NRECA Power Wellness Program

SUMMARY PLAN DESCRIPTION

For:

Wayne-White Counties Electric Cooperative

14002-003

EFFECTIVE DATE: January 1, 2012

NRECA

A Touchstone Energy® Cooperative

Introduction and Disclaimer

This document is a Summary Plan Description (SPD) providing you with a summary of the key provisions of the NRECA Power Wellness Program (referred to as the "Plan" in this document) for Wayne-White Counties 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.

If you are eligible to participate in the Plan, you may choose coverage for yourself and any eligible dependents, if such coverage is offered by your employer.

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

While the Plan's provisions determine the programs, activities and events that the Plan provides, you and your health care provider have ultimate responsibility for determining appropriate treatment and care and whether you are able to participate in the Plan's programs, activities and events. NRECA, the Plan and your employer are not responsible for any injury, loss or damage you may sustain as a result of your participation in the Plan's programs, activities and events.

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.

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Chapter 1: Contacts

Information about:	Benefits Administrator
• Eligibility • Enrollment • When Coverage Begins or Ends • Cost of Coverage • General Questions	**Wayne-White Counties Electric Cooperative** **PO Drawer E** **Fairfield IL 62837**

Chapter 2: Eligibility and Participation Information

Eligibility for Participation

The following employee and dependent classifications are eligible for participation in the Plan:

- Active Employees & their Spouses
- Disabled Employees receiving employer-sponsored LTD benefit

Your employer treats employees who are out on long-term disability (as defined by your employer's long-term disability plan) as Wayne-White Counties Electric Cooperative employees for purposes of eligibility to participate in this Plan.

For purposes of coverage under the Plan, your employer defines "Retiree" as a former employee who has met the following criteria:

Wayne-White Counties Electric Cooperative

Please see your Benefits Administrator for your employer's definition of Retiree.

The following job classifications of employees are not eligible for participation in this Plan:

Union Employees

Student Interns

Subsidiary Employees

Keep in mind: Participation in the Plan is voluntary.

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

Other 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 active 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 the other criteria above.

You and Your Spouse Work for Co-ops

If both you and your spouse work for an NRECA member cooperative and are eligible for coverage separately, both of you will be covered as employees unless you also wish to cover dependents. If you wish to cover dependents, either you or your spouse will be covered as an employee, and the other will be covered as a dependent. In no case can someone be covered under the Plan as both an employee and as a dependent.

When Coverage Begins (Participation Date)

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

Cost of Coverage

You and your employer may share in the cost of coverage.

Please see your Benefits Administrator for more information.

Making Changes During the Year and Special Enrollment

The following is applicable only if your Power Wellness Program benefit is considered "medical care" for purposes of ERISA.

If you decline coverage during your initial enrollment period, you may qualify to add or drop coverage for yourself and your eligible dependents, as applicable, if you experience the following events:

- Marriage, birth, adoption, placement of adoption, or legal guardianship if you enroll within 31 days after the event and the new dependents meet the requirements for eligibility.
- Divorce or death of spouse or dependent child, if you enroll within 31 days after the event date.
- Eligible dependent children may also add or drop coverage within 31 days of their loss or gain of other group health plan coverage (see "Losing Other Coverage" below).
- Changes in employment status that would make you eligible to participate in the Plan.
- Annual enrollment, if offered by your employer.

Coverage will become effective retroactively to the date of the divorce, marriage, birth, adoption, placement for adoption, or legal guardianship. If you, as an active employee, or your spouse are not currently enrolled, you may enroll yourself and your spouse when you add a new dependent child.

If you don't enroll new dependents within 31 days, you must wait for the next life event (i.e., marriage, birth, or adoption), change in employment status, or annual enrollment opportunity to obtain coverage for the new dependent.

Losing Other Coverage

If you decline coverage for yourself or your dependents because you or your dependents have other coverage and you or your dependents later lose the other coverage, you and your dependents may qualify for special enrollment in the Plan if your new enrollment form is completed within 31 days of the date coverage is lost.

A loss of other coverage qualifies for special enrollment treatment only if one of the following conditions are met:

- You, as an active employee, and your dependents were covered under another group health care plan or group health insurance policy at the time you were eligible for coverage from your employer;
- You, as an active employee, and your dependents lost the other coverage because you/they exhausted COBRA continuation coverage, were no longer eligible under that plan, or an employer's contributions for coverage under that plan stopped; or
- Your dependent child lost other group health plan coverage for any reason.

When Coverage Ends

You and your dependent's eligibility for Plan benefits terminate:

- When you terminate employment with your employer. (Please see your Benefits Administrator for the exact date your coverage ends.);
- If you fail to pay your share of the premium;
- If your hours drop below the required eligibility threshold;
- If you are no longer in the group of individuals eligible to participate in the Plan;
- If you or your dependents submit false claims;
- If you or your dependents intentionally misrepresent a material fact concerning coverage or benefits;
- If the Plan terminates; or
- If the employer terminates its participation in the Plan.

Coverage for your spouse and children (if covered) ends when your coverage ends, or when their eligibility for coverage ceases for other reasons, such as divorce or when a child no longer qualifies as a dependent under the Plan.

