BASIN ELECTRIC POWER COOPERATIVE HEALTH AND WELFARE PLAN

(PN 580)

SUMMARY PLAN DESCRIPTION

(Including COBRA Initial Notice)

Effective Date
January 1, 2025

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SUMMARY PLAN DESCRIPTION

THIS SUMMARY PLAN DESCRIPTION is effective for all purposes as of January 1, 2025.

ARTICLE I. INTRODUCTION

1.1. Purpose of Plan. The purpose of this Plan is to provide Participants and Beneficiaries with benefits related to the Plans listed in Exhibit A.

1.2. Purpose of This Document. This document, including Exhibits A, B, and C constitutes the Summary Plan Description (SPD) required to be distributed to all Participants in the Plan under Title I of ERISA. This SPD covers different groups of employees and different types of coverage. You will receive only those exhibits which relate to your group and your coverage. This SPD is a summary and thus cannot contain all the details of the Plan Document. Accordingly, if there is any conflict or inconsistency between this SPD and the Plan Document, the provisions of the Plan Document will govern.

ARTICLE II. DEFINITIONS

2.1. "Applicable Insurance Contract" means the Insurance Contract(s) under which a Participant is enrolled and receiving Benefits thereunder, as identified and set forth in Exhibit A.

2.2. "Beneficiary" means a person designated by a Participant pursuant to the terms of this Plan who is or may become entitled to a Benefit under the Plan.

2.3. "Benefits" mean the services provided or amounts paid to or on behalf of Participants and Beneficiaries under the Plan as benefits related to the Applicable Insurance Contracts listed in Exhibit A.

2.4. "COBRA" or "COBRA continuation coverage" means the right to continuation coverage, under a group health plan, created by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations promulgated thereunder.

2.5. "COBRA Administrator" means:

WEX, Inc.
4321 20th Avenue S.
Fargo, ND 58103
866-451-3399

2.6. "Code" means the Internal Revenue Code of 1986, as amended.

2.7. "Dependent" means a dependent as defined in the Applicable Insurance Contract.

2.8. "Employee" means any person providing services to any Employer as a common law employee. "Employee" does not include any individual, regardless of whether such individual is later determined by a court or any governmental agency to be, or to have been, a common law employee of an Employer: (1) who performs services for an Employer pursuant to a leasing or similar agreement between an Employer and a third-party; (2) who performs services for an Employer and is working in a classification described by the Employer as independent contractor; or (3) who performs services for an Employer pursuant to a contract or agreement which provides that the individual is an independent contractor or consultant.

2.9. "Employer" means Basin Electric Power Cooperative and any subsidiary.

2.10. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.11. "Insurance Contract" means the contract(s) between the Employer and any Insurer, service provider, or third-party administrator ("TPA"), the insurance policy, or any Self-insured Plan, under which Benefits for this Plan are provided.

2.12. "Insurer" means any Insurance Company, service provider, or TPA with which the Employer has contracted, as identified in Exhibit A, to provide Benefits under this Plan.

2.13. "Participant" means an Employee or Retired Employee who is eligible to be and becomes a Participant in accordance with Section 3.1 and Exhibit A.

2.14. "Plan" means the Basin Electric Power Cooperative Health and Welfare Plan established by Basin Electric Power Cooperative in the form of the Plan document and any Insurance Contract(s) which are attached to this document as Exhibits and which are herein incorporated by reference.

2.15. "Plan Administrator" means the Employer, Basin Electric Power Cooperative, unless the Employer designates another person to hold the position of Plan Administrator. The Plan Administrator shall have responsibility for the administration of the Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret the Plan, and decide all questions concerning the Plan and its administration. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. In addition to other duties, the Plan Administrator shall have full responsibility for compliance with the reporting and disclosure rules under the Code and ERISA.

2.16. "Plan Year" means the fiscal year of the Plan, a twelve (12) consecutive month period ending every December 31.

