NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

LONG-TERM DISABILITY PLAN

A Constituent Plan of the
NRECA Group Benefits Program

Employee Long-Term Disability Coverage
Providing 66 2/3% of Monthly Earnings

Employee Long-Term Disability Coverage
Providing 60% of Monthly Earnings

Employee Long-Term Disability Coverage
Providing 50% of Monthly Earnings

Grandfathered Employee Long-Term Disability Coverage
Providing 50% of Monthly Earnings

As Amended and Restated
January 1, 2012

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SECTION I
Establishment

1.01 Establishment and Continuation. NRECA hereby continues, amends and restates, effective January 1, 2012, the following long-term disability plan established for itself and its member systems. The purpose of this Plan is to allow eligible employees of NRECA and its Participating Cooperative members to obtain a partial continuation of wages during a period of disability under the terms and conditions of the Plan. The Plan is a component plan of the NRECA Group Benefits Program.

SECTION II
Definitions

Each term defined in this Section shall have the following meaning for the Plan, unless a different meaning is clearly required by the context of the Plan. To the extent not defined in this Plan, capitalized terms shall have the meaning given to them under the NRECA Group Benefits Program.

2.01 "Accident" means an Injury which is both:

(i) Caused by an event which is sudden and unforeseen; and

(ii) Exact as to time and place of occurrence.

2.02 "Active Work Requirement" or "Actively at Work" means a requirement that an Eligible Employee be present at work at the business establishment of the Participating Cooperative, or at other locations to which the Participating Cooperative's business requires the Eligible Employee to travel, on a day which is one of the Participating Cooperative's scheduled work days, and is performing, in the usual way, all of the regular duties of the Eligible Employee's job on a full-time basis on that day. An Eligible Employee will be deemed to be Actively at Work on a day which is not one of the Participating Cooperative's regularly scheduled work days only if the Eligible Employee was Actively at Work on the preceding scheduled work day.

An Eligible Employee will be deemed to satisfy the Active Work Requirement if the Eligible Employee is on an employer-approved leave of absence (e.g., Family and Medical Leave Act (FMLA) leave, jury duty, bereavement leave, vacation), but such employer-approved leave of absence does not include time off as a result of Injury or Sickness. The preceding sentence notwithstanding, in no event will an Eligible Employee be deemed to be on an employer-approved leave of absence for any absence that continues longer than twelve (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 the Participating Cooperative grants an approved leave of absence to an Eligible Employee and desires to keep coverage under the Plan in force for such Eligible

Employee, the required premium must be paid during such leave of absence in accordance with the terms of this Plan.

2.03 "Benefit Waiting Period" means a time of continuous Disability extending for thirteen (13) or twenty-six (26) consecutive weeks (as selected by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program) between the first scheduled day of work missed due to Disability and the day on which benefits commence. If the Participant returns to work with the Participating Cooperative for a period of thirty (30) days or less (whether or not consecutive) during the Benefit Waiting Period, the Benefit Waiting Period shall nevertheless commence from the first day of Disability, but the days worked shall not be counted for purposes of satisfying the Benefit Waiting Period.

2.04 "Compensation Limit" means the limit imposed by the Omnibus Reconciliation Act of 1993, as adjusted for inflation ($245,000 in 2011).

2.05 "Disability" or "Disabled" means that the Participant:

(i) is prevented from performing any or all of the Material and Substantial Duties of his Own Occupation due to any Injury, Sickness, Mental/Nervous Condition, or episode of Substance Abuse;

(ii) has lost at least twenty percent (20%) of his Pre-Disability Earnings; and

(iii) is meeting all other Plan requirements.

After 24 months of Disability, "Disability" then means that the Participant:

(i) is unable to perform any or all of the Material and Substantial Duties of any Gainful Occupation due to any Injury, Sickness, Mental/Nervous Condition (if so elected by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program), or episode of Substance Abuse (if so elected by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program), for which he is qualified based on education, training, and experience;

(ii) has lost at least forty percent (40%) of his Pre-Disability Earnings; and

(iii) is meeting all other Plan requirements.

2.06 "Earnings" or "Pre-Disability Earnings" means the Participant's earnings from the Participating Cooperative for a normal work week that does not exceed forty (40) hours, not including bonuses, deferred compensation, overtime pay and other additional compensation that the Employee may be receiving at the time of Disability.

2.07 "Earnings While Disabled" means the earnings the Participant receives from the Participating Cooperative (excluding sick leave, vacation leave, and paid time off) and any other employment while Disabled. However, if the other employment is a job held in addition to active full-time employment with the Participating Cooperative, then for the Benefit Waiting Period and the next twenty-four (24) months, any earnings from other employment will be Earnings While Disabled only to the extent that they exceed the average monthly earnings received from this other employment during the six (6)-month period immediately prior to becoming Disabled.

2.08 "Eligibility Waiting Period" means the period, if any, chosen by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program, of continuous employment by the Participating Cooperative that is required before participation in the Plan is available to an Employee.

2.09 "Eligible Employee" means an Employee who is in the group of Employees designated by the Participating Cooperative as eligible for participation in the Plan upon satisfaction of all of its participation requirements, but not including any Director, Director Emeritus or Retained Attorney or any Employee not satisfying the Active Work Requirement.

2.10 "Evidence of Insurability" means medical information and representations provided by the Employee, satisfactory to the Plan, that the Employee is in satisfactory good health and it is not reasonably expected that the Employee would become Disabled in the immediate future.

2.11 "Gainful Occupation" means any activity for profit or compensation which replaces or can be expected to replace more than sixty percent (60%) of the Participant's Pre-Disability Earnings.

2.12 "Hospital" means 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.

2.13 "Injury" means bodily harm that is a direct result of an Accident and not related to any other cause.

2.14 "Material and Substantial Duties" means the essential tasks of an occupation that cannot reasonably be modified or omitted, not including overtime work.