Continuation Coverage

If coverage under the Plan for you, your eligible spouse, or your eligible children ceases because of certain "qualifying events" (for example, termination of employment, reduction in hours, divorce, death, child's ceasing to meet the plan's definition of dependent) specified in a federal law called COBRA, then you, your eligible spouse, or your eligible children may have the right to purchase continuing coverage under the Plan for a limited period of time to the extent that any of the benefits under the Plan constitute "medical care" for purposes of ERISA (see "COBRA" section).

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to the extent that any of the benefits under the Plan constitute "medical care" for purposes of ERISA (see "USERRA" section).

Chapter 3: Wellness Benefits

The Plan serves an important role in keeping you and your family safe, healthy and happy. The Plan's approach to wellness is about more than just physical fitness or losing weight. It's about taking a comprehensive approach toward well-being by incorporating physical, mental, and financial wellness to achieve a long, fulfilled and prosperous life. And it's not just about preventing sickness and disease – it's about having fun, increasing energy, and generating excitement about life.

Keep in mind: Certain benefits in the following sections are considered "medical care" under ERISA and therefore, those benefits are subject to Federal laws such as COBRA, USERRA, FMLA, and HIPAA. These sections are noted for your convenience. For more information on your rights – please see Chapters 4 "Claims and Appeals" and 7 "Federal Laws Impacting this Plan".

Benefits under the Power Wellness Program

Health Screenings and Health Survey

Annual health screenings sponsored by your employer are important to the success of your wellness efforts. Annual health screenings are available for NRECA Medical Plan participants. (Screenings may be available for other employees as well. Please see your Benefits Administrator for more information.) These events provide a great way for you to learn your health. Annual health screenings may help you determine risk of ongoing diseases early, when there is still a chance to treat or prevent them. Health screenings may include:

- Blood pressure
- Blood sugar
- Cholesterol (full lipid panel to include breakdown of LDL and HDL cholesterol)
- Height and weight with body mass index (BMI) measurement

In addition to a health screening, a health survey is a brief, confidential questionnaire that helps people understand their health risks based on their screening results and health habits. The health survey is available for NRECA Medical Plan participants only. (The health survey may be available for other employees as well. Please see your Benefits Administrator for more information.) You will receive a summary report, with information that you can discuss with your doctor – or a health coach – to learn what changes you can make to reduce your health risks.

Your employer will receive a very high-level summary of the potential health risks of your employer's workforce that doesn't include any information specifically about you or any other employee. Your personal health information is kept confidential.

The health screenings benefit is considered "medical care" for purposes of ERISA.

Additional Benefits under the Power Wellness Plan

If checked, your employer may also offer the following benefits under the Plan for participants in the NRECA Medical Plan. (These benefits may be available for other employees. Please see your Benefits Administrator for more information.) If you are unsure if your employer offers a specific benefit or would like further information about a benefit, please see your Benefits Administrator.

○ Diabetes Education and Prevention Program

This program is designed to:

- Help you determine your risk for diabetes through the measurement of your cholesterol, blood pressure, body mass index, and blood sugar levels. This benefit is considered "medical care" for purposes of ERISA.
- Educate you about what diabetes is, what the risk factors are, how it affects the body, how to manage it, and most important, how to prevent it with the assistance if a health professional.
- Support you in your efforts to lower your diabetes risks, including awareness campaigns, incentives, counseling and/or MyHealth Coaches program (for NRECA Medical Plan participants only).
- Evaluation of your success after a period of time by re-measuring your cholesterol, blood pressure, body mass index, and blood sugar levels. This benefit is considered "medical care" for purposes of ERISA.

○ Fitness/Wellness Challenges

This option is designed to energize and engage you to achieve your personal wellness goals within a team setting. Examples include, but are not limited to:

- Walking challenges where you track the number of steps or distance walked
- Challenges for eating right
- Smoking cessation

This benefit is considered "medical care" for purposes of ERISA if your employer covers tobacco cessation support.

○ Heart Health Program

This program is designed to provide you with the following:

- A determination of your risk for heart disease through the measurement of your cholesterol, blood pressure, and hip-to-waist ratio. This benefit is considered "medical care" for purposes of ERISA.
- Education on what heart disease is; what the risk factors are; how to prevent it; and how to live a heart-healthy lifestyle with the assistance of a health professional.
- Support you in your efforts to lower your risk for heart disease, including awareness campaigns, incentives, counseling and/or MyHealth Coaches program (for NRECA Medical Plan participants only).
- Evaluation of your success after a period of time by re-measuring your cholesterol, blood pressure, body mass index, and hip-to-waist ratio. This benefit is considered "medical care" for purposes of ERISA.

○ Medical Self-Care Program

This program is designed to educate and provide resources so you and your family (if eligible for coverage) can take more responsibility for your own health and better understand how to use the health care system responsibly. This includes information from a health professional and support about knowing when to seek medical help and when to treat yourself at home or work using self-care through distribution of self-care handbooks like CPR training material and NRECA's *Wellness and Prevention Monthly* newsletter. If you are an NRECA Medical Plan participant, education is also available about the NRECA Medical Plan's preventive benefits, demonstrations of MyHealth Online and reminders for you about the availability of MyHealth Coaches).

