NRECA Short Term Disability Plan

SUMMARY PLAN DESCRIPTION

For:

COLES-MOULTRIE ELECTRIC COOPERATIVE

01-14008-003

EFFECTIVE DATE: January 1, 2013

NRECA

Introduction

This document is a Summary Plan Description (SPD) providing you with a summary of the key provisions of the NRECA Short Term Disability Plan (referred to as the "Plan" in this document) for COLES-MOULTRIE ELECTRIC COOPERATIVE. This Plan is a component plan of the NRECA Group Benefits Program. In the pages that follow, you will find information on the benefits provided by the Plan.

Each participant in this Plan is responsible for reading this SPD and related materials completely and complying with all rules and Plan provisions.

If the terms of this SPD conflict with the terms of the governing plan document, then the terms of the governing plan document will control, rather than this SPD.

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Chapter 1: Contacts

Information about: • **Claims**	Claims Administrator Cooperative Benefit Administrators, Inc. P.O. Box 6249 Lincoln, NE 68506 1-866-673-2299, press # 1 https://benefits.cooperative.com/app/ElectronicEob/ClaimsInformation
Information about: • **Eligibility** • **Enrollment** • **When Coverage Begins or Ends** • **Cost of Coverage** • **General Questions**	Benefits Administrator COLES-MOULTRIE ELECTRIC COOPERATIVE PO Box 709 Mattoon, IL 61938

Chapter 2: Short Term Disability Plan Highlights

Benefits	Amounts
Disability Weekly Benefit	66 2/3% of your weekly Earnings * up to a maximum weekly benefit payment of $800
Maximum Benefit Period	13 weeks

* The benefit is based on your basic weekly Earnings (not exceeding 40 hours, exclusive of bonus, deferred compensation, over-time pay, and other additional compensation you may be receiving at the time of Disability).

Chapter 3: Eligibility and Coverage Information

Eligibility for Participation

Active Employees (see "Definitions") are eligible for participation in the Plan, unless they are excluded by their job classification. The following job classifications (or job titles) of Employees are not eligible to participate in this Plan:

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

Eligibility Waiting Period

In order to be eligible to participate in the Plan, you must have satisfied your Employer's (see "Definitions") Eligibility Waiting Period (see "Definitions") and have completed and returned the NRECA Employee Worksheet to your Benefits Administrator within 31 days of satisfying your Employer's Eligibility Waiting Period.

The Eligibility Waiting Period is the length of time that you must have worked for your Employer before you can participate in the Plan.

Your Plan has the following Eligibility Waiting Period: No Waiting Period is required by this Plan.

Additional Eligibility Requirements

In addition to meeting the eligibility requirements noted above, you must also:

- Be expected to work at least 1,000 hours as an Employee during your first 12 months of employment;
- Have worked at least 1,000 hours during each subsequent calendar year; or
- Have worked at another co-op within the past six months and met one of the other criteria above.

You must also satisfy the Active Work Requirement (see "Definitions").

When Coverage Begins (Participation Date)

You are covered under this Plan effective on the later of: a) the effective date of the Plan, or b) the date you meet the eligibility criteria (see "Eligibility for Participation" and "Eligibility Waiting Period" sections).

Cost of Coverage

You and your Employer share the cost of your coverage as follows:

- You and the employer share in the cost of the coverage.

Please note that the cost of your coverage is subject to your Employer's policies and can change at any time.

Special Enrollment Opportunity

If you decline coverage during your initial enrollment period, you may qualify for an additional opportunity to enroll as a late enrollee, subject to evidence of insurability, if you experience the following events:

- Marriage, birth, adoption or placement for adoption, if you enroll prior to and within 31 days after the event date.
- Divorce or death of spouse or dependent child, if you enroll within 31 days after the event date.
- Changes in employment status that would make you eligible to participate in the Plan.
- Annual enrollment, if offered by your Employer.

As a late enrollee in the Plan, you are subject to the evidence of insurability requirement. You can provide evidence of insurability by completing a Statement of Good Health (see "Definitions") application within 60 days of the effective date of election. Your Benefits Administrator will provide you with instructions for satisfying this requirement. The Plan Administrator will then approve or deny coverage based on the evidence of insurability provided.

When Coverage Ends

Your Disability coverage ends the earliest of the following dates:

- Date your employment terminates or date you transfer to a job classification (or title) that your Employer does not cover;
- Date you cease to be eligible for participation under the Plan;
- Date you cease to pay premiums required under the Plan;
- Date you retire from your Employer;
- Date the Plan is terminated, changed, or no longer covers your job classification (or title); or
- Date you take a leave of absence for reasons other than Disability or an Employer-approved leave of absence, in which case coverage would terminate on the last day worked.