2.15 "Mental/Nervous Condition" means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of causes (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical manifestations thereof. Mental/Nervous Condition includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders. Mental Nervous Condition excludes demonstrable, structural brain damage.

2.16 "NRECA Excess Long Term Disability Plan" means the supplemental disability insurance policy that provides disability benefits attributable to compensation that exceeds the Compensation Limit.

2.17 "Own Occupation" means any similar job that involves Material and Substantial duties of the same general nature as the Participant's regular job at the Participating Cooperative when the Disability begins. It does not mean the specific job the Participant is performing for a specific Participating Cooperative or at a specific location.

2.18 "Participant's Earnings" means earnings for a normal work week from the Participating Cooperative not exceeding forty (40) hours, exclusive of bonus, deferred compensation, overtime pay and any other form of additional compensation, in effect at the time of Disability; provided that the amount of a Participant's Earnings taken into account for any calendar year shall not exceed the Compensation Limit.

2.19 "Physician" means a legally qualified medical doctor or practitioner who is licensed in the governing jurisdiction and practicing within the scope of the license and who is not related to the Participant by blood or marriage.

2.20 "Plan" means this welfare benefit plan for long-term disability benefits as described in this document with the optional provisions as selected by the Participating Cooperative pursuant to Section 2.02 of the NRECA Group Benefits Program.

2.21 "Pre-Existing Condition" means any Injury, Sickness, Mental/Nervous Condition, or episode of Substance Abuse. Pre-existing condition may also mean any manifestations, symptoms, findings or aggravations related to or resulting from such Injury, Sickness, Mental/Nervous Condition, or Substance Abuse for which an Eligible Employee received, or a reasonable person would have sought, Medical Care during the ninety (90)-day period that ends immediately before the Eligible Employee's effective date of coverage under this Plan – regardless of whether the condition was formally diagnosed or strongly suspected.

(a) "Medical Care" means a Physician is consulted or medical advice is given. It may also mean treatment is recommended, prescribed by or received from a Physician.

(b) "Treatment" means medical examinations, tests, attendance or observation. Treatment also means the use of drugs, medicines, medical services, supplies or equipment.

2.22 "Proof of Loss" means various medical, employment and financial documentation, medical provider information, and authorizations to obtain and release information as may be required by CBA in its sole discretion to document a Participant's Disability.

2.23 "Sickness" means any disease or illness. The term also includes pregnancy and any medical complications of pregnancy.

2.24 "Substance" means alcohol and those drugs, other than tobacco and caffeine, that are included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs.

2.25 "Substance Abuse" means the pattern of pathological use of a Substance, which is characterized by: impairments in social and/or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption of the Substance, or the need for daily Substance use for adequate functioning.

2.26 "Termination of Employment" means when an Employee is no longer engaged in work as an Employee for the Participating Cooperative.

SECTION III
Participation by a Cooperative

3.01 Cooperative Participation. Pursuant to Section 2.02 of the Group Benefits Program, a cooperative may become a Participating Cooperative in this Plan, and shall elect the optional features of the Plan, as well as the terms for eligibility and participation in the Plan.

SECTION IV
Employee Eligibility for Participation

4.01 Employees Eligible for Participation. The Participating Cooperative shall designate, pursuant to Section 2.02 of the Group Benefits Program, the groups of Employees that are Eligible Employees and the conditions, if any, for them to become Participants in the Plan.

4.02 Determination of Eligibility Status. The Participating Cooperative shall determine and notify NRECA when an Employee is an Eligible Employee under the Plan at the Participating Cooperative, but no Employee shall be eligible for benefits from more than one classification as an Eligible Employee. Such determinations shall be made on those dates that are established by the practices of the Participating Cooperative. The final determination of whether someone is eligible for participation shall be made by NRECA, subject to Section 8.05 of the Group Benefits Program.

SECTION V
Commencement of Participation

5.01 Initiation of Participation. An Employee shall be a Participant from the first day the Employee is an Eligible Employee and each of the following requirements, as applicable, are simultaneously satisfied:

(a) If the Participating Cooperative has specified an Eligibility Waiting Period, the Eligible Employee has completed such period selected by the Participating Cooperative;

(b) If the Participating Cooperative has required contributions from Eligible Employees in order for such Employees to participate in the Plan, the Employee has requested participation of the Participating Cooperative in a form (e.g., completed an enrollment form) satisfactory to the Participating Cooperative and has agreed to make the required contributions;

(c) The Eligible Employee complies with the Active Work Requirement;

(d) If any Evidence of Insurability is required pursuant to Section 5.03, the Eligible Employee has complied with that requirement. The Eligible Employee will be considered as having complied as of the date the Plan determines the evidence to be satisfactory; and

(e) If the Eligible Employee is confined for medical care or treatment in a Hospital, any institution or at home on the date participation would have otherwise become

effective, the Eligible Employee has received a final medical release from the medical confinement and has satisfied the Active Work Requirement.

5.02 Automatic Inclusion. An Employee who becomes included in a group of Eligible Employees for which the Participating Cooperative has required Employee contributions in order for the Employee to participate in the Plan will be considered as having satisfied the requirement of Subsection 5.01(b) on the date of such inclusion if, on the day before, the Employee was participating in the Plan because of the Employee's inclusion in another group of Eligible Employees for which the Participating Cooperative requires Employee contributions in order for the Employee to participate in the Plan. The preceding sentence will not apply if (a) such inclusion is caused by an amendment to the Plan or if (b) on or before the thirty-first day after such inclusion date, the Employee gives the Participating Cooperative written notice of the Employee's election not to participate in the Plan.

