NRECA Long Term Disability Plan

SUMMARY PLAN DESCRIPTION

For:

COLES-MOULTRIE ELECTRIC COOPERATIVE

01-14008-001

EFFECTIVE DATE: January 1, 2012

NRECA

A Touchstone Energy® Cooperative

Introduction

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

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

Important Disclaimer: Benefits under this Plan are provided pursuant to a written plan document adopted by your Employer. If the terms of this SPD conflict with the terms of the governing plan document, then the terms of the governing plan document will control, rather than this SPD.

Table of Contents

Chapter 1: Contacts

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

Chapter 2: Long Term Disability Plan Highlights

Benefit Period Begins	After 13 weeks of Disability (see "Chapter 4")
Disability Monthly Benefit	66 2/3% of your monthly Earnings (see "Definitions") up to a maximum monthly benefits payment of $15,000.
Maximum Benefit Period	Disability benefits will be paid monthly for as long as you qualify for benefits under this Plan, but will not exceed the Maximum Benefit Period. The Maximum Benefit Period is based on your age when your Disability occurs and ends at 65. Disabilities due to Mental/Nervous Conditions (see "Definitions") or Substance Abuse (see "Definitions") may be subject to a 24-month limitation on benefits (see "Chapter 4").

Chapter 3: Eligibility and Coverage Information

Eligibility for Participation

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

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

Eligibility Waiting Period

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

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

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

Additional Eligibility Requirements

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

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

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

When Coverage Begins (Participation Date)

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

Cost of Coverage

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

- You pay the entire cost of your coverage.

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

Special Enrollment Opportunity

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

- Marriage, birth, adoption or placement for adoption, if you enroll prior to and within 31 days after the event date.
- Divorce or death of spouse or dependent child, if you enroll within 31 days after the event date.

- Changes in employment status that would make you eligible to participate in the Plan.
- Annual enrollment, if offered by your Employer.

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

When Coverage Ends

Your Disability coverage ends the earliest of the following dates:

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

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

Chapter 4: Long Term Disability Benefits

Definition of Disability

To be considered Disabled during the Benefit Waiting Period (see "Definitions") and for the **first 24 months of your Disability benefits**:

- You must be prevented from performing any or all of the Material and Substantial Duties (see "Definitions") of your Own Occupation (see "Definitions") due to any Injury, Sickness, Mental/Nervous Condition, or episode of Substance Abuse;
- You have lost at least 20% of your Pre-Disability Earnings (see "Definitions"); and
- You have met all other Plan requirements.

After 24 months of Disability Benefits, measured from the end of the Benefit Waiting Period, you will continue to be considered Disabled if:

- You are unable to perform any or all of the Material and Substantial Duties of any Gainful Occupation (See "Definitions") for which you are qualified based on education, training and experience, due to any Injury, Sickness, Mental/Nervous Condition*, or episode of Substance Abuse*;
- You have lost at least 40% of your Pre-Disability Earnings; and
- You continue to meet all other Plan requirements.

*Disabilities due to Mental/Nervous Condition or Substance Abuse may be subject to a 24-month limitation on benefits – please see the section "Maximum Benefit Period for Disability Benefits due to Mental/Nervous Conditions or Substance Abuse".

Please keep in mind that the definition of Disability includes an earnings-based component called Earnings While Disabled (see "Definitions") that allows you to earn some income and still be considered Disabled under the terms of the Plan.

Other conditions that must be met before you will receive any benefits under the Plan:

- The period of Disability benefits begins while you are covered under the Plan; and
- You are receiving care from a Physician (see "Definitions") that is appropriate to the disabling condition, and such care is administered as often as necessary to achieve maximum medical improvement.

When Benefits Begin

Your long term disability benefits may begin once you have met the eligibility requirements under the Plan (see "Chapter 3") and you are found to be Disabled pursuant to the terms of the Plan. You may begin receiving Disability benefits after the Benefit Waiting Period – After 13 weeks of consecutive Disability.

