,000 but less than $5,000** following your termination of employment and no amount has previously been paid to you as an annuity or in installments, then you will receive an option form on which to make a payment election. If you are married, your spouse does not need to consent to your election. If you do not make a payment election within 90 days of the option form event date or the request date (whichever is later), then your account balance will not be paid until the later of your future election or the April 1 following the date you reach age 72 (age 70 1/2 if you were born on or before June 30, 1949).

If your account balance is **greater than $5,000** following your termination of employment, you may elect any form of payment available under the Plan, subject to your spouse's consent, if applicable.

If you die while you are still working and your surviving spouse's pre-retirement survivor annuity is worth more than $1,000 but less than $5,000, your surviving spouse automatically will receive a single cash payment. If your account balance is greater than $5,000, your surviving spouse may be eligible to receive a single cash payment or installments in lieu of the annuity.

Receiving Your Payment

The plan administrator will make payments as soon as administratively possible after receipt of your option forms, but not fewer than 30 days after the required explanation of payment options was provided to you, unless you elect to waive the 30-day period. The earliest date a distribution may be paid is seven days after the date you sign your option form (i.e., on the eighth day). The actual amount of the distribution will be based on current share prices at the time your payment is processed.

You will have up to 90 days to return your option form. During this 90-day period you may change your election; however, once payments begin, your election is then irrevocable. Intermittent withdrawals are the only form of payment that you may change or stop once they have begun. See the section titled *Other Forms of Payment* for more information.

If you do not return your option form before 90 days have elapsed from the later of the event date or the request date on the form, the form will no longer be valid. You may request another option form on which to make an election; however, if your account balance is $1,000 or less and you do not elect another form of payment within 90 days, you will automatically receive a lump sum. In addition, you may not defer payments indefinitely. See the section titled *Deferring Payments* for information about your required beginning date under this Plan.

Re-employment

If you are re-employed **within 90 days** from the date your prior employment was terminated and you have elected your payment (i.e., you signed your distribution option forms), then you may receive your payment if you are re-employed with another employer.

If you are re-employed **more than 90 days** after the date your prior employment was terminated, you **did not** make a payment election (i.e., you did not sign your distribution option forms) and you become a participant in the 401(k) Plan, you may not receive a distribution. On the other hand, if you do not become a participant in the 401(k) Plan upon re-employment, you may receive a distribution by electing a payment (i.e., by signing your distribution option forms).

Deferring Payments

If you elect to defer receipt of your benefits to a later date (or if you do not make a distribution election) then your benefit payments must begin no later than April 1 of the calendar year following the later of the year you either terminate employment or turn 72 (age 70 1/2 if you were born on or before June 30, 1949).

You must maintain a current address in NRECA's system if you delay your benefit payment. Contact your benefits administrator promptly to update any personal information for benefits purposes, including primary address, mailing address, marital status or legal name.

General Tax Information

The taxable portion of your payment from the 401(k) Plan could be subject to a 20% tax withholding if you do not roll over the distribution to another qualified plan or an Individual Retirement Account (IRA). It is recommended that you seek the advice of a qualified tax or financial professional before making a decision about Plan distributions.

If you receive a single cash payment from the 401(k) Plan directly, 20% of the taxable portion will be withheld for income tax. You may subsequently elect to roll over your payment, but you must complete the rollover within 60 days of the day you received the payment. You will receive only 80% of your total distribution for rollover. You may add money from other sources (e.g., your own savings) to your distribution to replace the 20% withholding in order to roll over an amount equal to 100% of your benefit.

A distribution may be made directly from the 401(k) Plan to either an IRA or another qualified plan. This is called a direct rollover. Because the 20% tax withholding does not apply to a direct rollover, 100% of your payment will be transferred to your IRA or to the plan of your new employer.

Distributions from the 401(k) Plan that are eligible rollover distributions (and thus subject to 20% tax withholding) include:

- Any total cash distribution, including an outstanding loan;
- Disability withdrawals from the Plan;
- Earnings on voluntary employee contribution withdrawals;
- Installment payments for a period of fewer than 10 years;
- Any portion of a distribution that is greater than the required minimum distribution received after the later of age 72 (age 70 1/2 if you were born on or before June 30, 1949) or your actual retirement (although if rolled over to an IRA, such amount would be taken into account in determining the required minimum distribution from the IRA); and
- Eligible distributions to a surviving spouse or an ex-spouse under a QDRO.