5.03 Evidence of Insurability Required. An Employee must provide Evidence of Insurability satisfactory to the Plan in order to become a Participant in each of the following situations:

(a) if the Employee does not satisfy Subsection 5.01(b) before the end of the thirty-one (31) day period immediately following the first day on or after the Employee was otherwise eligible to participate in the Plan,

(b) if the Employee requests participation in the Plan after previous termination from participation in the Plan for any reason, or

(c) if the Employee has not satisfied any previous requirement that Evidence of Insurability of the Employee be furnished to the Plan in order for the Employee to become a Participant in the Plan.

If required, Evidence of Insurability must be submitted to NRECA within sixty (60) days of the effective date of coverage.

5.04 Life Event Enrollment Opportunities. This Plan provides enrollment opportunities to Employees when the following life events occur:

(a) For Spouse and Dependent Events. If an Eligible Employee has not previously elected coverage under the Plan for himself, the Eligible Employee may at any time prior to, and within thirty-one (31) days after the date the Eligible Employee gains a Spouse or Dependent by marriage, birth, adoption or otherwise, elect coverage for himself, subject to the terms of the Plan and Evidence of Insurability. In the event of divorce of the Eligible Employee or death of Spouse or Dependent, the Eligible Employee may also elect coverage under the Plan for himself within thirty-one (31) days of the divorce or death subject to the terms of the Plan and Evidence of Insurability. Subject to Evidence of Insurability, coverage for the Eligible Employee shall be effective on the later of the date coverage was elected or the date all requirements of Subsection 5.01 have been met.

SECTION VI
Termination of Participation

6.01 Termination of Participation. An Employee's participation in the Plan will automatically terminate as of the first day when:

(a) the Employee ceases to be an Eligible Employee for any reason, including (but not by way of limitation) Termination of Employment, failure to satisfy the Active Work Requirement for reasons other than Disability, or change of the Employee's classification so as not to be within a group of Eligible Employees,

(b) any contribution required by the Participating Cooperative of Eligible Employees as a condition to their participation in the Plan is not made when due, or

(c) the Plan is terminated as to the group of Eligible Employees of which the Employee was a member.

6.02 Cooperative Termination. If a Participating Cooperative ceases to be a Participating Cooperative under the Plan, the Plan and participation in the Plan, will be terminated with respect to all Employees of that Participating Cooperative.

6.03 No Conversion. If an Employee's coverage under the Plan terminates for any reason, it may not be converted to an individual plan.

SECTION VII
Provision of Benefits

7.01 66 2/3% of Earnings Benefit. For those Participants for whom the Participating Cooperative has selected the Sixty-Six and Two-Thirds Percent (66- 2/3%) Benefit pursuant to Section 2.02 of the Group Benefits Program, the benefit payable for each calendar month throughout which the Participant's Disability, as determined by CBA in its sole discretion, that continues beyond the Benefit Waiting Period to termination of benefits shall be sixty-six and two-thirds percent (66-2/3%) of the Participant's Earnings determined as of the day before the first day of Disability reduced by each Benefit Offset provided in Section VIII, but not reduced to less than sixty-five dollars ($65.00). One-thirtieth of the applicable benefit shall be paid for each day during the Disability which is not part of a full calendar month. Under no circumstances shall the combined monthly benefit payable under this Plan and the NRECA Excess Long Term Disability Plan exceed fifteen thousand dollars ($15,000).

7.02 60% of Earnings Benefit. For those Participants for whom the Participating Cooperative has selected the Sixty Percent (60%) of Earnings Benefit pursuant to Section 2.02 of the Group Benefits Program, the benefit payable for each calendar month throughout which the Participant's Disability, as determined by CBA in its sole discretion, that continues beyond the Benefit Waiting Period to termination of benefits shall be sixty percent (60%) of the Participant's Earnings determined as of the day before the first day of Disability reduced by each Benefit Offset provided in Section VIII, but not reduced to less than sixty-five dollars ($65.00). One-thirtieth of the applicable benefit shall be paid for each day during the Disability which is not part of a full calendar month. Under no circumstances shall the combined monthly benefit

payable under this Plan and the NRECA Excess Long Term Disability Plan exceed fifteen thousand dollars ($15,000).

7.03 50% of Earnings Benefit. For those Participants for whom the Participating Cooperative has selected the Fifty Percent (50%) of Earnings Benefit pursuant to Section 2.02 of the Group Benefits Program, the benefit payable for each calendar month throughout which the Participant's Disability, as determined by CBA in its sole discretion, that continues beyond the Benefit Waiting Period to termination of benefits shall be one-half (50%) of the Participant's Earnings determined as of the day before the first day of Disability reduced by each Benefit Offset provided in Section VIII, but not reduced to less than sixty-five dollars ($65.00). One-thirtieth of the applicable benefit shall be paid for each day during the Disability which is not part of a full calendar month. Under no circumstances shall the combined monthly benefit payable under this Plan and the NRECA Excess Long Term Disability Plan exceed fifteen thousand dollars ($15,000).

7.04 Grandfathered 50% of Earnings Benefit. For those Participants for whom the Participating Cooperative has selected, and is eligible for, the Grandfathered Fifty Percent (50%) of Earnings Benefit pursuant to Section 2.02 of the Group Benefits Program prior to January 1, 2006, the benefit payable for each calendar month throughout which the Participant's Disability, as determined by CBA in its sole discretion, that continues beyond the Benefit Waiting Period to termination of benefits shall be one-half (50%) of the Participant's Earnings determined as of the day before the first day of Disability reduced by each Benefit Offset provided in Section VIII (except Subsections 8.08 and 8.09), but not reduced to less than sixty-five dollars ($65.00). One-thirtieth of the applicable benefit shall be paid for each day during the Disability which is not part of a full calendar month. Under no circumstances shall the combined monthly benefit payable under this Plan and the NRECA Excess Long Term Disability Plan exceed fifteen thousand dollars ($15,000).

7.05 Prior Condition for Benefits. No benefit shall be payable unless:

(a) The period of Disability commenced while the Eligible Employee was a Participant, and

(b) The Participant receives care from a Physician that is appropriate to the Disabling condition and is administered as often as necessary during the period of Disability to achieve maximum medical improvement, in CBA's sole discretion.