○ Nutrition Education Program

This program provides the following:

- An offer of NRECA's Eat SMART kit for your employer to assist you in designing a nutrition education program with the assistance of a local health professional.
- Information to you about various nutrition topics using the educational resources, awareness materials and activities provided in the Eat SMART kit and/or the use of a health professional to provide nutrition education to educate you about proper nutrition, the benefits of good nutritional habits, how nutrition impacts risk of disease, the importance of portion control and nutrition's role in health.
- Support for you in your efforts to eat healthily, including the use of awareness campaigns, incentives, counseling, and/or MyHealth Coaches program (for NRECA Medical Plan participants only).
- Evaluation of your success after a period of time by conducting brief program surveys.

○ Physical Activity and Fitness Program

This benefit is designed to educate you about the benefits of physical activity and encourage you to exercise by offering the following to participants:

- Access to onsite or local fitness centers, financial assistance for access to an offsite fitness center, and/or financial assistance with home fitness equipment.
- Incentives to encourage you to use an on-site, off-site, or home fitness center.
- Education about the importance of physical activity and how to exercise safely.
- Distribution of information about safe exercise practices.

Please visit with your Benefits Administrator about access to fitness centers or fitness equipment.

○ Rewards for Life Program

This benefit offers an incentive-tracking program where your employer may recognize you and your family for taking a more active role in your health and well-being. This benefit may reward you when you complete specific incentive wellness activities for different activities and programs.

Please see Appendix A to this SPD for more information about your Rewards for Life Program.

○ Weight Management Program

The weight management program is designed to educate people and provide social support around eating healthfully, being physically active and managing weight. The focus is on lifestyle changes instead of simply following a weight loss diet. This benefit is considered "medical care" for purposes of ERISA. The program provides the following:

- An offer and promotion of at least one of the following weight management opportunities year-round:
    - Onsite program where your employer sponsors and subsidizes weight management groups and classes at the worksite.
    - Offsite program where your employer subsidizes participation in an offsite weight management program; or
    - Web-based or home based program where your employer sponsors participation in online, phone-based or mail-based weight management programs.

- Support of your efforts to manage weight, including the use of awareness campaigns, incentives, environmental audits and/or MyHealth Coaches program (for NRECA Medical Plan participants only).

○ Activity Groups

This benefit is designed to engage people in healthful activities and provide you with social support and encouragement. Activity groups may include two of the following:

- Tobacco cessation support
- Group exercise (e.g. aerobics, circuit training, Pilates, yoga)
- Healthful recipe exchange
- Outdoor activity (e.g. biking, inline skating, hiking, running, skating, softball)
- Walking
- Weight-control support

This benefit is considered "medical care" for purposes of ERISA if your employer provides tobacco cessation support and/or weight control support.

○ Awareness Seminars

Awareness seminars provide you with education, including awareness campaigns, on various health topics such as physical health, mental and emotional health, and/or safety.

○ Healthful Environment Choices Program

This program is designed to ensure that your employer's workplace culture supports your efforts to live healthfully. In support of this program, your employer could do the following activities:

- Conduct an annual facility assessment whereby your employer assesses and correct its work facilities for various environmental health factors.
- Coordinate an NRECA Financial Seminar on-site.
- Create health observance bulletin boards.
- Conduct fresh fruit Fridays throughout the year.
- Coordinate a volunteer opportunity.
- Create or maintain a wellness committee of representatives from all major departments, which meets at least 3 times during the calendar year.
- Conduct an annual wellness interest survey.
- Offer healthful food choices at employer functions and in vending machines.
- Seek opportunities to promote environmental awareness and involvement at your employer office by conducting an environmental assessment of cooperative facilities and operations and identifying areas of improvement, as well as implementing policies and programs such as recycling programs, energy-saving initiatives or community clean-ups.

○ Stress Management Program

This benefit is designed to educate you about what stress is, what causes it, how it affects overall health, the signs and symptoms, and some ways to manage stress effectively. It's an important topic, since unmanaged stress can negatively affect people's physical, mental and emotional health. This program will provide you with the following:

- Determination of initial stress levels using a stress profile or assessment.

- Information about stress management, including 3 stress management or coping techniques, with the assistance of a health professional.

Stress assessments are considered “medical care” for purposes of ERISA.

○ Wellness Coordinator Training

This benefit is designed to train employees who are responsible for coordinating their employer’s wellness programs to develop and implement successful wellness programs at their worksites.

Chapter 4: Claims and Appeals

The following is applicable only if the Plan benefit at issue is considered “medical care” for purposes of ERISA, as noted in the benefit descriptions above. If the Plan benefit at issue is not considered “medical care” for purposes of ERISA, then there is no claims and appeals process for that benefit under the Plan.

Certain benefits under the terms of this Plan are deemed “medical care” for purposes of ERISA, and are eligible for the claims and appeals process described in this Chapter. This means that you, or your authorized representative, may file a claim for those benefits and may appeal adverse claim decisions. An authorized representative is a person you authorize in writing to act on your behalf. You also may provide Cooperative Benefit Administrators (CBA) your written authorization to have a doctor or other health provider request appeals of benefit denials on your behalf.