A return to active work for 30 days or less (whether or not consecutive), with your Physician's approval, is permitted during the Benefit Waiting Period.

Recovery guidelines allow 30 days of temporary recovery during the Benefit Waiting Period when you can return to work. This temporary recovery provision encourages Employees to attempt to return to work during the Benefit Waiting Period, if they are able, without penalty. These 30 days or fewer **do not** count toward satisfying the Benefit Waiting Period. Note that any time worked on a single day will be treated as one full day of work for this purpose. If you work more than 30 days during the Benefit Waiting Period, you will be required to satisfy a new Benefit Waiting Period.

Disability Benefit Amounts

Your monthly benefit is 66 2/3% of your basic monthly Earnings, subject to the compensation limit imposed by the Internal Revenue Code (IRC) (discussed below).

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

Maximum Benefit

Due to the compensation limit imposed by the IRC, effective January 1, 1994, no more than $250,000 (in 2012 and adjusted from time-to-time for inflation) of annual Earnings may be considered when the Plan calculates your benefit. However, a supplemental insurance policy outside the NRECA Group Benefits Trust has been established which will provide benefits to the extent an Employee's salary exceeds the compensation limit. This supplemental insurance policy is provided under the NRECA Excess Long Term Disability Plan.

The combined monthly benefit maximum from this Plan and the supplemental insurance policy (under the NRECA Excess Long Term Disability Plan) is $15,000.

Minimum Benefit

The minimum monthly benefit under this Plan is $65.

Maximum Benefit Period for Disability Benefits

Disability benefits will be paid monthly as long as you qualify for benefits under this Plan, but will not exceed the Maximum Benefit Period.

The Maximum Benefit Period is determined by your age when your Disability begins. The standard Maximum Benefit Period ends at age 65 for anyone who becomes Disabled before age 60.

Benefits will be paid, while you remain Disabled, up to the Maximum Benefit Period shown below except for Disabilities due to Mental/Nervous Conditions or Substance Abuse (see "Maximum Benefit Period for Disability Benefits due to Mental/Nervous Conditions or Substance Abuse"):

If age 65:

Your Age on Date Disability Begins	Your Maximum Benefit Period
Less than age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 through 74	12 months
75 and over	6 months

Benefits are based on a thirty (30) day month, and will be prorated accordingly for a partial month.

Once you reach the Maximum Benefit Period, your Disability benefits are no longer payable even if you remain Disabled.

Maximum Benefit Period for Disability Benefits due to Mental/Nervous Conditions or Substance Abuse

When Disability results from a Mental/Nervous Condition or Substance Abuse, an employee's Maximum Benefit Period for all such periods of Disability is limited to 24 months. This is not a separate maximum for each such condition, or for each period of Disability due to a Mental/Nervous Condition or Substance Abuse, but rather a combined lifetime maximum for all periods of Disability due to all these conditions, either separate or combined. If, at the end of the 24 months, the employee is confined in a Hospital or other facility qualified to provide necessary care and treatment for Mental/Nervous Conditions or Substance Abuse, then the Maximum Benefit Period may be extended to include the time during which the employee remains confined.

When Benefits End

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

- You no longer meet the definition of Disabled, as determined by CBA;
- You fail to furnish written proof of your continued Disability to CBA, when and as required by CBA;
- You have reached the end of the Maximum Benefit Period;
- You refuse to participate in a Workplace Accommodation (see "Definitions") supported and implemented by your Employer and CBA;
- You refuse to participate in a Mandatory Rehabilitation (see "Definitions") program designated by CBA;
- You refuse to submit to an independent medical examination(s), functional capacity evaluation(s), and/or personal interview(s) as required by CBA;
- You fail to provide Proof of Loss (see "Definitions") to CBA, when and as required by CBA;
- You refuse to receive ongoing care from your Physician that is appropriate to your Disabling condition and/or such care is not administered as often as necessary to achieve maximum medical improvement during the period of Disability, in CBA's sole discretion;
- You become confined to jail, prison, or other house of correction as a result of conviction for a criminal or other public offense; or
- You die.

