NRECA Long Term Disability Plan
Summary Plan Description
for
SOUTHEASTERN ILLINOIS ELECT CO-OP, INC.
01-14037-002

Effective Date: January 1, 2009

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 SOUTHEASTERN ILLINOIS ELECT CO-OP, INC. This Plan is a component plan of the NRECA Group Benefits Program. In the pages that follow, you will find information on the long term disability benefits provided by the Plan.

This document uses a number of terms that have specific meanings under the Plan. These terms are capitalized. A list of key terms and their definitions can be found at the end of this document in the **"Key Terms"** section.

This document provides a summary of benefits under the Plan. If there are any inconsistencies between what is written in this Summary Plan Description and what is written in the master Plan document, the master Plan document will govern in all cases. Your rights to benefits will always be determined under the provisions of the master Plan document.

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The NRECA Long Term Disability Plan (the Plan) at a Glance

The following table provides you with a snapshot of your disability benefit under the Plan.

However, you are strongly encouraged to go to more detailed sections of this document to learn the specifics about what the Plan does and does not cover. Do not rely solely on this table for information on how the Plan works, as this is merely an overview. In addition, please realize that benefits under this Plan will be paid only if the Plan Administrator determines that you are eligible to receive them.

Benefit	Amounts
Monthly Benefit	**66 2/3%** of an employee's monthly Earnings up to a maximum monthly benefit of $15,000 which is the combined monthly benefit maximum from this Plan and the supplemental disability insurance policy (under the NRECA Excess Long Term Disability Plan). The minimum monthly benefit is $65. This benefit will be reduced by certain other income to which the employee may be entitled.
Benefit Period Begins	After 13 weeks of Disability
Maximum Benefit Period	Benefits will be paid as long as the employee is Disabled under the terms of the Plan but no longer than the Maximum Benefit Period. The Maximum Benefit Period is based on the employee's age when Disability occurs. The standard Maximum Benefit Period ends at 60. The standard Maximum Benefit Period may be limited for Mental Nervous Condition and Substance Abuse Disabilities (see below).
Limitation on Maximum Benefit Period for Mental/Nervous Condition and Substance Abuse Disabilities	**Same as for other disabilities - no limitations**

The Plan is designed to provide you and your family with income during periods that you are unable to work due to injury or sickness.

The benefit is based on your (the employee's) Earnings for a normal work week that do not exceed 40 hours. These Earnings do not include bonuses, deferred compensation, overtime pay and other additional compensation you may be receiving at the time of Disability. If your Earnings change, your monthly benefit amount will not be adjusted until the first day that you satisfy the Active Work Requirement.

Who is Eligible for Coverage?

The following groups are eligible for coverage under the Plan:

- Active Employees

The following job classifications (or titles) of employees are not eligible for coverage under the Plan:

Employees of any subsidiary (including employees of affiliated business)
Management position
Non-union employee
Part-time employee
Seasonal worker
Temporary employee

If you have any questions, please see your Benefits Administrator.

Other Eligibility Requirements

In addition, to be eligible for coverage as an employee, you must:

- 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 rural electric cooperative within the past six months and met one of the other criteria above.

You must also satisfy the following requirements:

- You must complete the Eligibility Waiting Period, if any (see "When Coverage Begins");

- You must complete the NRECA enrollment form within 31 days of satisfying your Employer's Eligibility Waiting Period, if any; and

- You must satisfy the "Active Work Requirement**.**" The Active Work Requirement (or "Actively at Work") means 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 satisfy the Active Work Requirement 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/she is on an employer-approved leave of absence (e.g., Family Medical Leave, 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. If you are 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 your eligibility to participate in the Plan will be postponed until you receive final medical release from the medical confinement and you satisfy the Active Work Requirement.

If the Employer grants an approved leave of absence to a participant, the required premium must be paid according to the terms specified in the Plan to keep the insurance in force.

When Coverage Begins

Coverage under the Plan begins after you have satisfied your Employer's Eligibility Waiting Period, if any (see below), and you have completed and returned the NRECA enrollment form.