If your group disability coverage under this Plan terminates, for any reason, it may not be converted to an individual disability policy.

Chapter 4: Short Term Disability Benefits

Definition of Disability

To be considered "Disabled" due to Sickness (see "Definitions") or Injury (see "Definitions"), you must not be able to perform some of all of the Material and Substantial Duties (see "Definitions") of your job with your employer. The Injury must also have occurred while you were covered under this Plan (see "Chapter 3").

You don't have to be confined to your home, but you must be under the regular care of a Physician (see "Definitions").

It is important to keep in mind that to meet the definition of Disabled, you may not work and earn an income. If you are working and earning an income, you are not eligible to receive benefits under this Plan.

When Benefits Begin

Once you have met the eligibility requirements under the Plan (see "Chapter 3"), your weekly short term disability benefits begin on the eighth consecutive day on which you are Disabled and unable to work due to a covered Injury or Sickness.

Disability Benefit Amounts

Your short term disability benefit is 66 2/3% of your weekly Earnings (see "Definitions") up to a maximum weekly benefit payment of $800.

If your Earnings change while receiving a benefit under this Plan, your weekly benefit will not be adjusted until you are eligible to receive a benefit again after having first satisfied the Active at Work Requirement.

Length of Disability Benefits

Benefits will be paid while you remain Disabled, up to a maximum of 13 weeks.

When Benefits End

Benefit payments under this Plan will terminate upon, the earliest of the following:

- You no longer meet the definition of Disabled, as determined by CBA;
- You fail to provide Proof of Loss (see "Definitions") or written proof of your continued Disability to CBA, when and as required by CBA;

- You refuse to receive ongoing care from your Physician that is appropriate to your Disabling condition and/or such care is not administered as often as necessary to achieve maximum medical improvement during the period of Disability, in CBA's sole discretion;
- You have reached the end of the Maximum Benefit Period;
- You become confined to jail, prison, or other house of correction as a result of conviction for a criminal or other public offense; or
- You die.

Recurrent and New Disabilities

For purposes of satisfying the Benefit Waiting Period (see "Definitions"), if you have been Actively at Work for less than 14 days, a Disability resulting from the same or similar cause or condition will be regarded as a continuation of the prior Disability, and satisfaction of a new Benefit Waiting Period is not required. Please keep in mind that the Maximum Benefit Period (see "Definitions") for the two Disabilities combined will not extend the Maximum Benefit Period for the original Disability. If you have been Actively at Work for 14 or more days, a Disability resulting from the same or similar cause or condition will be regarded as a new Disability, and a new Benefit Waiting Period must be satisfied before benefits can begin.

If you become Disabled from a condition unrelated to your prior Disability after being Actively at Work for your Employer for at least one day, that Disability will be considered a new Disability, and a new Benefit Waiting Period must be satisfied before benefits can begin.

In all cases, benefits for new Disabilities require this Plan to be in force at the time of your new Disability. All exclusions and limitations in this Plan will apply to the new Disability.

Multiple Disabilities

If you suffer from two or more Disabilities at the same time, whether related or unrelated, benefits will be paid as if the Disabilities were caused by one Injury or one Sickness. In no event will you be considered to have more than one continuous period of Disability at the same time.

Disability Plan Exclusions

No Disability benefit will be paid for Disabilities:

- Arising out of, or in the course of, any employment for wage or profit, or disease covered, with respect to such employment, by any Workers' Compensation law, occupational disease law or similar legislation;
- Caused by or contributed to by service in the Armed Forces, National Guard, or military reserves of any country or international authority (including active duty, active duty for training purposes, undeclared war and resistance to armed aggression), except for a non-service connected Injury or Sickness while on a temporary tour of duty of 31 days or less;
- Caused by or contributed to an act of war, declared or undeclared;
- Resulting from an attempted suicide or intentionally self-inflicted Injury, while sane or insane;
- Caused by or contributed to, or resulting from participation in the commission of an assault, felony, strike, civil disorder, or riot;
- When you are confined to jail, prison, or other house of correction as a result of conviction for a criminal or other public offense;
- When you fail to provide Proof of Loss acceptable to CBA; or

- For which you are not being treated or for which you are not under the care of a Physician appropriate to the Disabling condition or for which you are not receiving care that is administered as often as necessary to reach maximum medical improvement.