2.17. "Qualified Medical Child Support Order" or "QMCSO" means an order which creates or recognizes the existence of a child's right to medical Benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court that is deciding the child support issues in a divorce or other family law action. A QMCSO must clearly specify:

a. the name and last known mailing address of an eligible Employee and the name and last known mailing address of each child covered by the order;
b. a reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined;
c. the period to which the order applies; and
d. each plan to which such order applies.

A QMCSO cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

2.18. "Retired Employee" or "Retiree" means any person formerly employed by an Employer as an Employee and who satisfies the definition of a retiree under the Applicable Insurance Contract.

2.19. "Self-insured Plan" means any arrangement under which Benefits for the Plan are funded other than by contract(s) between the Employer and any Insurer, HMO, service provider, or TPA. An arrangement in which the Employer and a TPA have entered into a service agreement under which the TPA will provide administrative services only to a plan shall be considered a Self-

insured Plan.

2.20. "Spouse" means a spouse as defined in the Applicable Insurance Contract.

2.21. "Summary Plan Description" means this document and its attached exhibits.

2.22. Construction. As used in this Plan, the masculine gender includes the feminine, and the singular may include the plural, unless the context clearly indicates to the contrary.

ARTICLE III. PARTICIPATION

3.1. Eligibility for Participation. An Employee or Retired Employee is eligible to become a Participant under the terms and conditions as described in the Applicable Insurance Contract described in Exhibit A. Other individuals, such as Dependents, may be eligible to participate in and receive benefits under one or more of the component benefit programs due to their relationship to an Employee or Retired Employee under such terms and conditions as described in the Applicable Insurance Contract described in Exhibit A.

3.2. Eligibility Effective Date. An Employee or Retired Employee is eligible to participate in the Plan, after meeting the eligibility requirements in section 3.1, at the time specified in the Applicable Insurance Contracts described in Exhibit A. Cessation and Reinstatement of Participation. Coverage under this Plan for any Employee, Dependent (including a Spouse), or Retired Employee will terminate in accordance with the terms described in the Applicable Insurance Contracts described in Exhibit A, or if the requirements do not appear in those Insurance Contracts, then participation in the Plan shall terminate when the individual no longer satisfies the eligibility criteria under the Plan. When a Participant's participation in the Plan terminates, Benefits

under the Plan for the Participant and all Beneficiaries covered through the Participant will cease. Participation in the Plan may thereafter be renewed upon satisfaction of the requirements described in Section 3.1.

ARTICLE IV. BENEFITS

4.1. Benefits. The Benefits under this Plan shall be provided as described in this document and Exhibit A. If you have misplaced your copy of those Exhibits, you can contact the Plan Administrator to have it replaced.

4.2. Limitations, Exclusions and Restrictions on Benefits. Exhibit A contains specific provisions as to limitations, exclusions, and restrictions on Benefits. Please refer to Exhibit A when checking to see if a particular condition is covered by the Plan.

ARTICLE V. ADMINISTRATION OF PLAN

5.1. Funding. The Benefits under this Plan shall be funded as set forth in Exhibit A. The cost of the Benefits shall be shared by the Employer and Participants in such amounts as the Employer in its absolute discretion shall determine from time to time.

5.2. Limitation of Rights. Nothing herein will be construed to require the Employer, Plan Administrator, or an Insurer to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer or Insurer from which any payment under the Plan may be made. The applicable breakdown and allocation of all premiums, costs, and other expenses shall be established by the Employer. The Employer reserves the right to modify the cost sharing of contributions as appropriate with respect to claims not yet incurred, based on the costs experienced by the Plan. Nothing in this Plan shall give any Employee any right to continued employment.

5.3. Anti-Assignment. No Benefits under this Plan may be subject to anticipation, garnishment, attachment, execution or levy of any kind, or be liable for any Participant's or Beneficiary's debts or obligations.