The Eligibility Waiting Period is the length of time that an active employee must work before he or she is eligible to participate in the Plan.

Your Plan has the following Eligibility Waiting Period:

This Plan has no waiting period.

Please see your Benefits Administrator with any questions or for more information.

Paying for Coverage

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

- **Active Employees:**

Specific information regarding the amount you must pay toward your coverage will be provided to you before you enroll in the Plan, whether your enrollment is your initial enrollment, annual enrollment, or special enrollment. The cost of this coverage is subject to your Employer's policies and can change at any time. Please see your Benefits Administrator if you have any questions regarding your specific cost information.

Late Enrollment

If you do not enroll in the Plan within 31 days after you are eligible for coverage, you will be required to provide a Statement of Good Health.

Your Benefits Administrator will provide you with instructions for satisfying this requirement. The Plan Administrator will then approve or deny coverage based on the Statement of Good Health provided.

Pre-Existing Condition Exclusion

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, unless such Disability begins after the last day of 365 consecutive days during which you have been continuously covered under this Plan.

Pre-Existing Condition means:

1. Any accidental bodily injury, sickness, Mental/Nervous Condition, pregnancy 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, pregnancy 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.

Disability Monthly Benefit

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

*The benefit is based on your (the employee's) Earnings for a normal work week that does not exceed 40 hours. These Earnings do not include bonuses, income from deferred compensation, overtime pay and other additional compensation you may be receiving at the time of Disability. If your Earnings change, your monthly benefit amount will not be adjusted until the first day that you satisfy the Active Work Requirement.

Due to the compensation limit imposed by the Internal Revenue Code, effective January 1, 1994, no more than $245,000 (in 2009 and adjusted annually 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 $245,000 (2009) 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, and the minimum monthly benefit is $65.

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 or be entitled to 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 from automobile insurance programs, including, but not limited to, no-fault insurance programs;

- Distributions made under any defined benefit pension plan, including, but not limited to, the Retirement Security Plan and the 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.

- 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 (see "Key Terms");

- Disability benefits under any group life insurance policy;

- Disability payments from any employee benefit plan;

- Payments from any insurance policy, excluding individual disability insurance benefits;

- Social Security benefits for disability (including dependent benefits) or retirement;

- 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 Retirement Security Plan (excluding 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).

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 don't apply for other benefits to which you are entitled, Cooperative Benefits Administrators (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.

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) of benefits attributable to your accrued benefit from the 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.

Third Party Liability Provision

Your Plan includes a third party liability provision (also known as subrogation and the Plan's right to reimbursement). If your Disability is caused by an injury due to the fault of a third party and you receive compensation for your loss of income due to that injury, the Plan reserves the right to recover the benefits that it has paid on your behalf for loss of income due to that injury. See the "Additional Administrative Information" section later in this document.

Disability

The definition of **Disability** includes an earnings-based component called **Earnings While Disabled** (see "Key Terms") that allows you to earn some income and still be considered **Disabled** under the terms of the Plan. To be considered **Disabled** during the Benefit Waiting Period and for 24 months thereafter:

- You, the employee, must be prevented from performing any or all of the Material and Substantial Duties of your Own Occupation due to any accidental bodily injury, sickness, Mental/Nervous Condition, pregnancy or episode of Substance Abuse;
- Your have lost at least 20% of your pre-Disability Earnings;
- You have met all other Plan requirements; and
- You are not serving a sentence in a penal institution or other house of correction.

After 24 months of 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 for which you are qualified based on education, training and experience;
- You have lost at least 40% of your pre-Disability Earnings;
- You have met all other Plan requirements; and
- You are not serving a sentence in a penal institution or other house of correction.

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

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

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

Length of Disability Benefits

Your long term disability benefits begin after 13 consecutive weeks* of total disability.

* A return to active work for up to 30 days, with your Physician's approval, is permitted during this 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.

Recurrent and Successive Disabilities

For purposes of satisfying the Benefit Waiting Period, if you have been Actively at Work for less than 181 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 more than 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 successive Disabilities require this Plan to be in force at the time of your recurrent or successive Disability.