Workers' Compensation Benefits

CBA may, in its discretion, advance the disability benefits to you (to the extent you are otherwise eligible for disability benefits under the terms of the Plan) while your Workers' Compensation benefits are pending. However, if CBA advances such benefits, you will be required to promise in writing that you will repay the advance as soon as you receive the such benefits, whether permanent partial, temporary total, lump sum, or settlement. If you do not repay the advance within 30 days of your receipt of these benefits, CBA reserves the right to take legal action to pursue repayment plus interest at the rate equal to the Prime Rate + three percent (3%) (compounded annually from the date that is 30 days after your receipt of the Workers' Compensation benefits) on the principal amount of the advance that is not repaid within 30 days of your receipt of these benefits. CBA may also recover from you reimbursement of CBA's costs and attorney's fees incurred to enforce this repayment provision. You agree to notify CBA within forty-five (45) days of the date when notice is given to any third party of your intention to recover Workers' Compensation relating to your disability.

Chapter 5: Applying for Short Term Disability Benefits

Initial Proof of Disability

You must notify Cooperative Benefit Administrators (CBA) of your Disability within **90 days** of the onset of the Disability by sending CBA the completed claim form and Attending Physician's Statement of Disability. Contact your Benefits Administrator for a claim form and instructions on how to complete the form.

Once CBA has been notified of the Disability, you will be required to provide Proof of Loss (see "Definitions") by sending CBA the completed claim form with the Attending Physician's Statement of Disability, along with any additional information CBA may need to approve the application for Disability benefits. Contact your Benefits Administrator for a claim form and instructions on how to complete the form. You and your Employer each have sections of the form to fill out.

Proof of Loss must be furnished in writing to CBA not more than 90 days after the last day of your Benefit Waiting Period. If it is not reasonably possible to give initial notice or Proof of Loss within the time limits, benefits may not be invalidated or reduced as long as CBA receives it as soon as reasonably possible.

No claim for disability shall in any event be approved by CBA if notification of Disability and application are not provided to CBA within two years of the onset of the Disability.

Completed claim forms and documentation supporting Proof of Loss should be sent to:

Claims Administrator
Cooperative Benefit Administrators, Inc.
P.O. Box 6249
Lincoln, NE 68506

If you disagree with CBA's determination in whole or in part, you may file an Appeal (see "Claims and Appeals Procedures").

Continuing Proof of Disability

Proof of continuing disability indicating you are under the regular care of a Physician, may be required and must be provided at your expense upon request. In some cases, you may be required to give CBA authorization to obtain additional medical information, and to provide non-medical information as part of the continuing proof of Disability. CBA may also require you to be examined by CBA's Physician or personally interviewed by CBA or its agents at such times and such frequency as CBA, in its sole discretion, deems necessary to establish Proof of Loss. The claim may be denied or benefits may end if the requested information is not submitted.

Chapter 6: Claims and Appeals Procedures

You may file claims for Plan benefits and appeal adverse claim decisions, either yourself or through an authorized representative. An authorized representative is a person you authorize in writing to act on your behalf. An authorized representative may not be a doctor or other health provider.

Using an Authorized Representative

If you use an authorized representative, you will need to complete the form "Authorization to Use and Disclose Protected Health Information". Ask your Benefits Administrator for the form. Before you submit the form to NRECA, you may contact the Plan's Privacy Officer to ask questions about the use and disclosure of your health information. You may contact the Privacy Officer by telephone at (703) 907-6601, by fax at (703) 907-6602, or by email at privacyofficer@nreca.coop. Please send the completed form to the Plan's Privacy Officer at the following address to be reviewed and accepted:

Privacy Officer
NRECA
4301 Wilson Boulevard
Arlington, VA 22203-1860

Process for Disability Claims and Appeals

Time limit for you to notify CBA of your Disability:	Not later than 90 days from the onset of your Disability.
Time limit to file Proof of Loss:	Not later than 90 days from the last day of your Benefit Waiting Period.
Submit your claim to:	Claims Administrator CBA P.O. Box 6249 Lincoln, NE 68506
Date your claim is considered "filed":	The date CBA receives your completed claim in writing.
Time Period that CBA has to notify you that your claim is approved or	Not later than 45 days after receipt of claim by the Plan; two extensions of up to 30 days each, if circumstances warrant, may be required. CBA will notify you within the initial 45-day period if an extension is required. If CBA

denied:	needs the initial 30-day extension because you did not provide all of the information needed to process your claim, CBA will tell you what information is missing. If an additional 30-day extension is needed, CBA will notify you before the end of the first 30-day extension.
If your claim is incomplete, the time you have to submit additional requested information to CBA:	Not later than 45 days from the date CBA sends you the notice to tell you that your claim is missing information. If you do not send the information within the 45-day period, CBA will deny your claim.