7.06 Maximum Benefit Period for Disabilities due to Mental/Nervous Conditions or Substance Abuse. The maximum benefit period for Disabilities contributed to by (i.e., the Participant's physical conditions alone do not result in Disability), caused by, or due to Mental/Nervous Conditions or Substance Abuse shall be a lifetime limit of twenty-four (24) months unless the Participating Cooperative elects, pursuant to Section 2.02 of the Group Benefits Program, to treat such Mental/Nervous Conditions and Substance Abuse Disabilities as any other Disabilities, in which case the maximum benefit period for Disabilities due to Mental/Nervous conditions or Substance Abuse will be the period of benefit payment described in Section 7.07.

7.07 Period of Benefit Payment. Benefit payments shall begin for a Disabled Participant on the day following the end of the Benefit Waiting Period, if the Participant is Disabled on such date, and shall continue during the period of Disability until payments are terminated as provided in Subsection 7.10, subject to the special period of benefit payment described in Section 7.06, if applicable.

7.08 Recurrent and New Disabilities. For the purpose of determining the Benefit Waiting Period, if a period of an Employee's Disability commences while the Employee is a Participant and after a prior period of the Employee's Disability for which any benefits were paid or payable under the Plan, the subsequent period shall be considered a continuation of the prior period unless:

(a) the periods are separated by an interval during which the Employee satisfied the Active Work Requirement for at least one hundred eighty (180) consecutive days, or

(b) the periods are due to entirely unrelated causes and separated by a period of time during which the Employee satisfied the Active Work Requirement for at least one (1) day.

If the Employee becomes Disabled due to a cause that is unrelated to his or her prior Disability after being Actively at Work for at least one day, that new Disability will be considered a new Disability, and a new Benefit Waiting Period must be satisfied before benefits begin.

7.09 Multiple Disabilities. Benefits payable to a Disabled Participant suffering from two or more Disabilities, whether related or unrelated, shall be made as if the Disabilities were caused by one Injury or one Sickness.

7.10 Termination of Disability Benefits. Benefit payments to a Disabled Participant shall terminate on the first of the following to occur:

(a) the Participant dies or no longer meets the definition of Disabled, as determined by CBA in its sole discretion;

(b) the Participant fails to furnish Proof of Loss with respect to the Participant's continued Disability, satisfactory to CBA, when and as required by CBA;

(c) the Participant becomes confined to jail, prison or other house of correction as a result of a conviction for a criminal or other public offense;

(d) the Participant refuses to cooperate with an examination by a Physician or other licensed professional selected by CBA or a personal interview by CBA or its agent or subcontractor pursuant to Subsection 7.12;

(e) in accordance with a benefit end date of age 60, age 62 or age 65, as elected by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program, the expiration of the applicable period of benefits corresponding with the age at which the Participant's Disability commenced, as follows:

(i) Benefit end date age 60

Participant's Age when Disability Occurred	Period of Benefits
Less than age 55	To age 60
Age 55	60 Months
Age 56	48 Months
Age 57	42 Months
Age 58	36 Months
Age 59	30 Months
Age 60 through 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
Age 69 through 74	12 Months
Age 75 and over	6 Months

(ii) Benefit end date age 62

Participant's Age when Disability Occurred	Period of Benefits
Less than age 57	To age 62
Age 57	60 Months
Age 58	48 Months
Age 59	42 Months
Age 60	36 Months
Age 61	30 Months
Age 62 through 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
Age 69 through 74	12 Months
Age 75 and over	6 Months

(iii) Benefit end date age 65

Participant's Age when Disability Occurred	Period of Benefits
Less than age 60	To age 65
Age 60	60 Months
Age 61	48 Months
Age 62	42 Months
Age 63	36 Months
Age 64	30 Months
Age 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
Age 69 through 74	12 Months
Age 75 and over	6 Months

(f) the Participant refuses to participate in a rehabilitation program designated by CBA;

(g) the Participant refuses to return to work to participate in a workplace accommodation supported and implemented by the Participating Cooperative and CBA; or

(h) as determined by CBA in its sole discretion, the Participant fails to receive ongoing care from a Physician that is appropriate to the Participant's Disabling condition or fails to receive treatments as often as necessary (as appropriate to the Participant's Disabling condition) to reach maximum medical improvement during the period of Disability.

7.11 Disabilities Not Covered. No benefits shall be payable for any Disability:

(a) caused or contributed to by intentionally self-inflicted Injury or attempted suicide, whether the Participant is sane or insane,

(b) caused or contributed to by any declared or undeclared war or act of war, including resistance to armed aggression,

(c) caused by or contributed to or resulting from the Participant's participation in the commission of an assault, felony, strike, civil disorder or riot,

(d) caused or contributed to by service in the Armed Services, National Guard, or military reserves of any nation or international authority (including active duty, active duty for training purposes, undeclared war or resistance to armed aggression), except a non-service connected Injury or Sickness while on a temporary tour of duty of thirty-one (31) days or less,

(e) due to a Pre-Existing Condition before the end of the 365-day period starting on the day the Employee became a Participant, and during which the Employee was continuously covered under the Plan, and each subsequent Disability due to the same Sickness or

Injury unless the Active Work Requirement of one hundred eighty (180) consecutive days has been met before the onset of each subsequent Disability,

(f) for which the Participant fails to provide Proof of Loss acceptable to CBA,

(g) when the Participant is confined to jail, prison, or other house of correction as a result of a conviction for a criminal or other public offense,

(h) as determined by CBA in its sole discretion, for which the Participant is not being treated by, or is not under the care of, a Physician appropriate to the Disabling condition, or is not receiving treatments as often as necessary (as appropriate to the Participant's Disabling condition) to reach maximum medical improvement during the period of Disability, or

(i) regarding which the Participant fails to cooperate with CBA with respect to Subsections 7.05, 7.12, 7.14, and 7.15.