5.4. Powers of the Plan Administrator. The Plan Administrator shall have full power to administer the Plan, in accordance with its terms, for the exclusive benefit of Plan Participants and their Beneficiaries. For this purpose, the Plan Administrator's powers include, but are not limited to, the following:

a. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims and appeals procedures that may be required by applicable law;

b. To interpret the Plan (any such interpretation, made in good faith, shall be final and conclusive on all persons claiming Benefits under the Plan) and to resolve and clarify any inconsistencies, ambiguities, and omissions in the

Plan document and other related documents, subject to the Claims and Appeals Procedures set forth in Exhibit B;

c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan (any such decision, made in good faith, shall be final and conclusive on all persons claiming Benefits under the Plan) subject to the Claims and Appeals Procedures set forth in Exhibit B;
d. To prescribe forms and procedures to be followed by Participants in making elections under the Plan and filing claims and appeals under the Plan;
e. To approve reimbursement requests and to authorize the payment of Benefits;
f. To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan;
g. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation or designation shall be in writing;
h. To prepare and distribute information explaining the Plan to Participants;
i. To furnish the Employer and Participant such annual reports with respect to the administration of the Plan as are reasonable and appropriate;
j. To make or cause to be made such reports as may be required by the federal government on an annual basis;
k. To modify, alter or amend the Plan; and
l. To take any further actions which may be required to properly administer the Plan in accordance with its terms and with the requirements of the Code, ERISA and the Insurance Contracts.

The Plan Administrator (including, for purposes of this Section, its delegate) has the exclusive right, power, and authority, in its sole and absolute discretion, to carry out its power and responsibilities. The decisions of the Plan Administrator on any disputes arising under the Plan, including (but not limited to) questions of construction, interpretation, and administration shall be final, conclusive, and binding on all persons having an interest in or under the Plan. Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

5.5. Equitable Doctrines Inapplicable. The Plan expressly disavows and repudiates all equitable doctrines including, but not limited to, the make whole doctrine (which would prevent the Plan from receiving a recovery unless a Participant, Dependent, or Beneficiary has been "made

whole" with regard to illness or injury that is the responsibility of a third party), and the common fund doctrine (which would require the Plan to pay a portion of the attorneys' fees and costs expended in obtaining a recovery). Equitable doctrines have no application to this Plan, since the Plan's refund rights apply to the first dollars payable by a third party.

5.6. Right to Reimbursement, Subrogation and Benefit Offset. The Plan maintains the equitable right to reimbursement from any third-party settlement, judgment, award, overpayment, or otherwise for any amount paid on behalf of a Participant, Dependent, or Beneficiary, whether those funds were paid to a Participant, Spouse, Dependent, Beneficiary, or any agent or representative of the foregoing parties. The Plan may recover the foregoing amounts from the Participant, Spouse, Dependent, Beneficiary or any estate, agent or representative of the foregoing parties regardless of whether such funds have been commingled with other assets and regardless of whether the amounts recovered from any third party are specifically identified as a reimbursement of medical expenses. By accepting Benefits related to an injury, illness, or other loss caused or potentially caused by a third party, the Participant grants the Plan subrogation rights, authorizing the Plan to be substituted in place of any Participant, Spouse, Dependent, or Beneficiary with respect to that individual's lawful claim, demand, or right of action against a third party who may have wrongfully caused the individual's injury, illness, or other loss that resulted in a payment of Benefits by the Plan. The Participant further agrees to promptly notify the Plan when a potential claim against a third party exists, and to avoid any action or inaction that might prejudice the Plan's ability to recover the Benefits paid. The Plan reserves the right to offset unpaid reimbursements against future Benefits and use any other method to collect unpaid reimbursements, as may be required or permitted in the sole discretion of the Plan Administrator or the applicable Insurer. Additional rights to reimbursement, subrogation, and benefit offset, if any, will be described in the Applicable Insurance Contract.