Distributions that are not eligible for rollover (and not subject to 20% tax withholding) are:

- Any payment in a series of substantially equal periodic payments made over the life expectancy of the participant or joint life expectancies of the participant and beneficiary;
- Any payment in a series of substantially equal periodic payments over a period of ten years or more;
- A required minimum distribution (following the later of age 72 (age 70 1/2 if you were born on or before June 30, 1949) or actual retirement);
- A distribution to an alternate payee or a beneficiary who is not the spouse; and
- A hardship distribution (if permitted by your employer).

If you are under age 59 1/2, your payment may be subject to income tax and to an additional 10% penalty on the taxable portion of your distribution(s), unless an exception applies. The plan administrator does not withhold this 10% penalty from your distributions; you should speak with a tax professional to ensure that you properly report the 10% penalty on your tax return, if applicable.

If you receive your distribution as a series of substantially equal periodic payments (an annuity), there is an exception to the application of the 10% penalty. However, this exception only applies if your payment is the result of your retirement in the year you turn age 55. It does not apply if your payment is the result of quasi-retirement (if permitted by your employer) and you are under age 59 1/2, even if you are over age 55.

Distributions From Roth Accounts

You may take tax-free distributions from the Roth 401(k) portion of your account, if the distribution is qualified. A distribution is considered qualified if it satisfies two conditions:

- It is made five years after the first day of the year in which you began making Roth 401(k) contributions; and

- It is made after you reach age 59 1/2 (or your Normal Retirement Date, if later), die or become disabled.

If the above conditions are met, then the earnings on the Roth 401(k) balance are distributed tax free along with your Roth 401(k) contributions. If the above conditions are not met, then the earnings portion of the Roth 401(k) distribution will be considered taxable. All distributions are subject to the rules of this Plan.

Overpayments

An overpayment occurs when you (or your contingent annuitant, your beneficiary or an alternate payee) are paid more than you (or he or she) are entitled to under the terms of the Plan. If an overpayment of retirement benefits is made from the Plan to any of these parties, the Plan is entitled to correct the overpayment or request that it be returned. The Plan may utilize any means that are necessary to ensure that the error (overpayment) is corrected and the Plan is made whole.

You, your contingent annuitant, your beneficiaries or an alternate payee are obligated to repay, immediately upon request by the Plan, any overpayments (plus interest and earnings from the date of the distribution through the date of the request) stemming from mistakes, errors or corrections.

In the case of annuities, the Plan is entitled to offset the overpayment or error against ongoing annuity payments to you, your contingent annuitant, beneficiary or an alternate payee, as applicable. In the case of single cash payments, the recipient may repay the excess he or she received.

For single cash payments, if the Plan does not receive repayment, the plan administrator may take affirmative steps to collect the overpayment, plus interest and earnings, through any means at its disposal, up to and including reversal of rollovers, collections activity or legal action, in which case the Plan shall be entitled to collection of the overpayment in full, plus attorneys' fees and costs.

Procedure For Claiming Benefits

This section describes how you present a claim for your benefits.

Pursuant to federal authority related to the Novel Coronavirus Outbreak, the time to file or perfect benefit claims and to appeal a denied claim has been extended. Notwithstanding any other provisions in this chapter, the Plan will disregard the COVID-19 "Outbreak Period" for purposes of determining the deadline to file or perfect a benefit claim and to appeal an adverse benefit determination. The Outbreak Period begins March 1, 2020 and ends 60 days after the end date of the COVID-19 National Emergency. The National Emergency does not currently have an end date.