7.12 Examinations and Verifications. (a) CBA may periodically require any Participant who has applied for or who is receiving Disability benefits to furnish such Proof of Loss as CBA, in its sole discretion, deems necessary to establish the Participant's initial or continuing eligibility for payment of Disability benefits. CBA may also require that the Participant be examined by a Physician or licensed professional of CBA's choice or be personally interviewed by CBA or its agent, or subcontractor at such times and at such frequency as CBA, in its sole discretion, deems necessary to establish the Participant's initial or continuing eligibility for payment of Disability benefits.

(b) CBA may, at its sole discretion, suspend the payment of Disability benefits for any period during which the Participant does not promptly furnish the Proof of Loss required or fails to cooperate with the examinations or interviews requested in paragraph (a) above. The suspended benefits shall be paid to the Participant without interest when the Participant cooperates with the examinations or interviews, or furnishes the required Proof of Loss in a form satisfactory to CBA, provided the examinations, interviews and/or Proof of Loss, as applicable, establish Disability.

7.13 Changes in Benefit Amounts. When a Participant's classification changes or the benefits applicable to the Participant's classification are changed, the change will not result in an adjustment of the Participant's benefits (including the amount) until the Participant again becomes eligible to receive a Disability benefit, in the case of a new Disability, after the first day on which the Participant satisfies the Active Work Requirement, or in the case of a recurrent Disability, after the Participant has returned to work for at least one hundred eighty (180) days. The Participant's benefits will be adjusted on that day to those then applicable to the Participant's employee classification.

7.14 Workplace Accommodation Benefit. If a Participant who is receiving Disability benefits returns to work for the Participating Cooperative as a result of a workplace accommodation made by that employer, the Plan will reimburse the Participating Cooperative for expenses related to such accommodation, up to five thousand dollars ($5,000). The Participant's participation under this Subsection shall be mandatory if CBA determines that the accommodation is necessary and the employer agrees to it.

7.15 Rehabilitation Benefit. If CBA determines that participation in a rehabilitation program is within the ability of a Participant who is receiving Disability benefits, such Participant's participation under this Subsection shall be mandatory. Such rehabilitation program may include (but is not limited to) any necessary and feasible vocational testing; vocational training; alternative treatment programs, including but not limited to physical therapy, occupational therapy, and speech therapy; workplace modification to the extent not otherwise provided; job placement; and similar services. Notwithstanding the foregoing, vocational testing, vocational training, and job placement are mandatory under this Subsection only for Disability periods after twenty-four (24) months. Benefits under the Plan may be terminated if a Participant refuses to participate in a vocational rehabilitation program that CBA determines is necessary and for which CBA has agreed to pay the expenses (up to ten thousand dollars ($10,000)); provided that the expenses will not be paid by the Plan to the extent that coverage for the expenses is required to be provided or is available without cost to the Participant under any law or governmental program providing such vocational rehabilitation nor to the extent that coverage for the expenses is provided by any other plan or arrangement (exclusive of the Plan) whether on an insured or uninsured basis.

7.16 Recovery of Overpayment. If CBA makes an overpayment to a Participant who is receiving benefits under this Plan, CBA shall have the right at any time to recover that overpayment from the Participant, or to offset a future benefit payment by the amount of such overpayment. The circumstances under which CBA shall have the right to recover overpayments include, but are not limited to:

(a) Payments are made to the Participant by the Plan as a result of fraud;

(b) Payments are made in error by the Plan resulting in an overpayment to the Participant; and

(c) Payments are made after the death of the Participant resulting in an overpayment.

7.17 Third Party Responsibility.

(a) Subrogation and Right of Reimbursement. Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a Participant has against any party potentially responsible for making any payment to a Participant due to a Participant's Disability, to the full extent of benefits provided or to be provided by the Plan. If a Participant receives any settlement or compensation from any potentially Responsible Party as a result of a Disability, the Plan has the right to recover from, and be reimbursed by, the Participant for all amounts this Plan has paid and will pay as a result of that Disability, up to and including the full amount the Participant receives from all potentially Responsible Parties. The Plan's right to reimbursement of the Plan comes first, even if the Participant is not paid for all claims for damages or if the payment received is for damages other than lost wages.

(b) Responsible Party. As used throughout this provision, the term Responsible Party means any party possibly responsible for making any payment to a Participant due to a Participant's Disability or any insurance coverage, including but not limited to

uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, worker's compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

(c) Participant's Responsibilities. The Participant shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Participant to notify the Plan within forty-five (45) days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries causing or exacerbating the Participant's Disability. Any and all such funds recovered by the Participant shall remain traceable from the Responsible Party to the Participant and in the hands of the Participant. A Participant shall not dissipate any such funds received before reimbursing the Plan.

(d) Participant's Acknowledgements. The Participant acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential Responsible Parties and are to be paid to the Plan before any other claim for the Participant's damages. This Plan shall be entitled to full reimbursement first from any potential Responsible Party payments, even if such payment to the Plan will result in a recovery to the Participant which is insufficient to make the Participant whole or to compensate the Participant in part or in whole for the damages sustained. The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

(e) Full Right of Recovery. The terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially Responsible Party and regardless of whether the settlement or judgment received by the Participant identifies the benefits the Plan provided. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only. However recoveries, claims, settlements or judgments are classified or characterized by the courts, parties, or any other entity, shall not impact the Participant's responsibilities described in this Section VII or the Plan's entitlement to first-dollar recovery, regardless of whether the Participant is made whole. The Plan's right of subrogation and reimbursement shall also not be affected by the comparative fault, regulatory diligence, or the common fund doctrine.

(f) Plan Interpretation. If any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

(g) Right to get a lien. This Plan, once benefits are paid, is granted a lien on the proceeds of any payment, settlement, or judgment, received by the Participant.