5.7. Participant's Responsibilities. Each Participant shall be responsible for providing the Plan Administrator and, if required by an Insurer, the Insurer with his or her current address and, if required, with the address of any individual covered through the Participant. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first-class United States mail. The Insurers, the Employer, and the Plan Administrator shall have no obligation or duty to locate a Participant.

5.8. Right to Information and Fraudulent Claim. Any person claiming Benefits under the Plan shall furnish the Plan Administrator or, if applicable, the Insurer with such information and documentation as may be necessary to verify eligibility for or entitlement to Benefits under the Plan. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the Insurer, if applicable, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the Insurer may refuse to honor any claim for Benefits under the Plan for the Beneficiary related to the person submitting falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of Benefits.

5.9. Examination of Records. The Plan Administrator will make available to each Participant such records as pertain to the Participant for examination at reasonable times during normal business hours.

5.10. Claims for Benefits. Claims for Benefits must be submitted to the applicable Insurer or third-party administrator under an Applicable Insurance Contract. Such claims shall be processed and, if denied, adjudicated in accordance with the provisions of the Applicable Insurance Contract and Section 503 of ERISA and the U.S. Department of Labor regulations thereunder.

ARTICLE VI. AMENDMENT AND TERMINATION

6.1. Amendment. This Plan may be amended at any time and from time to time by a written instrument approved by the Employer and executed by a duly authorized officer of the Employer provided such amendment applies only to claims not yet incurred and is communicated to those Participants participating in this Plan.

6.2. Duration and Employer's Right to Discontinue Plan and Contributions. This Plan is established with the intention of being maintained for an indefinite period of time. Nevertheless, the Employer expressly reserves the right to discontinue or terminate the Plan with respect to claims not yet incurred and make no further contributions. No Employee, Retired Employee, Dependent, Spouse or Beneficiary shall have or attain any vested right, contractual or otherwise, to any further contributions to the Plan by the Employer after the Employer has discontinued or terminated the Plan.

ARTICLE VII. ERISA INFORMATION

7.1. Plan Name. The name of the Plan is Basin Electric Power Cooperative Health and Welfare Plan.

7.2. Principal Employer Information. The name and address of the Principal Employer are:

Basin Electric Power Cooperative
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

7.3. Employer Identification Number (EIN). The Principal Employer's identification number is 45-0277395.

7.4. Plan Number (PN). The Plan Number assigned by the Principal Employer is 580.

7.5. Type of Plan. The Plan is an umbrella plan, also known as a wraparound plan, which provides Benefits related to the Plans listed in Exhibit A.

7.6. Type of Administration. The administration of the Plan is performed by the service providers and insurers listed on Exhibit A.

7.7. Plan Administrator Information. The name, business address, and business phone number of the Plan Administrator are as follows:

Basin Electric Power Cooperative
Attn: Human Resources Department
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

7.8. Agent for Service of Legal Process. The name and address of the Plan's agent for service of legal process is the General Counsel, Basin Electric Power Cooperative, 1717 East Interstate Avenue, Bismarck, ND 58503. Service of legal process may also be made upon the Plan Administrator.

7.9. Trustee. The Plan does not use a trust and therefore does not have any trustees.

7.10. Collective Bargaining Agreement ("CBA"). The Plan is not maintained pursuant to a CBA.

7.11. Eligibility for Participation and Benefits. The Plan's requirements for participation and Benefits are set forth in Section 3.1 and in Exhibit A.

7.12. Summary of Benefits. The Benefits provided under this Plan are summarized in Exhibit A. To the extent that any Plan benefit includes access to a provider network, the providers in the network will be listed on a separate document, which will be provided to you automatically and free of charge. The provider network is described generally in Exhibit A.

7.13. Qualified Medical Child Support Orders ("QMCSOs"). The procedures governing QMCSOs are set forth in Section 7.27.

7.14. Loss of Eligibility and Benefits. The circumstances which could result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery of benefits, are set forth in Section 3.1, Section 5.6, Section 5.8, and in Exhibit A.