Reduction of Monthly Benefit Due to Other Sources of Income

The Plan will reduce your monthly Disability benefits by other benefits or income you might receive after becoming Disabled. These are called benefit offsets. Examples of these benefit offsets are:

- Workers' compensation benefits or benefits from any similar government plan or program. To the extent such benefits are paid in a lump sum settlement, the settlement will be characterized as lost wages over the Maximum Benefit Period for purposes of determining the monthly benefit offset.
- Payments made pursuant to state, provincial or federal laws of the United States or Canada including but not limited to motor vehicle insurance statutes 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.
- Distributions made under any defined benefit pension plan, including, but not limited to, the NRECA Retirement Security Plan and the International Brotherhood of Electrical Workers (IBEW) pension plan.
- Other income received as a retirement benefit from a retirement plan that is wholly or partially funded by Employer contributions unless:
    a) you began receiving regular periodic distributions prior to becoming Disabled; or
    b) you immediately transfer or roll over the payment or benefit to another qualified retirement plan or to an individual retirement account (IRA) for the funding of future retirement, and the balance of the transferee account or IRA at the end of

each year does not fall below the amount transferred as a result of any withdrawal by the Participant.

- Amounts withdrawn from a qualified retirement plan or IRA attributable to amounts transferred or rolled over from a retirement plan that is wholly or partially funded by Employer contributions.
- Disability benefits from the Veteran's Administration or any other foreign or domestic governmental agency unless:
  a) the benefit began before you became Disabled; or
  b) if you were receiving the benefit before becoming Disabled, only the amount of any increase in the benefit that is attributable to your Disability will be a benefit offset.
- Earnings While Disabled.
- Disability benefits under any group life insurance policy.
- Disability payments from any employee benefit plan.
- Certain amounts withdrawn from the 401(k) Pension Plan (or other qualified retirement plan) or IRA attributable to quasi-retirement transfers from the Retirement Security Plan and rollovers from the Retirement Security Plan (excluding any Employee contributions). If a withdrawal causes the balance of such plan or IRA as of the end of each year to fall below the amount transferred, your Disability benefits will be reduced by the amount that is the difference between your ending balance and the amount transferred or rolled over. No reduction in your Disability benefits will occur if, at the end of each year, there have not been any withdrawals, even if the ending balance is less than the amount transferred (e.g., due to investment losses).
- Payments from any deferred compensation plan, executive compensation plan, "top hat" plan or similar type of benefit arrangement.
- Social Security benefits for disability (including dependent benefits) or retirement.

You should not consider this to be an all-inclusive list. If you are not sure about a particular type of payment, you should contact your Benefits Administrator. It is possible to receive income not specifically mentioned on the list above that will reduce your Disability benefit payments.

Any cost of living increases you and your family receive from the above sources will not affect your benefits.

Entitlement to other benefits may reduce your monthly benefit even if you do not apply for and receive such benefits.

If you do not apply for other benefits to which you are entitled, CBA has the right to reduce your monthly benefit by an estimate of what you would have received if you had applied for the benefits. If you subsequently receive such benefits, any necessary adjustments will be made to your monthly benefit.

CBA may, in its discretion, advance the full monthly benefit to you without reduction while you are waiting for payment of the other benefits. However, if CBA advances such benefits, you will be required to promise in writing that you will repay the advance as soon as you receive the other benefits. If you do not repay the advance on a timely basis, CBA reserves the right to suspend your Disability benefit and/or take legal action to pursue payment plus interest at the rate of 8% compounded annually on the principal amount of the advance that is not repaid within 30 days of your receipt of the other benefits. CBA may also recover from you reimbursement of CBA's costs and attorney's fees incurred to enforce this repayment provision.