Maximum Benefit Period

The Maximum Benefit Period is determined by your age when your Disability begins. The standard Maximum Benefit Period ends at 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 and Substance Abuse –see the section below for limitation on Maximum Benefit Period):

If age 60:

Your Age on Date Disability Begins	Your Maximum Benefit Period
Less than age 55	To age 60
55	60 months
56	48 months
57	42 months
58	36 months
59	30 months
60 through 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 cut-off for the Maximum Benefit Period, your disability benefits are no longer payable *even if you remain Disabled.*

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

There is no separate Maximum Benefit Period for Disability due to Mental/Nervous Conditions or Substance Abuse under this Plan.

When Benefits End

Benefit payments will end on the first of the following to occur:

- You die or 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;
- The date your Earnings While Disabled exceed 80% of your pre-Disability Earnings if you are receiving benefits for being Disabled from your Own Occupation;

- The date your Earnings While Disabled exceed 60% of your pre-Disability Earnings if you are receiving benefits for being Disabled from any Gainful Occupation;

- The date you refuse to participate in a rehabilitation program designated by CBA;

- The date you refuse to cooperate with an examination by a Physician or other licensed professional, or with a personal interview by CBA or its agent or subcontractor;

- The date you refuse to return to work to participate in a Workplace Accommodation supported and implemented by your Employer and CBA; or

- The date you refuse to receive treatment by your Physician that is generally acknowledged by Physicians to cure, correct or limit the disabling condition.

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

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 (see the Benefits At a Glance table for your Employer's elected percentage) multiplied by your pre-Disability Earnings (the standard benefit) minus your Earnings While Disabled and any benefit offsets.

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

Vocational 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. Disability benefits may be terminated if you refuse to participate in a vocational 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 three 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 percent 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 3-month trial work period may be extended or renewed by CBA, in consultation with the Employer and your Physician, but not for more than three months at a time. In no event may the trial work period exceed twelve 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.

Time Limit on Claiming Benefits and Providing Proof of Loss

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

Once CBA has been notified of the Disability, you will be provided with the forms necessary for the filing of a Proof of Loss. 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 of disability shall in any event be approved by CBA if notification of disability and Proof of Loss are not provided to CBA within two years of the onset of disability.

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; and
   c) pharmacies which have filled your prescriptions within the past three years;

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

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

At any time during your Disability, CBA has the right to have a Physician or other licensed

professional examine you, or to have its agents and subcontractors conduct personal interviews with you. Claims are regularly reviewed by CBA to confirm continuing eligibility for benefits.

Long Term Disability Plan Exclusions

This Plan does not cover:

- Disability 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 achieve maximum medical improvement;

- Disability resulting from or contributed to by any act of war (including undeclared war and resistance to armed aggression);

- Disability resulting from an intentionally self-inflicted bodily injury or attempted suicide, whether sane or insane;

- Disability caused by, contributed to by, or resulting from participation in the commission of a felony;

- A Pre-Existing Condition;

- Any period in which 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 interviews and/or requests for verification of your financial status;

- Disability occurring while on active duty (including active duty for training purposes) in the military, naval or air service of any nation or international organization, or in any civilian unit which serves with military forces in combat, except a non-service connected injury or sickness while on a temporary tour of duty of less than 31 days; or

- Any period in which you fail to provide Proof of Loss acceptable to CBA.

Claims and Appeals Procedures

Claim Forms

You must notify Cooperative Benefit Administrators (CBA), the Claims Administrator for the Plan, when you become Disabled. This notification must occur **not later than 90 days from the onset of your Disability**. Contact your Benefits Administrator for a claim form and instructions on how to complete the form. You and your Employer each have sections of the form to fill out. In addition, your Physician must complete the Attending Physician's Statement of Disability.

Once CBA has been notified of the Disability, you will be furnished with the forms necessary for filing the Proof of Loss. Proof of Loss must be submitted to CBA **not later than 90 days from the last day of your Benefit Waiting Period**. Completed claim forms and documents supporting Proof of Loss should be sent to:

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

Claims and Appeals

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.

- **Self** - You may file claims and other documents related to your claim. It is not necessary for you to complete the form "Authorization to Use and Disclose Protected Health Information."