(h) Future benefits. Amounts due to repay benefits, interest, costs and attorney's fees may be deducted from other benefits payable under the Plan after payments by or on behalf of the Responsible Party are made.

SECTION VIII
Benefit Offset

8.01 Application of Offset. (a) The "Benefit Offset" used in determining the Participant's benefit under the Plan for a calendar month is the aggregate amount of benefits, payments or other compensation (adjusted to a monthly basis if not so payable) from the offset sources provided in Subsections 8.02 through 8.11 of this Section and which, for that month, are payable to, or on behalf of, the Participant, or would in CBA's judgment be so payable upon timely pursuit of claim for them.

(b) For each Participant CBA determines is or may be eligible for benefits that may be offset, except for the offsets of Subsections 8.06, 8.07 and 8.08 (to the extent payable before age 62), CBA may, in its sole discretion, either (i) require the Participant to apply for the benefits as a condition to receiving Disability benefits under the Plan, (ii) estimate and apply the offset as provided in Subsection 8.12(a) and/or (iii) pay the benefit without offset after the Participant agrees to reimburse CBA as provided in Subsection 8.12(b).

8.02 Workers' Compensation. Benefits (including any commutation of, or substitute for, such benefits) on account of the Participant's Sickness or Injury arising out of any employment, under or by reason of any workers' compensation law, occupational disease law, or similar legislation, or the maritime doctrine of maintenance, wages and cure. To the extent such benefits are paid in lump sum settlement, the settlement will be characterized as lost wages over the Period of Benefit Payment, described in Subsection 7.07, for purposes of determining the monthly benefit offset.

8.03 Welfare Benefits. Benefits on account of any group insurance or any disability, health or welfare plan or other employee benefit plan.

8.04 State and Federal Laws. Benefits on account of any state, provincial or federal law of the United States or Canada (including any motor vehicle insurance statute or similar legislation to the extent "no fault" loss of time coverage is required in policies or contracts to meet the requirement of such statute or legislation), but not including any benefits or payments on account of military service, except any increase in such benefits or payment on account of military service after benefits become payable for that period of Disability.

8.05 Earnings from Work. Any wage or salary, or other compensation payments received by the Participant from any source, including compensation that the Participant has constructively received, e.g., deferred compensation. Wage payments also include Earnings While Disabled.

8.06 Pension Payments. Benefits in the nature of retirement benefits derived from contributions of an employer of the Participant, under or by reason of any employee pension or welfare plan, but only to the extent paid to the Participant and only to the extent such payments did not begin prior to the Participant's Disability. Amounts transferred or rolled over from a qualified retirement plan to another qualified retirement plan or individual retirement account or annuity (IRA) shall not be treated as pension payments, provided that the balance in the

transferee plan or IRA at the end of each year does not fall below the amount transferred as a result of any withdrawal by the Participant. Distributions to a Participant from the 401(k) Pension Plan will come first from deposits attributable to 401(k) Pension Plan contributions. Any subsequent distribution to a Participant from the 401(k) Pension Plan attributable to amounts transferred from the Retirement Security Plan will reduce benefits under this Plan.

8.07 Life Insurance Disability. Benefits, on account of the Participant's Disability, under any group life insurance if the Participant elects to receive such benefits.

8.08 Social Security Retirement. With respect to the 66 2/3% Benefit, 60% Benefit, and the 50% Benefit (excluding the Grandfathered 50% Benefit), benefits available under the United States Social Security Act as amended from time to time, for any month after the Participant's attainment of age 62, including benefits paid to the Participant's spouse or children on account of the Participant's employment and earnings record. However, this does not include benefits for any month prior to the Participant's attainment of age 65 (or the age at which the Participant is eligible to receive an unreduced Social Security benefit, if older), unless the Participant elects to receive benefits for that month, nor benefits paid to a former spouse of the Participant or to a child of the Participant residing with such former spouse.

8.09 Social Security Disability. With respect to the 66 2/3% Benefit, 60% Benefit, and the 50% Benefit (excluding the Grandfathered 50% Benefit), benefits on account of the United States Social Security Act as amended from time to time, including benefits paid to the Participant's spouse or children on account of the Participant's employment and earnings record, but excluding benefits paid to a former spouse of the Participant or to a child of the Participant residing with such former spouse.

8.10 Veteran's Administration or Similar Benefits. Benefits on account of the Participant's Disability received from the Veteran's Administration or any other foreign or domestic governmental agency unless the benefit began before the Participant's Disability, in which case only the amount of any increase in the benefit that is attributable to the Participant's Disability will be a Benefit Offset.

8.11 Deferred Compensation. Benefits in the nature of payments from any deferred compensation plan, executive compensation plan, "top hat" plan or similar type of benefit arrangement.

8.12 Advances and Their Recovery. The Benefit Offsets of this Section, except for those of Subsections 8.06, 8.07 and 8.08 (to the extent payable before age 62), shall be applied as follows during such time as CBA determines, in its sole discretion, that a Participant is or may be eligible for a benefit that may be offset under this Section and the benefit has not been approved or paid:

(a) CBA shall use such information as is available to it to estimate the amount of the benefit that is or may be available to the Participant and shall offset any benefit due to a Participant under the Plan by the estimated amount of the benefit unless the Participant agrees in writing as provided in paragraph (b) to reimburse the Plan when any benefits are paid ("Reimbursement Agreement").