The time period for deciding your claim is suspended from the date CBA notifies you that your claim is incomplete until the date you provide CBA with the requested information. CBA may then use the remainder of the review period to complete its evaluation of the claim.

If your claim is denied: CBA will provide you a notice that contains:

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

Time period that you, or your authorized representative, have to request an appeal:	Not later than 180 days from the date you receive the notice that your claim is denied.

You may request copies of all documents, records, and other information related to your denied claim from the Plan, free of charge. You also have the right to submit with your appeal written comments, records, documents and other information to support your appeal, whether or not you already submitted these items.

Submit your Appeal to:	Appeals Administrator CBA P.O. Box 6249

Lincoln, NE 68506

The Appeals Administrator is a different person than the person who made the original decision to deny your claim and is not someone directly supervised by the original decision-maker. The Appeals Administrator will conduct a full and fair review of all documents and evidence to support your claim for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different from the ones previously consulted.

Time Period the Appeals Administrator has to review your appeal:	Not later than 45 days from the date the Appeals Administrator receives your appeal. The Appeals Administrator may request one 45-day extension and will notify you during the initial 45-day period if the extension is required.
If your appeal is denied:	The Appeals Administrator will provide you a notice that contains: • Specific reason(s) for the benefit denial; • Reference to specific Plan provisions on which denial is based; • Description of any additional information needed to perfect the claim, and an explanation of why such information is needed; • Description of the Plan's appeal procedures and time limits that apply to them; • Explanation of your rights under ERISA's claims and appeals rules; and • A copy of any internal rule, guideline, protocol or similar criterion relied on (or a statement that the material is available upon request for free).

You have now completed the Plan's appeal process. However, you may voluntarily take part in one more level of review of your denied appeal called the Voluntary Final Appeals Process. If you do not choose to use the Voluntary Final Appeals Process, you may seek legal action by filing suit under ERISA within one year from the date your appeal was denied.

Voluntary Final Appeal Process:	You may use this option if you wish to have the Plan's Appeals Committee review your denied appeal. Using this Voluntary Final Appeal Process has no effect on your rights to any other benefits under the Plan or your rights to legal action. Before you submit your written request, you may request additional information about the Voluntary Final Appeal Process by calling (402) 483-9200.

Time period that you have to file your voluntary final appeal:	Not later than 60 days from the date you receive the notice that your appeal is denied by the Appeals Administrator.

You may request copies of all documents, records, and other information related to your denied claim from the Plan, free of charge. You also have the right to submit with your appeal written comments, records, documents, and other information to support your appeal, whether or not you already submitted these items.

Submit your voluntary final appeal to:	Appeals Committee CBA 9284 P.O. Box 6249 Lincoln, NE 68506

The Appeals Committee is selected by the Plan Administrator, and was not involved in the original decision to deny your claim or the denial on appeal. The Appeals Committee will conduct a full and fair review of all documents and evidence to support your claim for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different persons than the ones previously consulted.

Time period the Appeals Committee has to review your voluntary final appeal:	Not later than 60 days from the date the Appeals Committee receives your appeal. An extension may be requested for up to 60 days, if circumstances warrant. CBA will notify you within the initial 60-day period if an extension is required. The Appeals Committee will conduct a full and fair review of all documents and evidence submitted to support your claims for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different persons than the ones consulted previously.
If your voluntary final appeal is denied:	The Appeals Committee will provide you a notice that contains: • Specific reason(s) for the benefit denial; • Reference to specific Plan provisions on which denial is based; • Description of any additional information needed to perfect the claim, and explanation of why such information is needed; • Explanation of your rights under ERISA's claims and appeals rules; and • A copy of any internal rule, guideline, protocol or similar criterion relied on (or a statement that the

material is available upon request for free).

You may take legal action by filing suit under ERISA within one year from the date your voluntary final appeal was denied.

Chapter 7: Plan Information

Plan Name: The Plan operates under the official name of the National Rural Electric Cooperative Association's Group Benefits Program.

