SUMMARY PLAN DESCRIPTION
of the
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

For the Employees of

Wayne-White Electric Cooperative

14-002-003

Effective Date: January 1, 2011

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Your employer believes this plan is a "grandfathered medical plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered medical plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered medical plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered medical plans must comply with certain other consumer protections in the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered medical plan and what might cause a plan to change from grandfathered medical plan status can be directed to the plan administrator at 618-842-2196. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered medical plans.

Introduction to Your Health Reimbursement Arrangement (HRA) Plan

This Summary Plan Description is intended to highlight only the basic features of the Health Reimbursement Arrangement ("HRA") Plan ("the Plan"). Actual benefits are subject to the definitions and limitations in the Plan. If there is any conflict between this Summary Plan Description and the Plan document, the Plan document will control.

HRAs are designed to reimburse you, up to certain limits, for your own and your covered spouse's and dependents' medical care expenses. Reimbursements for medical care expenses paid by the Plan are excludable from taxable income. HRAs are employer-funded accounts established by your employer to reimburse you on a nontaxable basis for the cost of eligible out-of-pocket medical expenses you and your covered dependents incur. Balances remaining in your HRA account at the end of a coverage period (in most cases, the Plan year) may be carried forward to the next coverage period to reimburse qualified out-of-pocket medical expenses incurred during that next coverage period.

Eligibility and Participation

Who is eligible to participate in this Plan?

To be eligible to participate in this Plan, you must be an active employee who is covered by a NRECA medical plan. Dependents of an eligible employee may only participate in this Plan if they are also covered by the NRECA medical plan that covers the eligible employee. Directors are eligible to participate in this Plan at the election of the employer if directors are treated as employees under the law of the employer's state.

Active employees and disabled employees and their dependents may continue to participate in the Plan after termination of employment (see *What happens to my HRA account if I terminate employment?* below), but are not required to continue coverage under a NRECA medical plan to do so. A "disabled employee" for this purpose is an eligible employee who is receiving long-term disability payments under a long-term disability plan sponsored by the employer.

When does my participation in this Plan begin?

Your participation in this Plan begins when your coverage begins under your employer's NRECA medical plan, provided that you have completed and submitted a HRA Plan enrollment form to your employer.

As a participant, you may request reimbursement of the eligible expenses that you and your covered dependents incur during a Period of Coverage (see *What is a "Period of Coverage"?* below).

What is a "Period of Coverage"?

A Period of Coverage is generally the Plan year (the calendar year). If you begin participation in the NRECA medical plan after January 1, your Period of Coverage begins on the date your participation in the medical plan begins. If you terminate employment during the Plan year, your Period of Coverage ends on your date of termination, except for active employees and disabled employees whose Period of Coverage will continue to be the Plan year.

When does my participation in this Plan end?

Your participation in this Plan generally ends upon the earliest of (a) the date the Plan terminates; (b) the date you are no longer an eligible employee (that is, you no longer participate in a NRECA medical plan) or (c) the date you terminate employment. Active employees and disabled employees and their covered dependents, however, may continue to participate in the Plan (see *What happens to my HRA account if I terminate employment?* on page 6 below).

What happens to my HRA account balance when my participation in this Plan ends?

You will forfeit your HRA account balance when your participation ends.

May I take my HRA account with me when I terminate employment?

No. You will forfeit your HRA account balance when your participation ends. HRA accounts are not portable, even if you change employment from one cooperative to another.

What happens to my HRA account balance if I die?

In the event of your death, under no circumstances may your eligible dependent receive any of the remaining balance in your HRA account in cash. Your eligible dependent may only be reimbursed for eligible medical expenses.

What happens to my HRA account balance if I die and I have no eligible dependents?

In the event of your death with no eligible dependents, any remaining balance in your HRA account shall be forfeited. Your HRA account balance may not be paid in cash or in any other taxable or non-taxable benefit to any other person, persons, or entity seeking such payment.

How does a leave of absence that is subject to the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) affect my participation in this Plan?

If you take qualifying leave under FMLA or USERRA, your employer, to the extent required by FMLA or USERRA, will continue to maintain your HRA account on the same terms and conditions as if you were still an active employee.

How does a leave of absence that is not subject to FMLA or USERRA affect my participation in this Plan?