(b) Estimated benefits that would otherwise be offset in accordance with paragraph (a) above will be advanced to the Participant if the Participant (or if incapable, the Participant's legal representative) agrees in writing, on forms provided by CBA, to pay back the benefits advanced to the extent of any payments received within 30 days of receipt of payment. The written Reimbursement Agreement shall further provide:

(i) that the Participant agrees to immediately file a claim with the benefit provider as soon as eligible to apply, to keep CBA informed of the status of the claim and to notify CBA immediately of the award or denial of any benefits,

(ii) that the Participant shall pursue the claim with diligence and not abandon the claim before filing and diligently pursuing an appeal to an administrative law judge (or any other administrative appeal body) of any denial of the claim,

(iii) that, if the appeal to an administrative law judge (or other administrative appeal body) is denied, the Participant shall notify and consult with CBA before any further appeals are abandoned,

(iv) that the Participant will cooperate in good faith with CBA and its agents and representatives in pursuit of the claim,

(v) that to the extent not prohibited by Federal law, and to the extent of any benefit advances made, CBA and the Plan are subrogated to the Participant's claims and rights of recovery against any third party, plan or program,

(vi) that fees and costs incurred to obtain payment of the benefit shall not be deducted from the amounts to be repaid unless CBA agrees in writing to allow a deduction for reasonable fees and costs,

(vii) for the payment of interest at a rate equal to the Prime Rate + three percent (3%) (compounded annually from the date that is 30 days after receipt of the other benefits) on the principal amount of the benefits advanced that are not repaid within thirty (30) days and for the payment of costs and attorneys' fees to CBA for the enforcement of the Reimbursement Agreement, and

(viii) to notify the Plan within forty-five (45) days of the date when notice is given to any third party of the Participant's intention to recover damages relating to the Participant's disability.

(c) In the event the Participant fails to repay benefits advanced by CBA as provided in paragraph (b) above, then, in addition to any other rights or remedies available to it, CBA may recoup the advanced benefits by exercising a right of set off against any current or future benefits payable to the Participant under this Plan or any of the Plans of the NRECA Group Benefits Program, other than benefits payable on account of the Participant's death. CBA shall be entitled to set off the principal amount of the benefits advanced, plus interest at a rate equal to the Prime Rate + three percent (3%) (compounded annually from the date benefits were advanced), and any costs and attorneys' fees associated with recouping the advanced benefits.

8.13 Changes in Offset Amounts. In determining the Benefit Offset for any calendar month during a period of Disability, any adjustment in the Benefit Offset of Subsections 8.02, 8.04, 8.08 and 8.09 shall be disregarded which results other than from a change in the Participant's personal or family status becoming effective after the Benefit Waiting Period for that period of Disability.

8.14 Application of Offsets. (a) Any payments for, in lieu of, in substitution for or in commutation of, any of the Benefit Offsets provided in this Section shall be offset whether the payment is made to, or on behalf of, the Participant, the Participant's spouse or any dependent of the Participant.

(b) All of the offsets provided in this Section shall be applied whether or not payment is made to, or on behalf of, the Participant, the Participant's spouse or dependents, if in the judgment of CBA such payments would be payable if the Participant made timely application for them.

(c) Any nonperiodic payments made to the Participant (whether by scheduled payments, lump sum payment, settlement, award or otherwise) shall be adjusted by CBA to the equivalent equal monthly periodic payments for the purpose of applying these Benefit Offset provisions. Such nonperiodic payments shall be adjusted by CBA to the equivalent monthly periodic payment by either (i), (ii), (iii) or (iv) below as determined by CBA:

(i) if the maximum monthly periodic payment available to the Participant is determinable by CBA, CBA shall apply such maximum monthly periodic benefit available to the Participant as the equivalent equal monthly periodic payment until the total of such payments equals the nonperiodic payment,

(ii) if the maximum monthly periodic payment available to the Participant is not determinable by CBA, CBA shall determine the equivalent equal monthly periodic payment by dividing the nonperiodic payment over the period for which periodic payments would otherwise be payable (but not more than the life expectancy of the Participant), as determined by CBA,

(iii) in the case of a lump sum cash distribution from the Retirement Security Plan, CBA shall determine the equivalent monthly periodic payment based on a fifty percent (50%) joint and survivor annuity for a married Participant and a single life annuity for an unmarried Participant, or

(iv) in the case of a lump sum cash settlement paid on account of Workers' Compensation described in Subsection 8.02, CBA shall characterize such settlement as lost wages over the maximum period for which Disability benefits may be paid, and shall determine the equivalent equal monthly periodic payment by dividing the settlement payment over the maximum period for which Disability benefits may be paid.

(d) Cost of living increases will not be applied to reduce benefits under the Plan.

SECTION IX
Trial Work Period

9.01 Availability of Trial Work Period. A Participant receiving benefits for Disability may be considered to be on "trial work status" for a limited period of time not to exceed three (3) months during a trial work period. A Participant may make an advance written request to CBA to be placed on a trial work period. CBA will review the Participant's request and determine in its sole discretion whether a program of trial work is necessary and appropriate for the Participant, subject to the approval of the Participating Cooperative and the Participant's Physician. CBA will notify the Participant in writing of its determination.

9.02 Benefits During Trial Work Period. A Participant on trial work status who engages in an approved Gainful Occupation shall not, by reason of engaging in such occupation, be considered as failing to satisfy the requirements for being Disabled while that status continues. However, the maximum benefit payable to the Participant during the trial work period shall equal the Participant's Earnings at the time of Disability, offset as required under Section VIII, and offset by earnings during the period of trial work period, including annual vacation or sick leave elected.

9.03 Extensions. A Participant's trial work status may be extended or renewed by CBA from time to time, but not for more than three (3) months at a time. In no event shall the aggregate period of time of a Participant's trial work period exceed twelve (12) months for all Disabilities due to the same or related causes.

SECTION X
Application for Benefits

10.01 Requirement for Disability Application. No benefits shall be paid or payable under this Plan unless the Participant makes timely application for such benefits as provided in this Section and in accordance with the procedures prescribed by CBA.

10.02 Notification of Disability. The participant must notify CBA in writing of the Disability not more than ninety (90) days after the date of onset of Disability by sending CBA a completed claim form and Attending Physician's Statement of Disability.