Any single lump sum payment you receive will be considered as a monthly series of payments for the purpose of this Plan. If you receive a single lump sum payment, and the corresponding maximum monthly payment can be determined by CBA, then the benefit offset will be determined by prorating the single sum over the time period for which the sum is paid.

If the maximum monthly payment cannot be determined by CBA, then the monthly benefit offset will be determined by dividing the lump sum payment over the period for which payments would otherwise be made.

In the case of cash distribution(s) attributable to your accrued benefit from the NRECA Retirement Security Plan, the monthly benefit offset is determined using an actuarially determined monthly annuity payment based on a 50% joint and survivor annuity for married Employees and a life only annuity for unmarried Employees.

Mandatory Rehabilitation Provision

To help you get back to work, your coverage has a Mandatory Rehabilitation provision. CBA may determine, for a particular Disability that rehabilitation is within the ability of a Disabled Employee who is entitled to benefits under this Plan, meaning that your Disability is not so severe that you are not able to learn new productive skills and become self-supporting.

Rehabilitation is mandatory. Your Disability benefits may be terminated if you refuse to participate in a rehabilitation program that CBA has determined is appropriate and for which CBA has agreed to pay expenses up to $10,000.

Trial Work Period

To help you get back to work, your coverage provides for a trial work period, during which you can continue to receive Disability benefits and return to work for the Employer in some capacity, as your Disability allows, for up to 3 months. The trial work period gives you the opportunity to determine how much work you can handle with your medical condition(s) and to receive as much as 100% of your Pre-Disability Earnings from your Employer and the Plan combined. If you are interested in the trial work period, you must submit a written request to CBA in advance. The trial work period must be approved by CBA, the Employer and your Physician.

During the trial work period, your monthly Disability benefit will be calculated as your Pre-Disability Earnings minus your Earnings during the trial work period and minus applicable offsets. The three-month trial work period may be extended or renewed by CBA, in consultation with the Employer and your Physician, but not for more than 3 months at a time. In no event may the trial work period exceed 12-months. You may have only one trial work period during any single period of Disability due to the same or related causes.

If your Disability prevents you from completing a trial work period and you continue to satisfy the definition of Disability under this Plan, you will continue to receive your Disability benefits, and the

full amount of your Disability benefit will be reinstated prospectively. You may be required to submit medical documentation to confirm your inability to complete the trial work period.

Workplace Accommodation

If you return to work as a result of a Workplace Accommodation made by the Employer, the Plan may reimburse your Employer for certain related expenses.

Your participation, by returning to work, is mandatory if CBA deems accommodation necessary to ensure your return to work and the Employer supports it. Failure to participate may result in the termination of Disability benefits.

Loss of Earnings Provision

As a way to provide opportunity for rehabilitation and productivity, Employees are allowed to work while Disabled and continue to receive a percentage of the Disability benefit in addition to their work Earnings while Disabled. The combination of the reduced Disability benefit and your (the Employee's) work Earnings may not exceed your standard Disability benefit. Your Earnings While Disabled may come from your Employer or from another employer. Your Disability benefit is calculated as the Disability benefit percentage multiplied by your Pre-Disability Earnings minus your Earnings While Disabled and any benefit offsets.

For the first 24 months of Disability you may earn no more than 80% of your Pre-Disability Earnings. After 24 months of Disability you can earn no more than 60% of your Pre-Disability Earnings.

Recurrent and New Disabilities

For purposes of satisfying the Benefit Waiting Period, if you have been Actively at Work for less than 180 days, a recurring Disability resulting from the same or similar cause or condition will be regarded as a continuation of the prior Disability, and a new Benefit Waiting Period is not required. If you have been Actively at Work for at least 180 days, a recurring Disability resulting from the same or similar cause or condition will be regarded as a new unrelated Disability, and a new Benefit Waiting Period must be satisfied before benefits can begin.

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

In all cases, recurrent and new Disabilities require this Plan to be in force at the time of your Disability.