Benefits will be paid to participants and beneficiaries without a formal claim when a recognized distribution event occurs. As a general rule, a claim for a benefit occurs when there is a dispute with regards to the amount of a payment. All claims for Plan benefits will be subject to a full and fair review. You may appoint a duly authorized representative to assist you at any time, if you provide written notice of such authorization. All communications under this procedure must be sent to:

401(k) Pension Plan
c/o Plan Administrator
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Mail Stop IFS 7-300
Arlington, VA 22203-1860

Submitting a Claim

If you feel you are entitled to a benefit you have not received or if you believe the amount of your benefit is wrong, you should submit your request for a claim review to the plan administrator in writing. You should explain the problem and include any information or documents you feel will assist in the review. Initial claims determinations are made by the plan administrator.

You (or your beneficiary) have three years to submit a claim review request, as measured from the earlier of the date that you knew (or had reason to know) that either:

- The benefit paid to you was incorrect; or
- Your claim for benefits would have been denied.

If you do not submit your claim within this three-year timeframe, your request for claim review will be denied.

Claim Determination

The plan administrator will, in most circumstances, provide a decision about your claim within 90 days of receipt. If circumstances require an extension, written notice will be given to you prior to the expiration of the initial 90 day period, along with:

- An explanation of the reason(s) for the extension; and
- The date when you will be notified of decision about the claim.

The plan administrator has discretion to determine whether an extension is necessary.

Claim Denial

If your claim is wholly or partially denied as a result of the claim determination process, the plan administrator will notify you in writing of this denial within the time periods described above.

The written explanation will contain:

- The specific reason or reasons for the denial;
- The specific reference to the Plan provisions on which the denial is based;
- A description of any additional information or material necessary to perfect your claim as well as an explanation of why such material or information is necessary; and
- A description of what steps are necessary to submit your claim for review.

If you are not notified of a claim denial as discussed above, the claim will be deemed denied on the 90th day after receipt. The plan administrator determines whether a claim has been submitted or received and, if so, the date on which it was sent or received.

If you wish to challenge the claim determination, you must proceed with the claim review (appeal) procedure described below.

Claim Review (Appeal)

If your claim has been denied, either in writing or because the 90th day following receipt of your claim has passed, you may submit your claim for review. The I&FS Committee (or their duly authorized delegate other than the individual or entity who performed the initial claim determination) reviews claim appeals. Your request for review must be in writing and must follow this procedure:

- File the request for review no later than 90 days after you receive written notification that your claim has been denied or, if there is no written decision, the 90th day following the date the Plan received your claim. If you or your representative fail to submit a written request for appeal in a timely fashion to the correct address listed in this procedure, this will bar review of your claim denial by the I&FS Committee, as well as any judicial review.
- Include any documents related to the denial of your claim and send any issues and comments in writing. The information you send will supplement the administrative record and should contain all the information you wish to be considered during the review, including relevant documents, records and correspondence. In preparing your appeal, you may request a copy of the pertinent documents, including claims records, that the plan administrator used to make the initial decision.
- Your appeal must be given a full and fair review. The I&FS Committee will evaluate claim review requests at its regularly scheduled meeting. Or, review will occur by telephone (if required to meet the applicable time periods), and this telephone review shall be as effective as if the review was conducted in person. If the review period is not within normal scheduled meeting times or a meeting cannot be held without undue cost and inconvenience, the review period will automatically be extended to 120 days. Claimants and their authorized representative may request an in-person review by the I&FS Committee at their regularly scheduled meeting, provided that the I&FS Committee has the sole and exclusive authority to approve or deny such request, in its discretion.
- The I&FS Committee’s decision on appeal will be written. It will contain the specific reason(s) for the denial and the specific Plan provisions on which a denial is based. The I&FS Committee’s decision on appeal is final.

Once the I&FS Committee or its delegate renders a final decision in writing, if you want the decision reviewed by a court, that review can only occur after this claims review procedure is complete and you have exhausted your administrative remedies. You must apply for judicial review of the I&FS Committee’s decision within one year of the decision date and your review request must be filed in the United States District Court for the Eastern District of Virginia. A claimant or their representative’s failure to seek judicial review in the required venue and within

one year of the date the I&FS Committee rendered its final decision bars judicial review of your claim, including the plan administrator's or the I&FS Committee's determinations.

Statement of ERISA Rights

This section explains your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

As a participant in the Plan described in this Summary Plan Description (SPD), you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to the rights and protections outlined below.