If you take an unpaid leave of absence that is not subject to FMLA or USERRA, you will be treated as having terminated your participation in this Plan only to the extent you are treated as having terminated your participation in the NRECA medical plan. A paid leave of absence will have no effect on your participation in this Plan.

What happens to my participation in this Plan if I am rehired?

If you terminate your employment for any reason (or you are treated as having terminated employment due to an unpaid leave of absence that is not subject to FMLA or USERRA) and you are rehired within 30 days from the date of termination, your HRA account will be reinstated at the same level as immediately prior to your termination of employment so long as you participate in a NRECA medical plan. You will begin a new Period of Coverage on the date your HRA account is reinstated.

If you terminate your employment for any reason (or you are treated as having terminated employment due to an unpaid leave of absence that is not subject to FMLA or USERRA) and you are rehired more than 31 days from the date of termination, your former HRA account balance will not be reinstated.

Are there any special enrollment rights under this Plan?

Yes. You may enroll in this Plan if you gain a dependent due to marriage, birth, adoption or otherwise, so long as (i) you request coverage any time prior to but not later than 31 days after the date of such event; (ii) you have not enrolled in this Plan previously; and (iii) you are otherwise eligible to participate in the Plan.

In addition, if you have not enrolled in this Plan previously because you were covered by a group medical plan that was not a NRECA medical plan, then you may enroll in this Plan if you lose coverage under the other group medical plan. This special enrollment right is limited to the following situations where the other group medical plan coverage is lost: (i) the other group medical plan coverage was COBRA coverage; (ii) you are no longer eligible for the other group medical plan coverage; or (iii) you are required to begin to pay for the other group medical plan coverage.

How do I enroll in the Health Reimbursement Arrangement (HRA) Plan?

You must submit an enrollment form to your employer. You may elect to have your unreimbursed eligible health expenses automatically transferred for payment from your HRA account (known as the claim interface option). If you do not elect the claim interface option, you will need to submit a written request for reimbursement to obtain reimbursement from your HRA account (see *Claims and Appeals Procedures* below).

How long does this enrollment last?

Once you enroll in the Plan, you will remain enrolled in the Plan until your participation ends (see *When does my participation in this Plan end?* above). Your employer will require you to complete a new enrollment form each year at the time of open enrollment.

Benefits

How does this Health Reimbursement Arrangement (HRA) Plan benefit me?

This HRA is designed to help you manage the higher deductibles and increased out-of-pocket expenses of the NRECA medical plans. Employer contributions will be credited to your HRA account on an annual basis. Your HRA Account is merely a recordkeeping account. This means that the HRA Account is not funded (all reimbursements are paid from the general assets of your employer). The HRA Account does not bear interest or accrue earnings of any kind. Your employer will determine this contribution prior to the start of the Plan year. These amounts may be used to reimburse you on a nontaxable basis for the cost of eligible out-of-pocket health expenses you and your covered dependents incur during a Period of Coverage (see *What is a "Period of Coverage"?* above). Unused balances remaining in your HRA account at the end of a Period of Coverage (in most cases, the Plan year) may be carried forward to the next Period of Coverage to reimburse eligible out-of-pocket health expenses incurred during that next Period of Coverage, so long as you are eligible to participate. There is no limit on the amount of your unused HRA account balance that may be carried forward.

How will the Plan work?

The Plan will reimburse you for eligible medical care expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- You must submit a claim to the NRECA medical plan and provide any additional information requested by CBA;
- A request for payment must relate to medical care expenses incurred by you, your spouse, or your dependent during the time you were a participant under this Plan; and
- A request for payment must be submitted by March 31 following the close of the plan year in which the medical care expense was incurred.

Are there any limitations on benefits available from the Plan?

Only medical care expenses are covered by the Plan. A medical care expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible medical care expenses are (a) prescription medicines; (b) dermatology; and (c) physical therapy. Your employer can provide you with more information about which expenses are eligible for reimbursement.

Some examples of expenses that are not medical care expenses and are not eligible for reimbursement include the following:

- Pregnancy testing kits.
- Health insurance premiums for any other plan (including a plan sponsored by the Employer). (Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the employer.)
- Long-term care services.

- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an employee's, spouse's, or dependent's inability to perform physical housework).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code §213.

What are the eligible out-of-pocket health expenses that may be reimbursed through a HRA?