Multiple Disabilities

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

Disability Plan Exclusions

General Exclusions

No Disability benefit will be paid for Disabilities:

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

- Caused by or contributed by service in the Armed Forces, National Guard, or military reserves of any country or international authority (including active duty, active duty for training purposes, undeclared war and resistance to armed aggression); except a non-service connected Injury or Sickness while on a temporary tour of duty of 31 days or less.
- Caused by or contributed to an act of war, declared or undeclared, including resistance to armed aggression.
- Resulting from attempted suicide or intentionally self-inflicted Injury, while sane or insane.
- Caused by or contributed to, or resulting from participation in the commission of an assault, felony, strike, civil disorder, or riot.
- When you are confined to jail, prison, or other house of correction as a result of conviction for a criminal or other public offense.
- When you fail to provide Proof of Loss acceptable to CBA.
- When you do not cooperate with CBA in accordance with the terms of the Plan, including but not limited to, the Mandatory Rehabilitation provision, independent medical examination(s), functional capacity evaluation(s), personal interview(s) and/or requests for verification of your financial status.

Exclusion for Pre-existing Condition

No benefits will be payable under the Plan for any Disability that is due to or results from, in whole or in part, a Pre-Existing Condition (see "Definitions"), unless such Disability begins after the last day of 365 consecutive days during which you have been continuously covered under this Plan. In the event that your Disability is excluded as a Pre-Existing Condition, a recurring Disability resulting from the same or similar cause or condition shall be excluded unless the Active Work Requirement of 180 consecutive days is met before the onset of the subsequent Disability can be treated as a new Disability.

Chapter 5: Applying for Long Term Disability Benefits

Initial Proof of Disability

You must notify CBA of your Disability within **90 days** of the onset of the Disability. Contact your Benefit Administrator for a Long Term Disability Claim Form Packet and instructions on how to complete the forms. You, your Employer, and your treating Physician each have sections of the forms to complete.

Once CBA has been notified of the Disability, you will be required to provide Proof of Loss by sending CBA the completed claim forms, which includes:

- Employee Application;
- Employer's Information;
- Attending Physician's Statement of Disability;
- Authorization to Obtain Information; and
- Essential Job Functions Statement.

Proof of Loss must be furnished in writing to CBA not more than 90 days after the last day of your Benefit Waiting Period. If it is not reasonably possible to give initial notice or Proof of Loss within

the time limits, benefits may not be invalidated or reduced as long as CBA receives it as soon as reasonably possible.

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

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

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

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

Continuing Proof of Disability

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

Chapter 6: Claims and Appeals Procedures

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

Using an Authorized Representative

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

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

Process for Disability Claims and Appeals	
Time limit for you to notify CBA of your Disability:	Not later than 90 days from the onset of your Disability.
Time limit to file Proof of	Not later than 90 days from the last day of your Benefit

Loss:	Waiting Period.
Submit your claim to:	Claims Administrator CBA P.O. Box 6249 Lincoln, NE 68506
Date your claim is considered "filed":	The date CBA receives your completed claim in writing.
Time Period that CBA has to notify you that your claim is approved or denied:	Not later than 45 days after receipt of claim by the Plan; two extensions of up to 30 days each, if circumstances warrant, may be required. CBA will notify you within the initial 45-day period if an extension is required. If CBA needs the initial 30-day extension because you did not provide all of the information needed to process your claim, CBA will tell you what information is missing. If an additional 30-day extension is needed, CBA will notify you before the end of the first 30-day extension.
If your claim is incomplete, the time you have to submit additional requested information to CBA:	Not later than 45 days from the date CBA sends you the notice to tell you that your claim is missing information. If you do not send the information within the 45-day period, CBA will deny your claim.
The time period for deciding your claim is suspended from the date CBA notifies you that your claim is incomplete until the date you provide CBA with the requested information. CBA may then use the remainder of the review period to complete its evaluation of the claim.	
If your claim is denied:	CBA will provide you a notice that contains: • Specific reason(s) for the benefit denial; • Reference to specific Plan provisions on which denial is based; • Description of any additional information needed to perfect the claim, and an explanation of why such information is needed; • Description of the Plan's review procedures and time limits that apply to them; • Explanation of your rights under ERISA's claim and appeals rules; and • A copy of any internal rule, guideline, protocol or similar criterion relied on (or a statement that the material is available upon request for free).
Time period that you, or	Not later than 180 days from the date you receive the

your authorized representative, have to request an appeal:	notice that your claim is denied.