Plan Number: 501

Type of Plan: Short Term Disability Plan

Plan Year: The Plan Year begins on January 1 and ends the following December 31, unless otherwise designated in the Plan document.

Effective Date: January 1, 2013

Plan's Self-Insured Status: Coverage under the Plan is self-insured and funded through contributions made solely by NRECA, or jointly by NRECA and participating cooperatives:

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

Administration: Except where pre-empted by ERISA or other U.S. laws, the validity of the Plan and any other provisions will be determined under the laws of the Commonwealth of Virginia.

Plan Sponsor: The name and address of the Plan Sponsor is:

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

NRECA, as the Plan Sponsor, must abide by the rules of the Plan when making decisions related to how the Plan operates and how benefits are paid.

Plan Sponsor's Employer Identification Number: 53-0116145

Plan Administrator: The Plan Administrator has discretionary and final authority to interpret and implement the terms of the Plan, resolve ambiguities and inconsistencies, and make all decisions regarding eligibility and/or entitlement to coverage or benefits. The Plan Administrator is:

Senior Vice-President
Insurance & Financial Services
National Rural Electric Cooperative Association
4301 Wilson Boulevard

Arlington, VA 22203-1860
Telephone number: (703)907-5500
Employer Identification Number: 54-2072724

In addition to the Senior Vice-President of Insurance & Financial Services, the individual listed below is the person who has Plan Administrator responsibilities for your Employer:

Benefits Administrator
COLES-MOULTRIE ELECTRIC COOPERATIVE
PO Box 709
Mattoon, IL 61938
Employer Identification Number: 37-0223453

Plan Trustee: The trustee for the Plan is:

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

Claims Administrator: The Claims Administrator for the Plan is:

Cooperative Benefit Administrators, Inc.
P.O. Box 6249
Lincoln, NE 68506

Agent for Service of Legal Process: The agent of service of legal process is the Plan Administrator. This is the person who receives all legal notices on behalf of the Plan Sponsor regarding the claims or suits filed with respect to this Plan. Such legal process may also be served upon the Plan Trustee.

Chapter 8: Administrative Information

Not a Contract of Employment

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

Non-Assignment of Benefits

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

Third Party Liability

The Plan does not cover Disability expenses that you incur as a result of an Injury or Sickness caused by a third party (such as in an automobile accident). This provision of the Plan allows you to receive Disability benefits, and, at the same time, places the expense of Disability coverage with the person or entity that caused the Injury or Sickness. As a condition of receiving benefits under this Plan, you are expected to cooperate with CBA with its recovery of any amounts for which the Plan is entitled to be reimbursed, including the completion of any forms, and to repay the Plan any amounts you receive for loss of income due to the Injury or Sickness. The Plan will seek recovery for payment of benefits through subrogation or reimbursement.

Subrogation

Immediately upon paying any benefits to you, the Plan shall be subrogated (that is, substituted for) all rights or recovery that you have against any party for loss of income due to your Injury or Sickness. This means that in the event you receive a settlement, judgment, or compensation from the third party for your loss of income due to your Injury or Sickness, the Plan has an independent right to seek reimbursement of the Disability benefits it paid on your behalf under this Plan. You must notify the Plan within 45 days of the date when notice is given to any third party of your intention to recover damages due to your Injury or Sickness. If you enter into litigation for payment of your Disability, you must not prejudice, in any way, the subrogation rights of the Plan. Any costs incurred by the Plan in matters related to subrogation will be paid for by the Plan. The costs of legal representation you incur will be your responsibility.

Reimbursement

In most cases, the Plan will not be reimbursed directly by the third party. Normally, your claim against the third party will be settled with the third party. Therefore, if your Disability benefits are paid by the Plan and then you receive settlement from the third party or the third party's insurer to compensate you for your loss of income, you must reimburse the Plan for the benefits it paid to you up to the amount of such compensation. This Plan's right of reimbursement is a first priority right of reimbursement, to be satisfied before payment of any other claims, including attorney's fees and costs, and regardless of any state's make-whole doctrine. **If you fail to repay the Plan any amounts you receive for loss of income due to the Injury or Sickness, the Plan reserves the right to bring legal action against you for amounts owed to the Plan and/or to suspend payment(s) for any future Disability benefits until it has recovered such amounts.**

Right of Recovery of Overpayment

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

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

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

Amendment or Termination

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

Severability

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

Additional Procedures

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

Chapter 9: Federal Laws Impacting This Plan

Statement of ERISA Rights

Your Rights

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, if any, and a copy of the latest annual report (Form 5500 series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case NRECA, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

Duties of Plan Fiduciaries

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

Enforce Your Rights

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

benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Please remember that you may not file a lawsuit in federal or state court to enforce your rights until you have exercised, and exhausted, all mandatory administrative claim and appeal rights described in the Plan and in this document. Any suit for benefits must be brought within one year from the date the final appeal determination was made.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, 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.