In general, this Plan will reimburse only eligible out-of-pocket health expenses (i) that have not been previously reimbursed and are not reimbursable under another group health plan; (ii) that were incurred during the Period of Coverage (see *What is a "Period of Coverage"?* above); and (iii) that you will not claim as a tax deduction on your federal tax return. If your HRA account balance becomes zero during any Period of Coverage, further expenses incurred during the same Period of Coverage will not be reimbursed. Future contributions credited to your HRA account may not be used to reimburse eligible out-of-pocket health expenses that you incurred during a prior Period of Coverage.

Active Employees: If you are an active employee (or director, if eligible), eligible out-of-pocket health expenses for HRA reimbursement are restricted to out-of-pocket expenses for medical services and prescription drugs that are covered under the NRECA medical plan in which you participate. Such out-of-pocket expenses would include annual deductibles and coinsurance amounts of the NRECA medical plan.

Former Employees: If you are a former employee or a disabled employee (as defined in *Who is eligible to participate in this Plan?* Above), eligible out-of-pocket health expenses for HRA reimbursement include the broader category of expenses for "medical care" that would be tax-deductible if claimed on your

federal income tax return. Such expenses for "medical care" would include health plan premiums, vision and dental expenses, expenses for over-the-counter medical items, and expenses for over-the-counter drugs accompanied by a prescription from a medical practitioner and used for the diagnosis, cure, mitigation, treatment or prevention of disease, but not used merely for your general good health. More information regarding tax-deductible medical expenses, including over-the-counter drugs, can be found in IRS Publication 502 *Medical and Dental Expenses*, available at the IRS website (www.irs.gov/formspubs/index.html).

What is my maximum annual reimbursement?

Your maximum annual reimbursement from your HRA account at any time during your Period of Coverage is your HRA account balance.

Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the Plan generally are not taxable to you. However, your employer cannot guarantee the tax treatment to any given participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

What happens to my HRA account if I terminate employment?

In general, if you terminate employment, you will forfeit your HRA account balance. HRA accounts are not portable, even if you change employment from one cooperative to another. Disabled employees and their dependents, however, may continue to receive reimbursements of eligible out-of-pocket health expenses from their remaining HRA account balances.

Claims and Appeals Procedures

How do I file a reimbursement request for eligible out-of-pocket health expenses?

Cooperative Benefit Administrators, Inc. ("CBA") is the Claims Administrator for this Plan. Benefits will be paid under the Plan only if the Plan Administrator, the Claims Administrator, the Appeals Administrator or the Appeals Committee, as applicable, determines in its sole discretion that you are entitled to them. The Appeals Administrator or, in the case of a Final Appeal, the Appeals Committee is the final reviewer of claims for benefits and its decisions are final. All expenses claimed for reimbursement must have been incurred during the current Period of Coverage.

Active Employees: Eligible health expenses must first be submitted as claims to your NRECA medical plan.

Former Employees: If you are a disabled employee, eligible expenses must first be submitted as claims to your medical, dental or vision plan. If you participate in a NRECA medical, dental or vision plan and you elected the claim interface option, you will not need to submit a written request for reimbursement to obtain reimbursement of these expenses from your HRA account. If you do not participate in a NRECA plan or you did not elect the claim interface option, you will need to submit a written request for reimbursement of these expenses. Similarly, you will need to submit a written request for reimbursement of premiums, expenses for over-the-counter medical items, and expenses for over-the-counter drugs accompanied by a prescription from a medical practitioner.

To submit a written request for reimbursement, you will need to complete the HRA Reimbursement Form, which can be obtained from your Benefits Administrator.

The reimbursement request form requires the following information:

- Name of the person receiving the services;
- Date and nature of the service and the name of the service provider (enclose a copy of the Explanation of Benefits (EOB) if applicable). If you have no coverage for the type of service for which you are requesting reimbursement (applicable to active employees and disabled employees only), please send an itemized bill and indicate that you have no coverage;
- Amount of the unreimbursed expense;
- Your certification that the expenses have not been reimbursed under your employer's or any other medical plan and will not be used to claim any federal income tax deduction or credit.

How do I file a reimbursement request for over-the-counter drug expenses?