Receive Information About Your Plan and Benefits

You are entitled to examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are entitled to obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may require a reasonable fee for providing you with copies of these documents.

You are entitled to receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

You are entitled to obtain a statement containing your total account balance, the value of each investment to which assets in your account have been allocated, determined as of the most recent valuation date under the Plan, and an explanation of any limitations or restrictions on your right to direct an investment. This statement must be requested in writing and is not required to be given more frequently than quarterly. The Plan must provide the quarterly statements free of charge.

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 their beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $171 a day, not to exceed $1,713 (2022 limit, indexed annually) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a 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 these costs and 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, 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.

Amendment and Termination of Your Plan

Your employer has the right to amend or terminate its participation in the 401(k) Plan.This section discusses the rights and responsibilities of your employer if the board of directors elects to either amend or terminate your employer's participation in the Plan.

If the Plan is amended, no amendment will permit any part of the Plan assets to be used for any purpose other than to provide benefits for participants and their beneficiaries. No amendment may cause any reduction in your account balance or cause Plan assets to be turned over to your employer.

If your employer elects to withdraw from participation, your employer may make distributions to you only when permitted by the Plan. Your account will continue to receive investment gains, losses or both until you experience a distributable event. Your employer will provide further information and instructions in the event of a Plan termination.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this Plan (called the premium) will be provided separately. For more information about your coverage, or if you want more detail about your coverage and costs, you can get the complete terms in the Plan document(s) by contacting your Benefits Administrator, by calling 1-866-673-2299 or by visiting us at cooperative.com > My Benefits. For definitions of common terms, such as allowed amount,[2] balance billing,[5] coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/or call 1-866-673-2299 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $2,000/individual or $4,000/family; for out-of-network providers $4,000/individual or $8,000/family.	Generally, you must pay all of the costs, including the allowed amount,[2] from providers up to the deductible amount before this Plan begins to pay for covered services. If you have other family members on the Plan, the overall family deductible must be met before the Plan begins to pay for covered services for an individual.
Are there services covered before you meet your deductible?	Yes. Preventive care[1] services administered by network providers are not subject to the deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this Plan covers certain preventive services[1] without cost-sharing and before you meet your deductible. See a list of covered preventive services[1] at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	For network providers $3,500/individual or $7,000/family; for out-of-network providers $7,000/individual or $14,000/family.	The out-of-pocket limit is the most you could pay in a year for covered services. For network providers once you meet your network deductible ($2,000/individual or $4,000/family) and in-network coinsurance maximum ($1,500/individual or $3,000/family), you will meet your network provider out-of-pocket limit. For out-of-network providers once you meet your out-of-network deductible ($4,000/individual or $8,000/family) and out-of-network coinsurance maximum ($3,000/individual or $6,000/family), you will meet your out-of-network provider out-of-pocket limit.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing[5] charges, penalties for failure to obtain Preauthorization[3] for services and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cooperative.com> My Benefits or call 1-866-673-2299 for a list of network providers.	This Plan uses a provider network. You will pay less if you use a provider in the Plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral. Preauthorization[3] and participation in the Center of Excellence (COE) is mandatory for both bariatric and transplant services.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] If you consult with a Teladoc physician for a general medical condition, you pay $55/consultation until deductible is met.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care[1]/screening/ Immunization	No charge.	40% coinsurance	Subject to allowed amount.[2] Age and gender limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your Plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2]
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for all non-emergency, outpatient imaging.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cooperative.com> My Benefits	Generic drugs (Tier 1)	20% coinsurance	40% coinsurance	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order & Exclusive Choice pharmacies). Subject to allowed amount[2] and prior authorization[3] is required for compound drugs greater than $300, and specialty drugs and nonformulary drugs. Generic preventive drugs are available at no cost through the Exclusive Choice network (including mail order).
	Preferred brand drugs (Tier 2)	20% coinsurance	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	20% coinsurance	40% coinsurance	
	Specialty drugs (Tier 4)	20% coinsurance	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to allowed amount.[2]
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	Subject to allowed amount,[2] copayment or coinsurance and deductible (if applicable).
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care: Part of a hospital	20% coinsurance	40% coinsurance	**For outpatient Emergency room care visits that are not an actual medical emergency at an out-of-network provider will be subject to the out-of-network deductible and coinsurance.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care: Not part of a hospital	20% coinsurance	40% coinsurance	**Note:** Urgent care is paid as an office visit, unless it is part of a hospital urgent care center.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Subject to allowed amount.[2]
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] If you consult with a Teladoc psychiatrist, you pay $220 for the initial consultation and $100 for each subsequent consultation until the deductible is met. If you consult with a Teladoc mental health, behavioral health, or substance abuse provider other than a psychiatrist, you pay $90 per consultation until the deductible is met. Applicable in-network coinsurance applies after the deductible is met. Preauthorization[3] is required for inpatient hospital stays. Partial hospitalization benefits are considered at the inpatient services benefit level.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services.[1] Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for inpatient hospital stays.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization.[3] Limited to 100 visits/ year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required after visit limitation has been reached. Restorative speech therapy and chiropractic services are limited to 25 visits each. Acupuncture, physical, occupational, and massage therapy are limited to a combined 25 visits.
	Habilitation services	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization.[3]
	Skilled nursing care	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization[3] and limited to 90-day limit.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to allowed amount[2] and preauthorization[3] is required (if the dollar amount is equal to or greater than the following amounts) for rentals $500, prosthesis $1,000 and purchases $1,500.
	Hospice services	20% coinsurance	20% coinsurance	Subject to allowed amount.[2] Lifetime maximum for hospice services is $50,000.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	No coverage for these services.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or Plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Eye exam
- Glasses
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside U.S.[4]
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Plan at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your Plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your Plan. For more information about your rights, this notice, or assistance, contact Cooperative Benefit Administrators, Inc. at 1-866-673-2299. You may also contact the Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan meet the Minimum Value Standards? **Yes**.
If your Plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-2299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-2299.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-673-2299.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-673-2299.