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

Submit your Appeal to:	Appeals Administrator CBA P.O. Box 6249 Lincoln, NE 68506

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

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

You have now completed the Plan's appeal process. However, you may voluntarily take part in one more level of review of your denied appeal called the

Voluntary Final Appeals Process. If you do not choose to use the Voluntary Final Appeals Process, you may seek legal action by filing suit under ERISA within one year from the date your appeal was denied.

Voluntary Final Appeal Process:	You may use this option if you wish to have the Plan's Appeals Committee review your denied appeal. Using this Voluntary Final Appeal Process has no effect on your rights to any other benefits under the Plan or your rights to legal action. Before you submit your written request, you may request additional information about the Voluntary Final Appeal Process by calling (402) 483-9200.
Time period that you have to file your voluntary final appeal:	Not later than 60 days from the date you receive the notice that your appeal is denied by the Appeals Administrator.

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

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

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

Time period the Appeals Committee has to review your voluntary final appeal:	Not later than 60 days from the date the Appeals Committee receives your appeal. An extension may be requested for up to 60 days, if circumstances warrant. CBA will notify you within the initial 60-day period if an extension is required. The Appeals Committee will conduct a full and fair review of all documents and evidence submitted to support your claims for benefits and may consult with medical or vocational experts in order to make a decision about your appeal. These medical or vocational experts are different persons than the ones consulted previously.
If your voluntary final appeal is denied:	The Appeals Committee will provide you a notice that contains: • Specific reason(s) for the benefit denial;

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

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

Chapter 7: Plan Information

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

Plan Number: 501

Type of Plan: Long Term Disability Plan

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

Effective Date: January 1, 2012

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

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

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

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

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

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

Plan Sponsor's Employer Identification Number: 53-0116145

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

Senior Vice-President
Insurance & Financial Services
National Rural Electric Cooperative Association
4301 Wilson Boulevard
Arlington, VA 22203-1860
Telephone number: (703)907-5500
Employer Identification Number: 54-2072724

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

Benefits Administrator
COLES-MOULTRIE ELECTRIC COOPERATIVE
P.O. BOX 709
MATTOON, IL 61938
Employer Identification Number: 37-0223453

Plan Trustee: The trustee for the Plan is:

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

Claims Administrator: The Claims Administrator for the Plan is:

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

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

Chapter 8: Administrative Information

Not a Contract of Employment

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

Non-Assignment of Benefits

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

Third Party Liability

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

Subrogation

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

Reimbursement

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

Right of Recovery of Overpayment

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

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

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

Amendment or Termination

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

Severability

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

Additional Procedures

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

Chapter 9: Federal Laws Impacting This Plan

Statement of ERISA Rights

Your Rights

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

Receive Information About Your Plan and Benefits

You have the right to:

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

Duties of Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other

Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Chapter 10: Definitions

Accident – An Injury which is:

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

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

Requirement if he is on an Employer-approved leave of absence (e.g., Family and Medical Leave Act (FMLA) absence, jury duty, bereavement leave, vacation), but does not include time off as a result of Injury or Sickness. In no event will an Employee be deemed to be on an Employer approved leave of absence for any absence that continues longer than 12 weeks, except for an FMLA leave of absence to care for family members who are injured while on active duty in the Armed Forces, including the National Guard or Reserves, which provides the Employee with a leave up to 26 weeks. If an Employee is confined for medical care or treatment in a Hospital, any institution or at home, however, on the date coverage would otherwise become effective, the effective date of his eligibility to participate in the Plan will be postponed until he receives final medical release from the medical confinement and he satisfies the Active Work Requirement.