Designating 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

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

Claims and Appeals

There are specific claim and appeal response periods for your claims. There are two different types of claims under the Plan:

- **Pre-Service Claim** – any claim for benefits for which the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining care under the Plan.
- **Post-Service Claim** – any claim for benefits for services or supplies already rendered. The table on the following pages explains the process for filing claims and appeals.

Any adverse benefits determination may be appealed. An adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination may also include a denial relating to a reduction,

termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan or a coverage rescission.

Process for Claims and Appeals of Adverse Benefit Determinations

	PRE-SERVICE CLAIMS	POST-SERVICE CLAIMS
File claim before or after treatment:	Before	After, but not later than **24 months** from the date the service was rendered.
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 **15 days** from the date CBA receives your claim. CBA may require one **15-day extension** if circumstances warrant additional time. CBA will notify you of the extension before the initial 15-day period is up. If CBA needs the 15-day extension because you did not provide all the information needed to process your claim, CBA will tell you what information is missing.	Not later than **30 days** from the date CBA receives your claim. CBA may require one **15-day extension** if circumstances warrant additional time, and will notify you that it needs more time to evaluate your claim. CBA will notify you of the extension before the initial 30-day period is up. If CBA needs the 15-day extension because you did not provide all the information needed to process your claim, CBA will tell you what information is missing.
If your claim is incomplete, the time period 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. The time period for deciding your claim is suspended from the date CBA notifies you that the claim is incomplete until the date you provide the missing information. If you do not send CBA the missing information within this 45-day period, CBA will deny your claim.	
The period of time CBA has to decide your claim once you submit additional requested	15 days	Remainder of time available in initial claim review period.

	PRE-SERVICE CLAIMS	**POST-SERVICE CLAIMS**
information:		
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 your authorized representative, have to request an appeal:	Not later than 180 days from the date you receive the 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. **CBA will provide you, free of charge, a copy of any new or additional evidence considered, relied upon, or generated by the Plan in relation to the claim during the appeals process.**		
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 experts in order to make a decision about your appeal. These experts are different from the ones previously consulted.		
Time Period the Appeals Administrator has to review your appeal and make a decision:	Not later than 30 days from the date the Appeals Administrator receives your appeal.	Not later than 60 days from the date the Appeals Administrator receives your appeal.
If your appeal is denied:	The Appeals Administrator will provide you a notice that contains: • Specific reason(s) for the benefit denial;	

	PRE-SERVICE CLAIMS	POST-SERVICE CLAIMS
	• Reference to specific Plan provisions on which denial is based; • Description of the Plan's external 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 internal appeal process. You may request an External Review, or you may seek legal action under ERISA within 12 months from the date of this appeal.

External Review Process for Adverse Benefit Determinations

You have the right to request an external review of a final claims denial or coverage rescission (adverse benefit determination) within four (4) months of receipt of such notice for claims.

The external review will be conducted by an independent review organization (IRO) with which the Plan has contracted to ensure an independent and unbiased review of your adverse benefit determination – a "fresh look". The IRO's decision to approve a claim is binding on the Plan.

Upon receipt of your request for External Review, the Plan shall conduct a preliminary review within five (5) business days to determine if the adverse benefit determination is eligible for external review. The adverse benefit determination is eligible for external review if:

- you are or were covered under the Plan at the time the claim was incurred;
- the adverse benefit determination involves medical judgment;
- you have exhausted the Plan's internal appeal process; and
- you have provided all the information and forms required to process the external review.

Within 1 business day after completion of the preliminary review, the Plan shall notify you that your request for external review:

- is acceptable in its current form, in which case the request will be referred to the IRO;
- is incomplete, in which case you will have 48 hours (or 4 months from the final notice of adverse benefit determination, if later) to provide additional materials; or
- is complete but not eligible for External Review, in which case the Plan will notify you of the reasons for its ineligibility and provide the contact information for the U.S. Department of Labor's Employee Benefits Security Administration.

If the request is referred to the IRO, such IRO's decision will be provided within 45 days of receipt, and will be binding on the Plan.

In addition to any documents you provide to the IRO, the IRO will consider the following items in reaching its decision:

- Your medical or other records, as applicable;
- Recommendation of the attending health care professional;

- Reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider;
- The governing plan terms in the Plan document;
- Appropriate practice guidelines, which must include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Plan; and
- The opinion of the IRO's clinical reviewer(s).

CBA will provide you, free of charge, a copy of any new or additional evidence considered, relied upon, or generated by the Plan in relation to the claim during the appeals process.

Below is a list of key steps and deadlines:

EXTERNAL REVIEW STEP	DEADLINE
You request an external review with CBA. **Submit your claim to:** **Appeals Committee** **Cooperative Benefit Administrators, Inc.** **External 9222** **P.O. Box 6249** **Lincoln, NE 68506**	Within 4 months following receipt of a final notice of benefits denial or coverage rescission.
Plan's preliminary review determination.	Within 5 business days following receipt of external review request.
Plan's notice to you regarding preliminary review determination.	Within 1 business day after completion of preliminary review.
Your time period for perfecting an incomplete external review request.	Remainder of 4-month filing period, or if later, 48 hours following receipt of notice.
Written notice by IRO to you of acceptance for review and deadline for submissions of additional information.	In a "timely" manner. You will have 10 business days to submit additional information that must be considered by IRO.
Time period for Plan to provide IRO documents and information considered in making benefit determinations.	Within 5 business days of referral to IRO.
IRO forwards to the Plan any additional information submitted by you to IRO.	Within 1 business day of receipt.