7.15. COBRA. Some of the Benefits offered by the Plan are subject to the laws concerning continuation coverage. A notice explaining your continuation coverage rights is set forth in Section 7.26.

7.16. Plan Funding. The Benefits offered by the Plan are funded by contributions from Participants and the Employer, in such proportions and amounts as the Employer may determine, in its sole discretion.

7.17. Exclusive Benefit and Legal Enforceability. This Plan is maintained for the exclusive benefit of Employees. The Employer intends that the terms of this Plan, including those relating to coverage and Benefits are legally enforceable.

7.18. Funding Medium. The following funding medium is used for the accumulation of assets under the Plan: Employer and Participant contributions. The Employer has absolute discretion to determine and to change contribution amounts.

7.19. Health and Welfare Insurance Issuer/Administrator. Exhibit A identifies the health and welfare insurance issuers and administrators that are responsible, in whole or in part, for financing or administering any of the benefits available under the Plan.

7.20. Plan Year. The plan year is the twelve (12) consecutive month period ending every December 31.

7.21. Claims and Appeals Procedures. The claims and appeals procedures under this Plan are set forth in the Applicable Insurance Contracts in Exhibit A, but in the event that the Applicable Contracts do not include claims and appeals procedures, or in the event that the claims and appeals procedures set forth in those Applicable Insurance Contracts do not comply with ERISA § 503 and the Department of Labor regulations thereunder, the Claims and Appeals Procedures set forth in Exhibit B shall be followed.

7.22. Further Information. An Employee or Retired Employee may obtain further information about the Plan by contacting the Plan Administrator.

7.23. Inspection of Plan. Upon request and reasonable notice, the Plan Administrator will allow any Participant or Beneficiary to examine, without charge, at the Plan Administrator's office,

a copy of the Plan document and all related documents incorporated therein by reference.

7.24. Copy of Plan. Upon reasonable notice and written request, a copy of this Plan and all related documents incorporated therein by reference may be obtained from the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

7.25. Statement of ERISA Rights.

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

Receive Information About Your Plan and Benefits

You have the right to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, 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 written 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), if any, and an updated Summary Plan Description. The Plan 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 Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents (including your Spouse) may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Neither your group health plan nor any other plan may restrict your entry into the plan based on a preexisting condition or exclude a preexisting condition from coverage under the Plan.

Prudent Action 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 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, 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.

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 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 a Federal court. In such a 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 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 and Appeals procedures available to you under the Plan (see section 7.21) you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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.

Your right to maintain a court action is subject, to the fullest extent permitted under applicable law, to the Plan's requirement that administrative procedures be completed first. This is

called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude you from bringing an action in court.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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.

7.26. Continuation of Group Health Coverage Under COBRA.

Introduction

You are receiving this notice because you are covered under the Basin Electric Power Cooperative Health and Welfare Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan Benefits offered under the Plan (i.e., medical, dental and health FSA components) and not to any other benefits offered under the Plan or by the Employer.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. This notice is intended to inform Participants and Beneficiaries under the Plan, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA. It does not fully describe all continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact the COBRA Administrator. It is intended that no greater rights be provided than those required by law.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when the coverage

would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below in the section titled "Who Is Entitled to Elect COBRA?" After a qualifying event occurs and any required notice of that event is properly provided to the COBRA Administrator or its designee, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse, and your Dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost 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 in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Initially, the coverage will be the same as the Plan coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a qualifying event. Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active Employees to change their coverage options or to add or eliminate coverage for Dependents at open enrollment. In addition, special enrollment rights under HIPAA will apply to those who have elected COBRA.

COBRA Coverage Under the Health FSA Component

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered Employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year.

Health FSA COBRA coverage lasts only until the end of the Plan Year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use it or lose it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, as extended by any grace period available under the Health FSA, and COBRA coverage will terminate at the end thereof.

