NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

SHORT-TERM DISABILITY PLAN

A Constituent Plan of the
NRECA Group Benefits Program

As Amended and Restated
January 1, 2012

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION
SHORT-TERM DISABILITY PLAN

SECTION I
Establishment

1.01 Establishment and Continuation. NRECA hereby continues, amends and restates, effective as of January 1, 2012, the following short-term disability plan established for itself and its member systems. The purpose of the Plan is to allow eligible employees of NRECA and eligible employees of its Participating Cooperative members to obtain a partial continuation of income during a short period of disability. 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 used herein shall have the meaning given to them under the NRECA Group Benefits Program.

2.01 "Accident" means a non-work related 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 seven day period of continuous Disability beginning on the first scheduled work day missed due to Disability.

2.04 "Disabled or Disability" means that the Participant is:

(i) due to Sickness or Injury, unable to perform some or all of the Material and Substantial Duties of the Participant's own occupation with the Participating Cooperative, and

(ii) not engaged in any Gainful Occupation.

2.05 "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 with the Participating Cooperative required before participation in the Plan is available to an Employee.

2.06 "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 eligibility requirements, but not including any Director, Director Emeritus or Retained Attorney or any Employee not satisfying the Active Work Requirement.

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

2.08 "Gainful Occupation" means working and earning an income.

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

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

2.11 "Participant's Earnings" means earnings for a normal work week from the Participating Cooperative, not to exceed forty (40) hours, exclusive of bonus, deferred compensation, overtime pay, and any other form of additional compensation, in effect at the time of Disability.

2.12 "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.

2.13 "Plan" means this welfare benefit plan for short-term disability benefits as described in this document with the optional provisions as selected by the Participating Cooperative.

2.14 "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 to document a Participant's Disability.

2.15 "Sickness" means any disease or illness that is not employment-related. The term also includes pregnancy and any medical complications of pregnancy.

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
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 an Individual's Participation

5.01 Initiation of Participation. An Eligible 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 satisfactory to the Participating Cooperative and has agreed to make, and makes, the required contributions,

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

(d) If 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 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 a 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 under the Plan will be terminated with respect to all Employees of that Participating Cooperative on the date the cooperative ceases to be a 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 Selection of Benefits. The benefit payable for each week throughout which the Participant's Disability, as determined by CBA in its sole discretion, 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, but not more than three hundred dollars ($300), five hundred dollars ($500), eight hundred dollars ($800), or twelve hundred dollars ($1,200), whichever amount is designated by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program.

7.02 Prior Conditions 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.

7.03 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 section 7.06.

7.04 Recurrent Disabilities. For the purpose of determining the Benefit Waiting Period and the length of time for which benefits are paid (thirteen (13) or twenty-six (26) weeks as selected by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program), 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, 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 fourteen (14) consecutive days, or

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

7.05 Multiple Disabilities. Benefit payments 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.

7.06 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 selected by CBA or a personal interview by CBA or its agent,

(e) 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 (appropriate to the Participant's Disabling condition) to achieve maximum medical improvement during the period of Disability, or

(f) the expiration of thirteen (13) or twenty-six (26) weeks, whichever period is designated by the Participating Cooperative pursuant to Section 2.02 of the Group Benefits Program.

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

(a) 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,

(b) caused or contributed to by any declared or undeclared war or act of war,

(c) 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,

(d) resulting from an intentionally self-inflicted bodily injury or attempted suicide, whether the Participant is sane or insane,

(e) 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,

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

(g) for which the Participant is not being treated or under the care of a Physician appropriate to the Disabling condition or not receiving care that is administered as often as necessary to reach maximum medical improvement, or

(h) for which the Participant fails to provide Proof of Loss acceptable to CBA.

7.08 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 of CBA's choice or be personally interviewed by CBA or its agent 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 cooperate with the conduct of the examinations requested in paragraph (a) above. The suspended benefits shall be paid to the Participant without interest when the Participant cooperates, or furnishes the required Proof of Loss in a form satisfactory to CBA, provided the information establishes Disability.

7.09 Changes in Benefit Amounts. When a Participant's employee classification changes or the benefits applicable to the Participant's employee classification are changed, the change will not result in an adjustment of the Participant's benefits (including the amount) until the Participant is eligible to receive a Disability benefit again after having first satisfied the Active Work Requirement. The Participant's benefits will be adjusted on that day to those then applicable to the Participant's employee classification.

7.10 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 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 cooperative 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.

7.11 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.

7.12 Advances and Their Recovery. Subsection 7.07(a) 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 under Subsection 7.07(a) and the benefit has not been approved or paid:

(a) CBA shall use such information as is available to it to determine whether the Participant is eligible or may be eligible to receive benefits under Subsection 7.07(a) and shall deny any benefit due to the Participant under the Plan unless the Participant agrees in writing as provided in paragraph (b) to reimburse the Plan when any benefits are paid ("Reimbursement Agreement").

(b) Benefits due to the Participant under this Plan that would otherwise be denied 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 thirty (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 the appropriate body of any denial of the claim,

(iii) that, if the appeal described in (ii) above 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 thirty (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.

SECTION VIII
Application for Benefits

8.01 Requirement for Disability Application. No benefits shall be paid or payable under this Plan unless the Participant makes application for such benefits within ninety (90) days from the onset of Disability in accordance with the procedures prescribed by CBA.

8.02 Proof of Loss. Upon receipt of the notification of Disability, CBA will require the Participant to complete the forms necessary for the filing of a 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 within the time frame designated by CBA. 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.

8.03 Time Limit for Claims. No claim of Disability shall be approved by CBA if the Participant does not comply with the requirements of Sections 8.01 and 8.02, unless CBA determines, in its sole discretion, that compliance was (a) not reasonably possible or (b) that such failure was due to excusable neglect and that no prejudice to CBA's ability to evaluate the claim for Disability would result from the delay.

8.04 Notice of Denial of Claim. Notice of denial of a claim shall contain the specific reason or reasons 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 procedure. Notification of the disposition of a claim 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 forty-five (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.

8.05 Claims Review Procedure. A claimant whose claim was denied (or his duly authorized representative) may request a review, upon written application to the Appeals Administrator 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.

8.06 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;

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

(b) 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;

(c) 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;

(d) 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

(e) 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.

8.07 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 8.01 is not provided to CBA within two (2) years of the onset of Disability.

8.08 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 Committee 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 Plan 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 claims review must be made within 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.

8.09 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 claims review pursuant to the provisions of Section 8.08, the bar date for judicial review shall be one year after receipt of the final notice of denial.

8.10 Authorized Representative for Purposes of Section 8. 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.