Other Information:

1 **Preventive Services, Preventive Care:** Under Section 2713 of the Affordable Care Act, the plan must provide coverage for a range of preventive services and may not impose cost-sharing (such as copayments, deductibles, or co-insurance) on participants receiving these services. The required preventive services come from recommendations made by four expert medical and scientific bodies – the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services. Only preventive services recommended by one of these four groups are covered without cost-sharing.

2 **Allowed Amount:** UCR - Referred to as Reasonable and Customary (R&C) Rates in the medical Plan materials, allowed amounts are the current, most common rates in a geographic area for a particular treatment or service. They are researched and reviewed by Cooperative Benefit Administrators, Inc. (CBA) on a regular basis.

3 **Preauthorize, Prior Authorization, or Prior Approval:**

- **Medical Plan Services and Supplies**. Failure to receive preauthorization for medical necessity will result in a 20% reduction in charges considered covered by the medical Plan. If such services or supplies are later determined not to be medically necessary, the services or supplies will be denied and not eligible for coverage under the medical Plan. You will be responsible for requesting preauthorization and the expenses for failure to obtain preauthorization. Exception: If you access the Choice Plus network, the provider is responsible for your preauthorization of a hospital in-patient admission and the expenses for failure to obtain preauthorization.
- **Prescription Drugs and Supplies**. Compound drugs greater than $300 and certain drugs and drug classes require Prior Authorization by either CBA or CVS Caremark. Refer to your medical Plan summary plan description for more information or contact CBA at 1-866-673-2299.

4 **Coverage While Traveling Outside the United States:** In order for a service obtained outside the U.S. to be covered, the information provided to the Plan must include the following: the service must be a recognized service in the U.S.; all provider billings and/or records must be translated into English; bills must clearly show the patient's name, provider's name, date of service, diagnosis and a description of the services rendered; and the current money exchange rate needs to be provided with the bill showing the daily rate for the dates the services were rendered. The participant is required to pay for all services up front before submitting charges to the Plan.

5 **Surprise billing and the No Surprises Act**: There are certain balance billing protections to protect consumers from getting a balance bill calculated at the out-of-network rate for out-of-network emergency services or when consumers have a scheduled procedure at an in-network hospital or surgery facility and are seen by an out-of-network provider. Note that some balance billing protections are waivable. Click here for more information.