EXTERNAL REVIEW STEP	DEADLINE
Notice to you and IRO if Plan reverses its adverse benefit determination	Within 1 business day of decision.
Decision by IRO	Within 45 days of receipt of request for review.

Other resources to help you: For questions about your appeal rights, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Chapter 5: 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: Group health plan to the extent the benefits constitute "medical care" under Sec. 733(a)(2) of ERISA.

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
PO Drawer E

Fairfield, IL 62837

Employer Identification Number: 37-0574965

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. (CBA)
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 6: 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. The one exception to this provision is in the case of a Qualified Medical Child Support Order (QMCSO) that requires you to provide benefits to a child (to the extent the Plan covers dependents and such child is otherwise eligible to be covered under the Plan).

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 Plan Administrator will make corrections that are deemed appropriate. You will be notified if a mistake is found.

Right of Recovery of Overpayment

If it is later determined that the Plan made an overpayment or a payment was made in error to you or on your behalf, the Plan has a right at any time to recover that overpayment from the person to whom or on whose behalf the overpayment or erroneous payment was made. The Plan has the right to recover overpayments as a result of, but not limited to:

- Fraud;
- Any error the Plan makes in processing a claim; or
- Benefits paid after the death of the Employee.

If the overpayment is not refunded to the Plan, the Plan reserves the right to bring a legal action 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.

Changing or Terminating the Plan

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.

Chapter 7: Federal Laws Impacting This Plan

The laws described in this Chapter apply to your Plan benefits only to the extent that such benefits are considered "medical care" for purposes of ERISA.

Statement of ERISA Rights

Your Rights

As a participant 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

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, 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 the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

ERISA also provides that all Plan participants will be entitled to:

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by 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 NRECA, as 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 Plan 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.

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 form 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.

HIPAA

Availability of HIPAA Notice of Privacy Practices

The privacy rules under HIPAA govern how health information about you may be used and disclosed by the Plan, and provide you with certain rights with respect to your health information. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan, and describe the Plan's legal duties and privacy practices relative to such information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact NRECA's Privacy Officer:

Privacy Officer
NRECA
4301 Wilson Boulevard
Arlington, VA 22203-1860
Telephone: (703) 907-6601
Fax: (703) 907-6602

Email: privacyofficer@nreca.coop

The Plan's Notice of Privacy Practices is also available on the NRECA Employee Benefit website at https://benefits.cooperative.com/myaccount in the Document Library>Documents for Employees>Insurance Plans>All Plans.

FMLA

The following is applicable if your Power Wellness Program benefit is considered "medical care" for purposes of ERISA.

The Family and Medical Leave Act (FMLA) requires some employers to maintain group health insurance for up to 12 consecutive weeks of continuous or intermittent unpaid leave each year for specific family and medical reasons. FMLA also contains rules regarding the rights of employees when and if they return from FMLA leave and other issues. Not all employers are covered by FMLA and not all employees of covered employers are eligible for FMLA rights.

Employers subject to FMLA are required to offer up to 26 weeks of FMLA leave to any eligible employee who is the spouse, daughter, son, parent, or next of kin of a member of the Armed Forces, to provide care for the service member with a serious injury or illness incurred while on active duty.

If you and your employer are covered by FMLA and you do not return from work at the end of a FMLA leave, you may be entitled to elect COBRA, even if you withdrew from coverage under this Plan during the leave.

Your Benefits Administrator can provide you with specific information on how FMLA affects you and your benefits.

USERRA (Military Leave of Absence Continuation Coverage)

The following is applicable if your Power Wellness Program benefit is considered "medical care" for purposes of ERISA.

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you go on active duty in the U.S. Armed Forces or the National Guard of a state that is called to federal service, you will have certain employment and employee benefit rights upon completion of duty, provided you were on an authorized military leave of absence.

If your military leave is for 31 days or less, the Plan coverage in effect for you and your dependents will be continued automatically and your employer will pay the same portion of the cost as if you were still working. If your military leave is for a period greater than 31 days, coverage for you and your dependents will be continued under USERRA/COBRA for up to 24 months or until you return from active duty (whichever occurs first), but only if you pay the full cost of the coverage. All other benefits for you and your dependents terminate as of either the last day of active employment or compensated leave, but in no case later than the date of your entry into the armed services.

When you return from military leave, you will be eligible to participate in all applicable benefit programs upon re-employment without having to again fulfill any waiting periods. You must enroll within 31 days of re-employment. See your Benefits Administrator for more information.

COBRA Continuation Coverage

The following is applicable if your Power Wellness Program benefit is considered "medical care" for purposes of ERISA.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), when you experience a qualifying event (described below) that causes you to lose eligibility for medical coverage under the Plan, you may have the option of continuing that coverage at your own expense (known as COBRA coverage). COBRA coverage is also available to your qualified beneficiaries (described below) who lose coverage due to a qualifying event (described below). Please note, however, that COBRA coverage is available only for the type of Plan coverage you had at the time of the qualifying event. Nothing in this SPD – except as expressly stated - is intended to expand your and your dependents' COBRA rights beyond the minimum COBRA requirements.