Chapter 10: Definitions

Accident – A non-work related Injury which is:

- Caused by an event which is sudden and unforeseen; and
- Exact as to time and place of occurrence.

Active Work Requirement or Actively at Work – A requirement that an Employee be present at work at the business establishment of the Employer, or at other locations to which the Employer's business requires the Employee to travel, on a day which is one of the Employer's scheduled work days, and is performing, in the usual way, all of the regular duties of the Employee's job on a full-time basis on that day. An Employee will be deemed to be Actively at Work on a day which is not one of the Employer's regularly scheduled work days only if the Employee was Actively at Work on the preceding scheduled work day. An Employee will be deemed to satisfy the Active Work Requirement if he is on an Employer-approved leave of absence (e.g., Family and Medical Leave Act (FMLA) absence, jury duty, bereavement leave, vacation), but does not include time off as a result of Injury or Sickness. In no event will an Employee be deemed to be on an Employer approved leave of absence for any absence that continues longer than 12 weeks, except for an FMLA leave of absence to care for family members who are injured while on active duty in the Armed Forces, including the National Guard or Reserves, which provides the Employee with a leave up to 26 weeks. If an Employee is confined for medical care or treatment in a Hospital, any institution or at home, however, on the date coverage would otherwise become effective, the effective date of his eligibility to participate in the Plan will be postponed until he receives final medical release from the medical confinement and he satisfies the Active Work Requirement.

Benefit Waiting Period – A seven day period of continuous Disability beginning on the first scheduled work day missed due to Disability.

Cooperative Benefit Administrators, Inc. ("CBA") – The claims adjudicator for the Plan.

Disability – See Chapter 4 "Definition of Disability".

Earnings – The Employee's Earnings for a normal work week that does not exceed 40 hours, not including bonuses, deferred compensation, overtime pay or other additional compensation that the Employee may be receiving at the time of Disability.

Eligibility Waiting Period – The period, if any, chosen by the Employer, of continuous employment with the Employer required before participation in the Plan is available to an Employee.

Employee – A person who is:

- actively working for the Employer; and
- receiving Earnings.

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

Hospital – An institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Injury – Bodily harm that is the direct result of an Accident and not related to any other cause. This Accident must not be employment-related.

Maximum Benefit Period – The maximum period for which Disability benefits may be paid.

Material and Substantial Duties – The essential tasks of an occupation that cannot reasonably be modified or omitted, not including overtime work.

Physician – A legally qualified medical doctor or practitioner who is licensed in the governing jurisdiction and practicing within the scope of the license. The physician or doctor must not be related to the participant by blood or marriage.

Plan - NRECA Short Term Disability Plan.

Proof of Loss – Proof of Loss may include, but is not limited to, the following:

1) Documentation of:
    - the date your Disability began;
    - the cause of your Disability;
    - the prognosis of your Disability;
    - your Earnings or income, including, but not limited to, copies of your filed and signed federal and state tax returns; and
    - evidence that you are under the care of a Physician that is appropriate to the disabling condition.

2) Any and all medical information, including X-rays and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;

3) The names and addresses of all:
   a) Physicians and practitioners of healing arts you have seen or consulted;
   b) hospitals or other medical facilities in which you have been seen or treated; and
   c) pharmacies which have filled your prescriptions within the past three years.

4) Your signed authorization for us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information we may reasonably require.

All proof submitted must be satisfactory to CBA. No benefits will be paid unless and until CBA has determined in its sole discretion that the Proof of Loss submitted satisfies the definition of Disability.

At any time during your Disability, CBA has the right to have a Physician or other licensed professional examine you, or to have its agents and subcontractors conduct personal interviews with you. Claims are regularly reviewed by CBA to confirm continuing eligibility for benefits.

Statement of Good Health – Satisfactory medical information and representations provided by the Employee, as determined by NRECA, that a person is in satisfactory good health, and it is not reasonably expected that the Employee would become Disabled in the immediate future.

Sickness – Any disease or illness not employment-related. The term also includes:

- pregnancy; or
- any medical complications of pregnancy.

Sickness must begin while the Employee is covered under the Plan.