To see examples of how this Plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this Plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the Plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The Plan's overall deductible*	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,500**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The Plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$720
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The Plan's overall deductible	$2,000
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like: Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

***Note**:This charge does **NOT** include facility charges for the newborn baby. Charges for the newborn baby would be subject to the family deductible. If you have family coverage, you must meet the family deductible before this Plan begins to pay for covered services.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

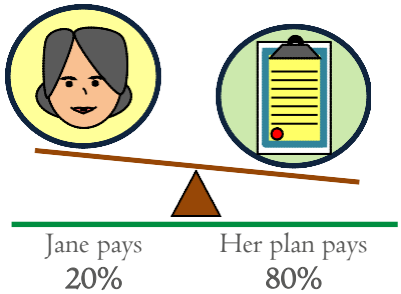
Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance



Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

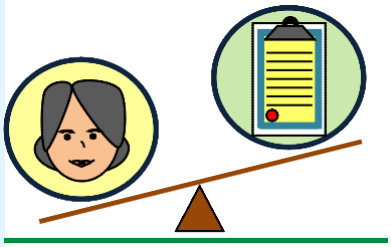
Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

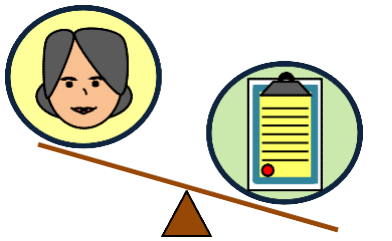
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

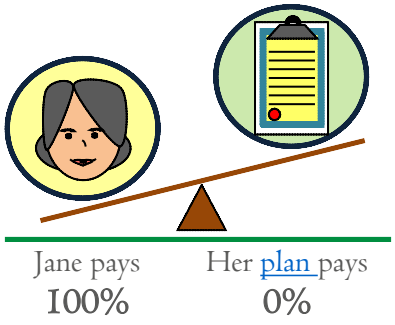
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

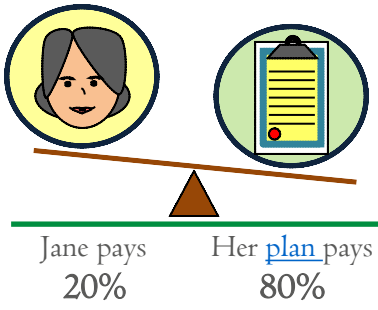
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

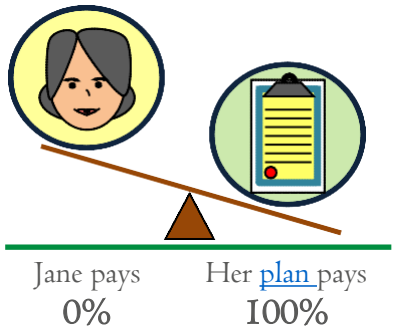
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

PHI CARES
National Air Membership Program

A service of PHI Air Medical

Air Medical Membership Program Benefits

2023

PHI Air Medical

PHI Air Medical is a leading air ambulance provider across the United States. PHI provides air medical services and outreach education to local communities and leading healthcare systems. We safely transport more than 30,000 patients each year, operating out of more than 60 bases across the United States. For more information on base locations, go to www.PHICares.com.

Membership Program Benefits

- We offer National coverage- Visit our website:www.phicares.com

- With Membership, **you will not have to pay any out-of- pocket expense for your air medical transport**, when flown by PHI Air Medical.
  - No co-payments, deductibles, co-insurance or out-of-pocket expenses for your PHI flights.
  - Covers the unpaid portion of your PHI Air Medical services.
  - Unlimited transports by PHI Air Medical.
  - Unlimited financial coverage for PHI flights.
  - Members can use their benefits for scene calls or Inter-Facility hospital transfers.
  - Emergency medical transportation must be requested by an authorized first responder.

PHI Cares Annual Membership Fee

Household memberships cover ALL dependent family members residing at the address, **plus** 3 non-family members who live at the same address

Jackson Electric Cooperative Employee Rate - ~~$50.00~~ Paid by JEC