For active employees and disabled employees and their dependents only: For over-the-counter drugs prescribed by a medical practitioner, cash register receipts specifying the date of the purchase, the name of the item purchased, the cost of the item, doctor's prescription and any other appropriate documentation should be attached to the HRA Reimbursement Form. The prescription will need to accompany your claim for reimbursement, and will need to identify the purchaser or the individual to whom the prescription was issued. This is the case even though the medicine or drug is available without a prescription. Medical practitioners include any health care professional, licensed by the appropriate state agency and acting within the scope of his or her license. Medical practitioners may include but are not limited to a medical doctor, doctor of osteopathy, optometrist, dentist, dental hygienist, psychologist, certified nurse practitioner, pharmacist, clinical psychologist, chiropractor, and podiatrist.

Over-the-counter medicines or drugs are generally eligible for reimbursement if primarily used to treat a medical condition *and prescribed by a medical practitioner*. Examples include, but are not limited to, antacids, allergy medication, pain relievers, cold medications, eye drops, cough drops, antibiotic ointments, and sleep aids.

Medical-only items and supplies are still eligible for reimbursement without a prescription. Medical-only items and supplies include, but are not limited to, bandages, crutches, contact lens solutions, durable medical equipment, sunburn ointments, nicotine gum or patches for smoking cessation, carpal tunnel wrist supports, pregnancy kits and diagnostic devices such as blood sugar test kits.

What is the procedure for filing benefit claims and appeals under the Plan?

The following table describes the process for filing claims for reimbursement and appeals of benefit denials. If you need more information, please contact your Benefits Administrator.

Process for Filing Claims and Appeals for Health Reimbursement Arrangement Benefits	
Time limit for filing a claim for reimbursement:	All reimbursement requests for the Plan year must be received by the Claims Administrator not later than **March 31st** following the end of the Plan year.

Submit your claim to:	Claims Administrator Cooperative Benefit Administrators, Inc. P.O. Box 6962 Lincoln, NE 68506 CBA also accepts FAX submission of claims at 1.402.483.9388.
Date your claim is considered to be "filed" with CBA:	The date CBA receives your complete claim in writing.
Time period within which CBA must notify you that your claim is approved or denied:	Not later than **30 days** from the date CBA receives your claim. CBA may require **one 15-day extension** if circumstances warrant. CBA will notify you of the extension before the initial 30-day period is up. If CBA needs the 15-day extension because you did not provide all the information needed to process your claim, CBA will tell you what information is missing.
If your claim is incomplete, the time period that you have to submit the additional requested information to CBA:	Not later than **45 days** from the date CBA sent you the notice to tell you that your claim is missing information. This gives CBA additional time to respond to your claim. If you do not send CBA the missing information within this 45-day period, CBA will deny your claim.
Time period for deciding a claim is suspended while CBA waits for you to submit additional information about your claim:	The time period for deciding your claim is suspended from the date CBA notifies you that your claim is incomplete until the date you provide CBA with the requested information. CBA may then use the remainder of the review period to complete its evaluation of your claim.
CBA will give you a notice if your claim is denied that contains:	• Specific reasons why your claim is denied • Reference to the specific Plan provisions on which the denied claim is based • Description of any additional information necessary for you to perfect your claim and why this information is needed • Explanation of the Plan's claims review and appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA §502(a) following a denial on review; and • If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.
Time period that you, or your authorized representative, have to request a Level One Claim Appeal:	**Not later than 180 days from the date you receive the notice that your claim is denied. Your appeal must be filed within this deadline.**

"Authorized representative" definition:	A person you authorize in writing to act on your behalf. An authorized representative does not have to be a doctor or other health care provider.
Information you may request from the Plan, free of charge:	Copies of all documents, records and other information related to your denied claim.
Materials that you may submit with your appeal:	Written comments, records, documents and other information to support your appeal, whether or not you already submitted these items.
Submit your written appeal to:	Lisa Arview Wayne-White Electric Cooperative PO Drawer E Fairfield, IL 62837
Identity of the Appeals Administrator:	The Appeals Administrator is a different person than the person who made the original decision to deny your claim and is not someone directly supervised by the original decision-maker.
Time period that the Appeals Administrator has to review your appeal and make a decision:	Not later than **60 days** from the date the Appeals Administrator receives your appeal. No extension of this appeal response deadline is permitted under ERISA. The Appeals Administrator will conduct a full and fair review of all documents and evidence submitted to support your claim for benefits and may consult with medical experts in order to make a decision about your appeal. These medical experts are different persons than the ones consulted previously. If the Appeals Administrator fails to notify you of the final outcome of the appeal, you may presume that your appeal is denied.