All qualified beneficiaries are covered together under the Health FSA unless otherwise elected. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the COBRA Administrator for more information.

No Health FSA open enrollment. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

If you are an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

a. Your hours of employment are reduced; or
b. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

a. Your spouse dies;
b. Your spouse's hours of employment are reduced;
c. Your spouse's employment ends for any reason other than his or her gross misconduct;
d. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
e. You become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the Dependent child of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

a. Your parent-Employee dies;
b. Your parent-Employee's hours of employment are reduced;
c. Your parent-Employee's employment ends for any reason other than his or her gross misconduct;
d. Your parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
e. Your parents become divorced or legally separated; or
f. You stop being eligible for coverage under the Plan as a "Dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Basin Electric Power Cooperative, and that bankruptcy results in the loss of coverage of any Retired Employee covered

under the Plan, the Retired Employee is a qualified beneficiary with respect to the bankruptcy. The Retired Employee's Spouse, surviving Spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Electing COBRA After Leave Under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an Employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the COBRA Administrator for more information about these special rules.

Special Second Election Period for Certain Eligible Employees Who Did Not Elect COBRA

Certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an Employee or former Employee and you qualify for TAA or ATAA, CONTACT THE COBRA ADMINISTRATOR PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD. Contact the COBRA Administrator for more information about the special second election period.

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the COBRA Administrator of any of these qualifying events.

You Must Notify the COBRA Administrator of Certain Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), a COBRA election will be available to you only if you notify the COBRA Administrator in writing within 60 days after the later of: (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice you must follow the notice procedures specified in the section below titled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the COBRA Administrator during the 60-day notice period, YOU AND ALL QUALIFIED DEPENDENTS WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator. An election notice will be provided to

qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the COBRA Administrator.

If mailed, your election must be postmarked no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Each qualified beneficiary will have an independent right to elect COBRA. However, covered Employees may elect COBRA on behalf of their Spouses, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA coverage, there may be other options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, or another group health plan. Some of these options may cost less than COBRA coverage.

Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Through the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions that lower your out-of-pocket costs for deductibles, co-insurance, and co-payments. You have a 60-day special enrollment period following the time you lose your job-based coverage in which to enroll in the Marketplace. After 60 days, your special enrollment period will end, and you may not be able to enroll until the Marketplace's next annual open enrollment period. To find out more about enrolling in the Marketplace, visit www.HealthCare.gov.

Medicare

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the of the COBRA election, COBRA coverage may not be discontinued on account of

Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Enrolling in Another Group Health Plan. You may be eligible to enroll in coverage under another group health plan (such as your Spouse's Plan) if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA coverage instead of enrolling in another group health plan for which you are eligible, you may have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA coverage.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below titled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Termination of employment or reduction of hours

When Plan coverage is lost due to the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

Death, Divorce, Legal Separation, the Covered Employee Becoming Entitled to Medicare or Child's Loss of Dependent Status

When Plan coverage is lost due to the death of the Employee, the covered Employee's divorce or legal separation, the covered Employee becoming entitled to Medicare benefits or a Dependent child's losing eligibility as a Dependent child, COBRA coverage can last for up to a total of 36 months.

If the Covered Employee Becomes Entitled to Medicare within 18 Months Before His or Her Termination of Employment or Reduction of Hours

When Plan coverage is lost due to the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last up to 36 months 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 Dependent 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 is available only

if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered Employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. The extension opportunities do not apply to a period of COBRA coverage resulting from a covered Employee's death, divorce, or legal separation or a Dependent child's loss of eligibility.