- **Authorized Representative** - If you use an authorized representative, please follow these procedures. To designate an authorized representative, 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.

  Once completed, send the form to the Plan's Privacy Officer at the following address to be reviewed and accepted:

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

  The Plan will provide you with a copy of the signed Authorization form for your records or files.

There are specific claim and appeal response periods for your disability claim. The following table explains the process for filing claims and appeals. If you need more information, contact CBA at 402-483-9200.

Process for Filing Long-Term Disability Claims and Appeals

Time limit for you to notify CBA of your disability:	Not later than **90 days** from the onset of your disability.
Time limit to file Proof of Loss:	Not later than **90 days** from the last day of your Benefit Waiting Period.
Submit your claim to:	Claims Administrator Cooperative Benefit Administrators, Inc. P.O. Box 6249 Lincoln, NE 68506
Date your claim is considered to be "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** from the last day of your Benefit Waiting Period. CBA may require a **30-day extension** if circumstances warrant and will notify you that it needs more time to evaluate your claim. CBA will notify you of the extension before the initial 45-day period is up. If a decision still cannot be made within the 30-day extension period due to circumstances outside of the Plan's control, the 30-day extension may be extended for an **additional 30 days**. CBA will notify you of this additional 30-day extension before the end of the initial 30-day extension. If CBA needs the initial 30-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. 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 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 needed and why this information is needed • Explanation of the Plan's claims review and appeal procedures.
Time period that you, or your authorized representative, have to request a claim appeal:	Not later than **180 days** from the date you receive the notice that your claim is denied.
"Authorized representative" definition:	A person you authorize in writing to act on your behalf. An authorized representative may not be a doctor or other health provider.
How to designate an authorized representative:	Fill out the form "Authorization to Use and Disclose Protected Health Information." Send the form to: Privacy Officer National Rural Electric Cooperative Association 4301 Wilson Boulevard Arlington, VA 22203-1860 The Plan will provide you with a copy of the form for your records after it is reviewed and accepted by the Privacy Officer.
Information that 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:	Appeals Administrator Cooperative Benefit Administrators, Inc. P.O. Box 6249 Lincoln, NE 68506
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 **45 days** from the date the Appeals Administrator receives your appeal. 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 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 Administrator may require **one 45-day extension** if circumstances warrant and will notify you that it needs more time to evaluate your appeal. The Appeals Administrator will notify you of the extension before the initial 45-day period is up.
If your appeal is denied, you will receive a notice that contains:	• Specific reasons why your appeal is denied • Reference to the specific Plan provisions on which the denied appeal is based • An explanation of your rights under ERISA's claim and appeal rules. 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 Appeal Process. If you do not choose to use the Voluntary Final Appeal 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 claim 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 review. Before you submit your written request, you may request additional information about the Voluntary Final Appeal Process from the Appeals Committee by phoning (402) 483-9200.
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 that you may request from the Plan, free of charge:	Copies of all documents, records and other information that relates 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 Cooperative Benefit Administrators, Inc. CBA 9284 P.O. Box 6249 Lincoln, NE 68506
Identity of the Appeals Committee:	The Appeals Committee is selected by the Vice President, Insurance & Financial Services Administration, and has no financial or personal interest in the final appeal's result.
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 request one **60-day extension** if circumstances warrant and will notify you that it needs more time to evaluate your appeal. 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 claim and appeal rules. You may seek legal action by filing suit under ERISA within one year from the date your final appeal was denied.

Important Administrative Information

Here is some important administrative information about this Plan.

- This Plan operates under the official name of the NRECA Group Benefits Program. Its Plan Number is 501.

- Coverage under the Plan is self-insured and funded through contributions made solely by the NRECA (address below), or jointly by NRECA and participating cooperatives:

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

- Type of plan: Group long term disability plan

- 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.