Benefit Waiting Period – A time of continuous Disability extending for 13 or 26 consecutive weeks (as selected by the Employer) between the first day of Disability and the day on which benefits begin.

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

Disability or Disabled – See Chapter 4 "Definition of Disability".

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

Earnings While Disabled-The monthly Earnings you receive from the Employer (excluding sick leave, vacation leave and paid time off) and any other employment while Disabled.

However, if the other employment is a job you held in addition to active full-time employment with the Employer, then during the Benefit Waiting Period and the next 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 6-month period immediately prior to becoming Disabled.

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

Employee – A person who is:

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

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

Gainful Occupation – Any activity for profit or compensation which replaces or can be expected to replace more than 60% of the Employee's Pre-Disability Earnings.

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

Injury – Bodily harm that is the direct result of an Accident and not related to any other cause. Disability as a result of the Injury must begin while the Employee is covered under the Plan.

Mandatory Rehabilitation -A rehabilitation program may include, when CBA considers it to be appropriate, any necessary and feasible:

1) Vocational testing;
2) Vocational training;
3) Alternative treatment programs including but not limited to those such as:
   a) physical therapy;
   b) occupational therapy; and
   c) speech therapy
4) workplace modification to the extent not otherwise provided;
5) job placement; and
6) similar services.

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

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

Mental/Nervous Condition—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.

Own Occupation—Any similar job that involves Material and Substantial duties of the same general nature as your regular job at the Employer when your Disability begins. It does not mean the specific job you are performing for a specific Employer or at a specific location.

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

Plan - NRECA Long Term Disability Plan.

Pre-Existing Condition—Pre-Existing Condition means:

1. Any accidental bodily Injury, Sickness, Mental/Nervous Condition, or episode of Substance Abuse; or

2. Any manifestations, symptoms, findings or aggravations related to or resulting from such accidental bodily Injury, Sickness, Mental/Nervous Condition, or Substance Abuse- for which you received, or a reasonable person would have sought, Medical Care during the 90-day period that ends immediately before your effective date of coverage under this Plan. However, any such manifestations, symptoms, findings or aggravations constitute Pre-Existing Conditions regardless of whether a condition was formally diagnosed or strongly suspected.

"Medical Care" for this purpose means:

1. A Physician is consulted or medical advice is given; or

2. Treatment is recommended, prescribed by or received from a Physician.

"Treatment" for this purpose includes but is not limited to:

1. Medical examinations, tests, attendance or observation; or

2. Use of drugs, medicines, medical services, supplies or equipment

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

1) Documentation of:
   a) the date your Disability began;
   b) the cause of your Disability;
   c) the prognosis of your Disability;
   d) your Earnings or income, including, but not limited to, copies of your filed and signed federal and state tax returns; and
   e) evidence that you are under the care of a Physician that is appropriate to the disabling condition.
2) Any and all medical information, including X-rays and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) The names and addresses of all:
   a) Physicians and practitioners of healing arts you have seen or consulted;
   b) hospitals or other medical facilities in which you have been seen or treated;
   c) pharmacies which have filled your prescriptions within the past three years;
4) Your signed authorization for us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information we may reasonably require.

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

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

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

Sickness – Any disease or illness. The term also includes:

- pregnancy; or
- any medical complications of pregnancy.

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

Substance—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.

Substance Abuse—The pattern of pathological use of a Substance, which is characterized by:

1) impairments in social and/or occupational functioning;

2) debilitating physical condition;

3) inability to abstain from or reduce consumption of the Substance; or

4) the need for daily Substance use for adequate functioning.

Workplace Accommodation- Steps taken by the Employer to adapt the workplace in response to an Employee's needs without major change.