After a qualifying event occurs and you have provided proper notice to your employer, if required, your employer must offer COBRA coverage to each qualified beneficiary. You, your spouse, and/or your dependent children would be qualified beneficiaries and thus entitled to elect COBRA if you, your spouse, and/or your dependent children lose coverage under the Plan because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail below.)

Qualified Beneficiaries – Qualified Beneficiaries are individuals who are Plan participants on the day before a qualifying event occurs. Generally, this applies to you, your spouse and your dependent children. It also includes a child born to, placed for adoption, or legal guardianship with you during the period of COBRA coverage, and alternate recipients under QMCSOs. Individuals who have terminated coverage under this Plan because they have other coverage are not considered qualified beneficiaries for COBRA. If your Plan covers Domestic Partners, Domestic Partners are eligible for COBRA coverage.

Qualifying Event—A qualifying event is a specific event that causes you or your covered dependents to lose coverage under this Plan.

Qualifying events for the covered employee include:

- Termination (voluntary or involuntary, including retirement) of employment for any reason other than gross misconduct; or
- Reduction in work hours that results in loss of medical coverage.

Qualifying events for your covered spouse include:

- Your divorce;
- The employee's death (see below "Special Rules for Death as the Qualifying Event");
- The employee's reduction in work hours are reduced, resulting in a loss of coverage; or
- The employee's termination of employment for any reason other than gross misconduct.

Qualifying events for your dependent children include:

- The employee-parent's death (see below "Special Rules for Death as the Qualifying Event");
- The employee-parent's reduction in work hours are reduced, resulting in a loss of coverage; or
- The employee-parent's termination of employment for any reason other than gross misconduct; or
- The dependent child ages out of coverage.

Qualifying events for retirees and their dependents also include:

- Your employer files for bankruptcy; or
- Your entitlement to Medicare followed by a loss of coverage (qualifying event for spouse and dependent children only).

Please note the following: Your right to post-retirement benefits is subject to the policies of your employer and can change at any time.

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you elect COBRA coverage for the maximum time available to you.

When your medical coverage or COBRA coverage ends, you will receive a certificate of creditable coverage. (Certification will also be provided for a dependent's loss of coverage once the Plan is aware that the dependent's coverage has ended. Please keep your employer informed if your dependents become ineligible for coverage.)

Procedures for Notifying Your Employer of Qualifying Events

Failure to follow the procedures for notifying your employer, listed in the paragraphs below, will result in the loss of eligibility for COBRA coverage.

Which Qualifying Events Require Employer Notification

You or your spouse must notify your employer of the following qualifying events:

- Your divorce;
- Loss of dependent eligibility for your dependent child;
- Your death;
- Determination by the Social Security Administration ("SSA") that you, your spouse or your dependent child is disabled;
- Determination by the SSA that you, your spouse or your dependent child is no longer disabled; or
- Second qualifying event (that is, a qualifying event that you, your spouse or your dependent child experiences during the 18-month COBRA coverage period that follows an employment-related qualifying event).

Who Must Receive the Notification at your Employer

You must notify the person who is named in the *General Notice of COBRA Continuation Rights* as the Plan Information Contact.

When Your Employer Must be Notified

You or your spouse must provide notice to your employer within 60 days after the date of the qualifying event or the second qualifying event.

In the event of a SSA disability determination and you (your spouse and/or your dependent children) want to elect to extend the initial 18-month continuation period for an additional 11 months, your employer must be notified within 60 days after the later of the SSA disability determination (but before the end of the initial 18-month period) or the date of the qualifying event.

In the event that the SSA has determined that you, your spouse or your dependent child is no longer disabled, your employer must be notified within 30 days after the SSA determination.

How Your Employer Must be Notified

The required information for notification of your employer must be provided on the form and in the format specifically required by your employer for this purpose. This form, required by your employer, will be available at no cost upon request from the Plan Information Contact named in the *General Notice of COBRA Continuation Rights*.

What Information and/or Documentation the Notification Must Include

- Name of the qualified beneficiary(ies)
- Address of the qualified beneficiary(ies)
- Telephone number(s) of the qualified beneficiary(ies)
- Qualifying event
- Date of the qualifying event

Your employer may require additional information or documentation as proof of the qualifying event. Examples of such additional information or documentation include:

- If the qualifying event is divorce, copies of the first and last page of the divorce decree.
- If the qualifying event is loss of dependent eligibility, a statement as to the reason (for example, age limit reached).
- If notifying the employer of a SSA disability determination, a copy of the SSA determination letter.
- If the qualifying event is the death of the employee, a copy of the death certificate.

Your employer reserves the right to request additional information or documentation if the information or documentation you provided is not sufficient for your employer to make its determination.

Who May Provide the Notification

- You as a covered employee may provide notice on behalf of yourself, your spouse and/or your dependent children.
- Your spouse may provide notice on behalf of him/herself and/or your dependent children.
- Your dependent child may provide notice on his/her own behalf.
- Any representative acting on behalf of you, your spouse, and/or your dependent children may provide notice.