If the Appeals Administrator denies your appeal, you will receive a notice that is readable and easily understood by the average person without an insurance background. The notice contains:	• Specific reasons why your appeal is denied. The reasons must be sound, logical and pertain to the facts of the claim. • Reference to the specific Plan provisions on which the denied appeal is based. An explanation of your rights under the Plan's claims and appeals rules, including that you have the voluntary right to a final appeal by the Appeals Committee. If your appeal is denied, the notice that you receive from the Committee will include the following information: • A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits; • If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and • You have now completed the Plan's appeal process. No action may be brought against the Plan, the employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated until you first follow the above claim procedures and receive a final determination from the Administrator. However, you may **voluntarily** take part in one more level of review of your denied appeal called the Level Two Appeal Process. If you do not choose to use the Level Two Appeal Process, you may seek legal action.
Level Two Final Appeal Process:	You may use this option if you wish to have the Plan's Appeals Committee review your denied claim appeal. Using this Level Two Final Appeal Process has no effect on your rights to any other benefits under the plan or your rights to seek legal action. You are not required to utilize this procedure. You may request additional information about the Level Two Final Appeal Process from the Appeals Committee prior to filing your written request for review.
Time period that you have to submit your request for review:	Not later than **60 days** from the date you receive the notice that your claim appeal is denied by the Appeals Administrator.
Information you may request from the Plan, free of charge:	Copies of all documents, records and other information related to your denied claim and denied appeal.
Materials that you may submit with your final appeal:	Written comments, records, documents and other information to support your appeal, whether or not you have already submitted these items.

Submit your written final appeal to:	Appeals Committee Wayne-White Electric Cooperative PO Drawer E Fairfield, IL 62837
Identity of the Appeals Committee:	You must be informed of the specific procedures by which the Appeals Committee is chosen and assured that the Appeals Committee is an independent reviewer.
Time period that the Appeals Committee has to review your final appeal and make a decision:	Not later than **60 days** from the date the Appeals Committee receives your final appeal. The Appeals Committee will conduct a full and fair review of all documents and evidence submitted to support your claim for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different persons than the ones consulted previously. The Appeals Committee may require **one 60-day extension** if circumstances warrant. The Appeals Committee will notify you of the extension before the initial 60-day period is up.
If your final appeal is denied, you will receive a notice that contains:	• Specific reasons why your final appeal is denied • Reference to the specific Plan provisions on which the denied final appeal is based An explanation of your rights under ERISA's claims and appeals rules, including a statement that if the Final Appeal is denied, you may seek judicial review of the claim denial.

Plan Information

- The Plan described in this Summary Plan Description is identified as follows:
  The Plan name is the Health Reimbursement Arrangement (HRA) Plan.
  The Plan year is January 1st – December 31st.
  The type of Plan is an employer-provided medical reimbursement plan under Code sections 105 and 106 and a health reimbursement arrangement as defined by IRS Notice 2002-45.
  The Plan Number is: 535

- The Employer is the Plan Administrator and the Employer, or a committee designated by the Employer, is the Named Fiduciary of the Plan for purposes of ERISA. The agent for service of process is the Plan Administrator. This is the person who receives all legal notices on behalf of the Plan regarding claims or suits filed with respect to the Plan. The name, address and telephone number of the Plan Administrator is:

  Lisa Arview
  Wayne-White Electric Cooperative
  PO Drawer E
  Fairfield, IL 62837
  618-842-2196

- The Employer Identification Number of your employer is:

  37-0574965

- The Claims Administrator for the Plan is:
  Cooperative Benefit Administrators, Inc. ("CBA")
  P.O. Box 6962
  Lincoln, NE 68506

- The Health Reimbursement Arrangement (HRA) Plan is a contract administration plan. CBA processes claims for the Plan, but the Employer pays all claims out of its general assets. A health insurer is not responsible for the financing or administration of the Plan.

ERISA Rights

The Health Reimbursement Arrangement (HRA) benefits are provided under an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Participants who contribute to a HRA are entitled to certain rights and protections under ERISA.