- The Plan Sponsor's Employer Identification Number is 53-0116145

- 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 the Insurance & Financial Services Department, the individual listed below is the person who has Plan Administrator responsibilities for your employer:

Benefits Administrator
SOUTHEASTERN ILLINOIS ELECT CO-OP, INC.
P.O. BOX 251
ELDORADO IL 62930

Employer Identification Number: 37-0524860

- The Plan Trustee is:

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

- The agent for service of legal process is the Plan Administrator— the Senior Vice-President of the Insurance & Financial Services Department of NRECA. This is the person who receives all legal notices on behalf of the Plan Sponsor regarding claims or suits filed with respect to this Plan. Such legal process may also be served upon the Plan Trustee.

- **The Claim Administrator for the Plan is:**

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

- 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.

Your Rights Under ERISA

As a 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 employees are entitled to:

- Receive information about the Plan and its benefits

- Examine, without charge, at the Plan Administrator's office or at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) 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 written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each employee with a copy of this Summary Annual Report.

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

If your claim for a 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 a 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, you may file suit in state or Federal court after exhausting all mandatory appeal procedures under the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after exhausting all mandatory appeal procedures under the Plan. If it should happen that the 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 Federal court. The court will decide who should pay the 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.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

Additional Administrative Information

Not a Contract of Employment or Guarantee of Other Benefits

This Plan must not be construed as a contract of employment and does not give any employee a right to 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.

Mistakes in Payment

Although every effort is made to pay your benefits from the Plan accurately, mistakes can occur. If a mistake is discovered, the Claims Administrator will make corrections that are deemed appropriate. You will be notified if a mistake is found.

Recovery of Overpayment

If the Plan makes an overpayment, it will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made, or to offset a future benefit payment by the amount of the overpayment.

Subrogation or Third Party Liability Provision

If your Disability is caused by an injury due to the fault of a third party (such as in an automobile accident), you may receive benefits from this Plan. Immediately upon paying any benefits to you, however, the Plan shall be subrogated to (that is, substituted for) all rights of recovery that you have against the third party for loss of income due to your injury. In the event that you receive a settlement, judgment or compensation from that third party for your loss of income due to your injury, the Plan reserves the right to seek reimbursement of the Disability benefits it paid on your behalf under this Plan.

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 a 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 subrogation and 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.

This provision of the Plan allows you to receive your disability benefits, and, at the same time, places the expense of disability coverage -- with the person who caused your injury. 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. If you fail to repay the Plan any amounts you receive for loss of income due to the injury, 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.

Changing or Terminating the Plan

The Plan Administrator and your employer reserve the right to make changes to this Plan or terminate this Plan at any time, for any reason. This includes the right to change the cost of coverage. These changes may be made with or without advance notice to Plan employees. .

Other Employee Classes

The Group Benefits Program may also cover employees in other employee classes for your Employer. If this is the case, a separate Summary Plan Description has been prepared for them that details the specific benefits for which they are eligible.

Key Terms

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 Medical Leave, 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. 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—To be considered **Disabled** during the Benefit Waiting Period and for 24 months thereafter:

- You, the employee, must be prevented from performing any or all of the Material and Substantial Duties of your Own Occupation due to any accidental bodily injury, sickness, Mental/Nervous Condition, pregnancy or episode of Substance Abuse;
- You have lost at least 20% of your pre-Disability Earnings;
- You have met all other Plan requirements; and
- You are not serving a sentence in a penal institution or other house of correction.

After 24 months of 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 for which you are qualified based on education, training and experience;
- You have lost at least 40% of your pre-Disability Earnings;
- You have met all other Plan requirements; and
- You are not serving a sentence in a penal institution or other house of correction.

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

Earnings or Pre-Disability Earnings—The employee's Earnings for a normal work week that do not exceed 40 hours, not including bonuses, income from 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 PTO) 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 length of time that an active employee must work before he or she is eligible to participate in the plan.

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.

ERISA—The Employee Retirement Income Security Act of 1974, as amended.

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.

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) work-place 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 or doctor must not be related to the employee by blood or marriage.

Plan—NRECA Long Term Disability Plan adopted by your Employer.

Pre-Existing Condition—Pre-Existing Condition means:

1. Any accidental bodily injury, sickness, Mental/Nervous Condition, pregnancy 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, pregnancy 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.

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 a worker's needs without major change.