Notice provided to your employer by one qualified beneficiary is considered notice on behalf of all related qualified beneficiaries.

How You Will Be Notified by Your Employer If COBRA Coverage Is Available

If COBRA coverage is available as a result of an initial qualifying event, your employer will provide you (your spouse and/or your dependent children) with an election notice and an election form. The election notice contains information regarding COBRA rights to continued coverage. The election form is an administrative form to continue NRECA-sponsored health coverage.

If the COBRA coverage period will be extended due to a second qualifying event (including a SSA disability determination), you will be notified by your employer of the extended coverage period.

If COBRA does not apply, your employer will send you (your spouse and/or your dependent children) a Notice of Unavailability of Coverage, explaining the reasons why COBRA coverage is not available.

Electing COBRA Coverage

Once the benefits administrator receives notice that a qualifying event has occurred, you will receive a notice describing your right to elect COBRA coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and you or your spouse may elect COBRA coverage on behalf of your children.

If you (your spouse and/or your dependent children) wish to continue coverage under this Plan, you (or they) must respond to the notice within 60 days of the date you (or they) receive the notice or the date of the qualifying event, whichever is later. If mailed, your election must be postmarked (or if hand-delivered, your election must be received by your employer) no later than this date. Failure to respond to the notice within this 60-day period will result in the loss of the right to elect to continue medical coverage. If you and/or your eligible dependents reject COBRA continuation coverage before the 60-day due date, you may change your mind as long as you furnish a completed election form before the 60-day due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed election form. Please note that your COBRA coverage will end at a maximum of 18 months or 36 months, whichever is applicable, from the date of the qualifying event, unless coverage ends based on an event listed under the section "When COBRA Coverage Ends" stated below.

You must give this notice to:

Lisa Arview
Wayne-White Counties Electric
PO Drawer E
Fairfield, IL 62837

Length of COBRA Coverage

If you and/or your eligible dependents elect COBRA coverage, the coverage begins on the date of the qualifying event. If you and/or your eligible dependents reject COBRA continuation coverage before the 60-day due date, you may change your mind as long as you furnish a completed election form before the 60-day due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed election form. Please note that your COBRA coverage will end at a maximum of 18 months or 36 months, whichever is applicable, from the date of the qualifying event. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "When COBRA Coverage Ends".

COBRA coverage is temporary. Depending upon the qualifying event, the duration of COBRA coverage is as follows:

- **18-Month COBRA Coverage Period**

  If the qualifying event is your termination of employment (except for gross misconduct) or reduction in hours, you, your spouse and/or your dependent children are entitled to elect COBRA coverage for a maximum period of 18 months after the qualifying event.

- **36-Month COBRA Coverage Period**

  If the qualifying event is divorce, your death (see "Special Rules for Death as a Qualifying Event" below), your entitlement to benefits from Medicare (retirees only) or the loss of dependent eligibility, your spouse and/or your dependent children are entitled to elect COBRA coverage for a maximum period of 36 months after the qualifying event.

  If the qualifying event resulting in a loss of Plan coverage was termination of employment (including retirement), or reduction in work hours, and you become entitled to Medicare benefits less than 18 months before the qualifying event date, COBRA coverage under the Medical Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months (depending on when Medicare entitlement occurs) after the date of Medicare entitlement.

  For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period extension is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

- **Disability Extension to 18-Month COBRA Coverage Period**

  If the qualifying event is your termination of employment (except for gross misconduct) or reduction in hours, and you, your spouse or your dependent child (i) has elected COBRA coverage, (ii) is determined by the Social Security Administration to be disabled and (iii) notifies the benefits administrator in a timely fashion, then you, your spouse and

your dependent children may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA coverage.

- **Second Qualifying Event to 18-Month COBRA Coverage Period**

  If you or your eligible dependents experience another qualifying event during the 18-month COBRA coverage period that would otherwise entitle your spouse and/or dependent children to 36 months of COBRA coverage, the 18-month period will be extended to a maximum of 36 months for your spouse and/or dependent children, if notice of the second qualifying event is properly given to the Plan. The second qualifying event may be your death (see below "Special Rules for Death as a Qualifying Event"), your divorce, or your dependent child's loss of dependent status under the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. To qualify for this extension you, your spouse or your eligible dependents must notify your employer within 60 days of the second qualifying event.

Special Rules for Death as the Qualifying Event

If the qualifying event is your death, the maximum COBRA coverage period for the surviving spouse and dependent children is 36 months. However, for the surviving spouse who has not re-married, coverage may continue beyond the 36-month period until the earlier of the surviving spouse's remarriage or the surviving spouse's death. Coverage for the dependent children may continue beyond the 36-month period until the earlier of the surviving spouse's remarriage or until the date there is a loss of dependent eligibility under the terms of the Plan (see "Coverage for Your Dependents").