10.03 Proof of Loss. Upon receipt of the notification of Disability, CBA will require the Participant to complete the forms necessary for the filing of the Proof of Loss. In the event the forms are not readily available to the Participant, the Participant must file a written explanation of the nature of the Disability, specifying the event or occurrence giving rise to the Disability and describing the extent of the Disability. Proof of loss must be furnished in writing to CBA not more than ninety (90) days after the last day of the Benefit Waiting Period applicable to the Participant. No benefits will be paid unless and until CBA has determined in its sole discretion that the Proof of Loss submitted is sufficient to support a finding of Disability as defined by this Plan.

10.04 Time Limit for Claims. No claim of Disability shall be approved by CBA if the Participant does not provide the notice, Proof of Loss or other information as provided in Subsections 10.02 and 10.03, unless CBA determines, in its sole discretion, that compliance with

Subsections 10.02 and 10.03 was (a) not reasonably possible or (b) was due to excusable neglect and that no prejudice to CBA's ability to evaluate the claim for Disability would result from the delay. In any event, no claim of Disability will be approved if Proof of Loss is not provided to CBA within two (2) years of the onset of Disability.

10.05 Notice of Denial of Claim. Notice of denial of a Claim shall contain the specific reason why the claim was denied with a specific reference to the Plan provisions on which the denial was based, and provide an explanation of the Plan's claims review and appeals procedures. The notice of denial shall be furnished to the claimant within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Plan. This period may be extended for up to thirty (30) days; provided that CBA both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which CBA expects to render a decision. If, prior to the end of the first thirty (30)-day extension period, CBA determines that, due to matters beyond the control of CBA, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional thirty (30) days; provided that CBA notifies the claimant prior to the expiration of the first thirty (30)-day extension of the circumstances requiring the extension and the date by which CBA expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

10.06 Claims Review Procedure. A claimant whose claim was denied (or his duly authorized representative) may request a review, upon written application to the Appeals Administer at CBA, of the denial of his claim. The claimant shall have one hundred eighty (180) days following receipt of the notice of denial within which to appeal the determination. The Appeals Administrator shall provide a review that does not afford deference to the initial adverse benefit determination and shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the adverse benefit determination was based in whole or in part on a medical judgment, the Appeals Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Appeals Administrator shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Any health care professional engaged by the Plan for purposes of consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. A final decision shall be made by the Appeals Administrator within forty-five (45) days of receipt of the appeal (unless there has been an extension of forty-five (45) days due to special circumstances and the delay and the special circumstances occasioning it are communicated to the claimant within the initial forty-five (45)-day period). In connection with her request for review, the claimant is entitled to review pertinent documents and submit issues and comments in writing to the Appeals Administrator. In the discretion of the Appeals Administrator and for the purpose of making

factual findings, which may be a necessary prerequisite to a decision, a hearing may be held in connection with the review of a claim that has been denied.

10.07 Notice of Denial on Appeal. The Appeals Administrator shall provide every claimant whose appeal is denied with a statement, written in a manner calculated to be understood by the claimant, setting forth:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific Plan provisions on which the determination is based;

(c) a statement that the claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered, or generated in the course of making the determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment, without regard to whether the statement was relied on;

(d) a statement of any voluntary appeals procedures and the claimant's right to receive information about the procedures, as well as the claimant's right to bring a civil action under section 502(a) of ERISA;

(e) a copy of any internal rule, guideline, protocol, or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request; and

(f) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request.

10.08 Bar Date for Claims. Notwithstanding any other provision of this Plan, no claim of Disability shall, in any event, be approved by CBA if the notice required by Subsection 10.02 is not provided to CBA within two (2) years of the onset of Disability.

10.09 Voluntary Claims Review Procedure. A claimant whose claim denial was upheld on review, or his duly authorized representative, may request an additional voluntary review within sixty (60) days following receipt of the denial on appeal by the Appeals Administrator upon written application to the Appeals Committee. In connection with the request for review, the claimant is entitled to review pertinent documents and submit issues and comments in writing to the Appeals Committee. In the discretion of the Appeals Committee and for the purpose of making factual findings, which may be a necessary prerequisite to a decision, a hearing may be held in connection with the review of a claim that has been denied. The Plan shall provide a review that does not afford deference to the initial adverse benefit determination or the denial on appeal and that is conducted by the Plan's Appeals Committee that is neither the individual who made the initial adverse benefit determination or the denial on appeal, nor the subordinate of such individuals. Any professional engaged by the Plan for purposes of consultation shall be an

individual who is neither an individual who was consulted in connection with the initial adverse benefit determination or the denial on appeal, nor the subordinate of any such individual. The timeframe for processing voluntary appeals shall be no later than sixty (60) days with one sixty (60)-day extension if circumstances warrant and notification of the sixty (60)-day extension is provided before the conclusion of the initial sixty (60)-day period. The Participant's request for the voluntary review must be made with sixty (60) days of receipt of notification of the notice of denial on appeal. If the denial is upheld upon voluntary review, the Participant shall receive a final notice of denial along with their right to bring a civil action under Section 502(a) of ERISA.

10.10 Bar Date for Judicial Review. Notwithstanding any other provision of this Plan, the Participant must exercise his or her right to bring a civil action under section 502(a) of ERISA within one (1) year after receipt of the notice of denial on appeal. If the Participant requests a voluntary review pursuant to the provisions of Section 10.09, the bar date for judicial review shall be one (1) year after receipt of the final notice of denial.

10.11 Authorized Representative for Purposes of Section10. An Authorized Representative is an individual designated by a Participant, pursuant to a procedure set by the Plan, that permits the individual to act on behalf of the Participant with respect to a claim for benefits or an appeal of an adverse benefit determination. An Authorized Representative is able to submit a claim in accordance with the claims and appeals processes designated within this Section. An Assignment of Benefits is not an authorized representative designation for purposes of this definition.