Disability Extension of COBRA Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the COBRA Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

(1) the date of the Social Security Administration's disability determination;
(2) the date of the covered Employee's termination of employment or reduction of hours; or
(3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice you must follow the notice procedures specified in the section below titled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the COBRA Administrator during the 60-day notice period and within 18 months after the covered Employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second Qualifying Event Extension of COBRA Coverage

An extension of coverage will be available to Spouses and Dependent children who are

receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Employee, divorce or legal separation from the covered Employee, a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan, or the Employee or former Employee becoming entitled to Medicare benefits (under Part A, Part B, or both). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice you must follow the notice procedures specified in the section below titled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

(1) any required premium is not paid in full on time;
(2) a qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
(3) a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
(4) the Employer ceases to provide any group health plan for its Employees; or
(5) 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 disabled qualified beneficiary, will terminate).

For more information about the disability extension period, see the section above titled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Beneficiary not receiving COBRA coverage (such as fraud).

<u>You Must Notify the COBRA Administrator if a Qualified Beneficiary Becomes Entitled to Medicare or Obtains Other Group Health Plan Coverage</u>

You must notify the COBRA Administrator in writing within 31 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 follow the notice procedures specified below in the section titled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify the COBRA Administrator of the date of your Medicare entitlement at the address shown in the section below titled "Notice Procedures."

<u>You Must Notify the COBRA Administrator if a Qualified Beneficiary Ceases to be</u>

Disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination. You must follow the notice procedures specified below in the section titled "Notice Procedures."

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Plan (including both Employer and Employee contributions) for coverage of a similarly situated Plan Participant or Beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How Premium Payments Must Be Made

Your first payment and all monthly payments (or such intervals specified by the Plan) for COBRA coverage must be paid to the COBRA Administrator in the manner specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When Premium Payments are Considered to Be Made

Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

First Payment for COBRA Coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked.) See the section above titled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The COBRA Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for COBRA coverage–it is your responsibility to pay your COBRA premiums on time).

Grace Periods for Monthly COBRA Premium Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month if payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption with the Covered Employee During a Period of COBRA Coverage

A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs

A child of the covered Employee who is receiving Benefits under the Plan pursuant to a

Qualified Medical Child Support Order ("QMCSO") received by the Plan Administrator during the covered Employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

Notice Procedures

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

How, When, and Where to Send Notices

Any notice that you provide must be in writing. Oral and electronic notice (including notice by telephone, email, or fax) is not acceptable. You must mail your notice to the address below:

WEX, Inc.
4321 20th Avenue S.
Fargo, ND 58103
866-451-3399

Your notice must be postmarked no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above titled "You must notify the COBRA Administrator of certain qualifying events by this deadline," "You must notify the COBRA Administrator of a qualified beneficiary's disability by this deadline," and "You must notify the COBRA Administrator of a second qualifying event by this deadline.")

Information Required for All Notices

Any notice you provide must include:

(1) the name of the Plan;
(2) the name and address of the Employee who is (or was) covered under the Plan;
(3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event;
(4) the qualifying event and the date it happened; and
(5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the COBRA Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the COBRA Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include:

(1) the name and address of the disabled qualified beneficiary;
(2) the date that the qualified beneficiary became disabled;
(3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
(4) the date that the Social Security Administration made its determination;
(5) a copy of the Social Security Administration's determination; and
(6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include:

(1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
(2) the second qualifying event and the date that it happened; and
(3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices

The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by

any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

If You Have Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the Plan Administrator or COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website.) For more information about the Marketplace, visit https://www.healthcare.gov/.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

Plan Contact Information

Questions concerning your COBRA continuation rights should be directed to the Plan Administrator or COBRA Administrator.

The COBRA Administrator can be contacted at:

WEX, Inc.
4321 20th Avenue S.
Fargo, ND 58103
866-451-3399

The Plan Administrator can be contacted at:

Basin Electric Power Cooperative
Attn: Human Resources Department
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

Continuation Coverage During Family and Medical Leave Act (FMLA) Leave

Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law, including the following:

(1) during an FMLA leave of absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage that would have been provided if the

covered Employee had not taken the FMLA leave (including any Employee contribution requirement); and

(2) if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon the Employee's return to work at the conclusion of the FMLA leave, but only for the person(s) who had coverage under the Plan when the FMLA leave began.