Cost of COBRA Coverage

If you elect COBRA coverage under the Plan, you must pay the full cost of that coverage (including both the share you now pay, if any, and the share your employer now pays). You may also be required to pay a 2% administrative fee, for a total of 102% of the cost. If you are disabled, this administrative fee may be higher than the 2% but no more than 50% of the cost of coverage. After you elect COBRA coverage, you will receive a bill for the initial premium. This initial premium must be paid in full within 45 days of the date you elect COBRA coverage. You will receive a bill for subsequent premiums before the first day of each month. Each subsequent premium must be paid in full within 31 days of the first day of each month (for example, the premium for May must be paid in full on or before May 31). Failure to pay the initial or subsequent premiums on time will result in the termination of your COBRA coverage.

When COBRA Coverage Ends

Qualified beneficiaries will lose COBRA coverage if any of the following occurs:

- Any required premiums are not paid in full within the required payment periods. You have 45 days from the date you elect COBRA coverage to pay your initial premium, and 31 days from the first of each month to pay each subsequent premium.
- Your former employer terminates group medical coverage for all employees.
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for preexisting conditions of the qualified beneficiary have been exhausted or satisfied).
- A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA. All other family members that may be qualified beneficiaries remain eligible to participate in COBRA.

- You must notify your employer in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form".
    - You may obtain a copy of this form from your employer at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify your employer of the date of your Medicare entitlement.
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disable qualified beneficiary, will terminate).
    - If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify your employer of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from your employer at no charge.
- A qualified beneficiary reaches the end of the maximum 18-month, 29-month, or 36-month COBRA coverage period (in general), whichever applies.
- COBRA coverage may also be terminated if for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Please remember that in order to protect your family's rights, you should keep the Benefits Administrator informed of any changes in the addresses of your family members. You should also keep for your records copies of any notices you send to the Benefits Administrator.

If you have questions concerning your Plan or your COBRA coverage rights, please contact:

Lisa Arview
Wayne-White Counties Electric Cooperative
PO Drawer E
Fairfield, IL 62837

Chapter 8: Appendix A – Rewards for Life Program

The Rewards for Life Program provides you the opportunity to earn points by participating in various Plan activities. The information below describes how the Rewards for Life Program works, including points assigned to each activity and any monetary rewards that me by earned.

Confirmation

Confirm the information you provide is truthful and accurate. **1 point**
Earn this by visiting the Rewards for Life homepage and checking the box under "Actions."

Health Screening

Attend your employer's health screening as directed by your Benefits Administrator. **10 points**

MyHealth Survey

Access MyHealth Survey under Get Started on the left side of the home page. You can update MyHealth Survey as often as needed; however you will only receive points one time for successfully meeting activity requirements. Earn points by:

- **Completing MyHealth Survey** **10 points**

- **Having Prevention Exams** **5 points for each exam**
  - Qualifying prevention exams, such as a physical or dental exam, must be earned in the past year.
- **Reporting healthy biometric data** **5 points for each biometric target**
  - Qualifying biometric levels, such as blood pressure and cholesterol, must be in range in order to receive points.
- **Reporting body mass index (BMI) less than 30** **10 points**
  - BMI is automatically calculated based on your reported height and weight.

Smoking Cessation

Access the Smoking Cessation Lifestyle Improvement Program through the top navigation bar under Healthy Living>Lifestyle Programs>Smoking Cessation and click "Enroll in Full Program." Earn points by:

- **Completing Smoking Cessation Lifestyle Improvement Program** **20 points**
  - Earn 1 point per phase and then 10 bonus points for completing all 10 phases.
- **Use Smoking Cessation Planner** **10 points**
  - Earn a maximum of 1 point per week. You must use the planner for 10 weeks total, either consecutively or within the program year.

MyHealth Assistant

Access MyHealth Assistant through the top navigation bar under Healthy Living>Improve Your Health>MyHealth Assistant. Earn points by:

- **Setting weight loss goal** **5 points**
- **Setting exercise goal** **5 points**

Health Management Centers

Access the Health Management Centers through the top navigation bar under Health Information>Health Management Centers. Earn points by:

- **Visiting the Weight Management Center** **1 point**
- **Visiting the Nutrition Management Center** **1 point**
- **Taking the Stress Assessment** **5 points**
  - The Stress Assessment is available through the Stress Management Center under tools.

Health Trackers

Access the Health Trackers through the top navigation bar Health Record>Health Trackers. Use the trackers for as long as you'd like, however you will only receive points for up to 20 weeks of activity. Earn points by:

- **Using Exercise Tracker** **60 points**
  - *Earn up to 3 points per week for a maximum of 60 points throughout the program year.*
- **Using Weight Tracker** **20 points**
  - *Earn up to 1 point per week for a maximum of 20 weeks, either consecutively or within the program year.*
- **Use Diet Tracker** **20 points**

- *Earn up to 1 point per week for a maximum of 20 weeks, either consecutively or within the program year.*

- **Use Stress Tracker 20 points**
    - *Earn up to 1 point per week for a maximum of 20 weeks, either consecutively or within the program year.*

Participate in Employer Sponsored Activities

Ask your Benefits Administrator if your employer offers this rewards category. If so, your tracker will be updated.

Monetary Rewards

Cash Rewards will be given for employees and their spouses who record exercise miles accumulating at least 25 miles.

Questions

If you have specific questions about Rewards for Life and how you can earn points, read the FAQs on the Rewards for Life homepage or talk with your Benefits Administrator.