Your Rights
ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the employer's office, all Plan documents.
- Obtain copies of all Plan documents and other Plan information upon written request to the employer. The employer may make a reasonable charge for the copies.

- File a suit in a federal court, if any materials requested are not received within 30 days of the participant's request, unless the materials were not sent because of matters beyond the control of the employer. The court may require the employer to pay up to $110 for each day's delay (beyond 30 days) until the materials are received.

Prudent Action by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries" in the law. Your employer, or committee appointed by your employer, is the named fiduciary with authority to control and manage the operation and administration of the Plan. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan. Your employer may not fire you nor discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. If you are improperly denied a benefit in full or in part, you have a right to file suit in federal court after exhausting all mandatory appeal procedures under the Plan. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorney's fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about this statement or your rights under ERISA, you should contact your employer or the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rights

Participants who contribute to a Health Reimbursement Arrangement are entitled to certain rights under HIPAA. The Health Reimbursement Arrangement Plan is required by federal law to protect the privacy of your individually identifiable health information that it creates or receives ("Your Protected Health Information") and to provide you with information about its legal duties and privacy practices.

Use and Disclosure of Your Protected Health Information
The Plan may use or disclose Your Protected Health Information to others without your authorization for purposes of treatment, payment or health care operations of the Plan. Treatment includes providing, coordinating, and managing your health care and related services. Payment includes obtaining payment for your coverage, administering claims, coordinating benefits and aiding other medical plans or health care providers in obtaining payment for their services. Health care operations include using or disclosing information for business planning, quality assessment, case management and disease management.

The Plan may also disclose Your Protected Health Information to a limited group of employees of NRECA or CBA to carry out the Plan Sponsor's responsibilities to administer plan payment and health care operations. The Plan may not disclose Your Protected Health Information to the NRECA or CBA for any other reason without your authorization. However, health information derived from other sources,

for example in connection with an application for disability benefits or a leave qualifying under the Family and Medical Leave Act, is not protected by HIPAA.

The Plan is not restricted from using or disclosing any health information that does not identify an individual. Your eligibility and enrollment information may also be used by or disclosed to the NRECA or CBA.

The Plan may also use or disclose Your Protected Health Information without your authorization for the following purposes: to comply with the law, for public health and health oversight activities, in connection with judicial and administrative proceedings, to law enforcement and government officials, for health or safety purposes, or for workers' compensation purposes.

In most other cases, the Plan cannot use or disclose Your Protected Health Information without your authorization. If you choose to authorize additional uses and disclosures of Your Protected Health Information, you may revoke your authorization at any time.

Your Rights
You may request additional restrictions on the use and disclosure of Your Protected Health Information for payment and health care operations; however, the Plan does not have to grant your request.

You may request that you receive Your Protected Health Information by an alternative means of communication or at another location if the standard method of communication will endanger you.

You have a right to inspect and copy Your Protected Health Information, however, the Plan may deny your request under certain circumstances.

You have a right to request that the Plan amend Your Protected Health Information in any system maintained by or for it, however the Plan may deny your request under certain circumstances. If your physician or other health care provider created the information that you desire to amend, you should contact them directly.

You may obtain an accounting of certain disclosures of Your Protected Health Information made after April 14, 2004. You may be charged if you request an accounting more than once within a 12-month period.

You may exercise your rights through a personal representative if they produce evidence of their authority to act on your behalf. For purposes of the Plan, a personal representative may not be a physician or other health care provider.

To exercise these rights or if you have additional questions, you should contact the Privacy Officer and/or Contact Person listed in the Plan's Notice of Privacy Practices, which has previously been furnished to you.

Other Important Administrative Information

Nondiscriminatory benefits
This Plan is intended not to discriminate in favor of highly compensated employees as to eligibility, contributions and/or plan benefits. The Plan Administrator can take appropriate action to assure nondiscrimination, including reducing plan contributions, benefits and participation.

Amendment or termination
This Plan may be amended or terminated at any time by action of your employer. However, your rights to claim benefits for the period *prior* to the termination or amendment will not be affected if such benefit is payable under the Plan as in effect before the Plan is terminated or amended.

Not a contract of employment
This plan must not be construed as a contract of employment and does not give any employee a right of continued employment.

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

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

Overpayments or Errors
If it is later determined that you and/or your spouse or dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan and the employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.