It is the intention of the Employer to provide FMLA benefits only to the extent required by applicable law and not to confer greater rights than those required by law on any Covered Person.

7.27. Procedures for Qualified Medical Child Support Order ("QMCSO").

a. Copies of each medical child support order ("Order") relating to the Plan should be forwarded immediately to the Plan Administrator along with any associated correspondence relative to the Order.

The Plan Administrator's contact information is:

Basin Electric Power Cooperative
Attn: Human Resources Department
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

b. Upon receipt of an Order, the Plan Administrator shall:

(i) Determine the employment status of the alternate recipient's employee-parent in order to determine which group health plan benefit programs are available to such alternate recipient.

(ii) Cause a written acknowledgment of receipt of the Order and a copy of these QMCSO procedures to be sent to each alternate recipient identified in the Order and to each alternate recipient's attorney or to a person designated by the alternate recipient to receive such information), if the names and addresses of such person are available.

(iii) Cause a copy of the Order to be sent to the Employee-parent of the alternate recipient, together with a notice that (i) the Plan Administrator is required by law to determine if the Order satisfied the requirements for a QMCSO as set forth in ERISA § 609, (ii) if the Order is found to be a QMCSO under the law, the Plan will be obliged to honor it, and (iii) the Employee-parent or his attorney should furnish, within ten days, any comments they may have. A copy of these procedures should be included with the correspondence.

c. The Plan Administrator shall review the Order for consistency with the terms of the Plan and applicable law and shall advise the Plan Administrator whether he/she believes it is a QMCSO.

d. Counsel or the Plan Administrator shall notify the Employee-parent and each alternate recipient (or his/her designated representative), in writing, of

the determination as to the qualification of the Order.

e. If the Order is qualified, the Plan Administrator shall distribute the necessary enrollment forms, sample claim forms, and a copy of the group health plan's Summary Plan Description to each alternate recipient under the Order (or his/her designated representative).

f. Upon receipt of the completed enrollment forms, the Plan Administrator shall instruct the Insurer to enroll each alternate recipient by adding their names to the group health plan eligibility roster in accordance with the selected health benefit plan options, with such coverage to become effective immediately on the effective date of the receipt of the completed enrollment forms for the medical plan, and the first day of the month coincident with or next following the receipt of such completed enrollment forms by the Plan Administrator for the dental and vision plans, without regard to the Plan's standard open enrollment season. Upon receipt of the completed enrollment forms, the Plan Administrator shall also distribute group health plan Identification Cards to each alternate recipient under the Order (or to his/her custodial parent).

g. If the Order is qualified, and the Plan Administrator does not receive completed enrollment forms from the alternate recipient, or his/her custodial parent or legal guardian within thirty-one (31) days after the date that such Order was approved as a QMCSO, the Plan Administrator shall automatically enroll the alternate recipient under the benefit plan options designated under the Order. If the Order is qualified but does not set forth the specific benefit options under which the alternate recipient is to be covered, then the Plan Administrator shall automatically enroll the alternate recipient as a "Dependent" of the Employee-parent under the same benefit plan options as the Employee-parent, with such coverage to become effective on the first day of the month following the date that the Plan Administrator initiates the necessary steps to enroll the alternate recipient on an automatic basis. Further, the alternate recipient shall not be entitled to enroll in a separate plan of coverage until the Plan's next standard open enrollment period.

h. In the event the Order requires the Plan to enroll an Employee-parent and/or the alternate recipients in the "default" health benefit plan, then the "default" health plan shall be the plan with the lowest premium for the applicable group. In addition, in the event the employee-parent or the alternate recipient fails to comply with any enrollment procedures while a qualified

Order is in place, and the employee-parent is not enrolled in any health benefit plan option, then the employee-parent or the alternate recipient shall be enrolled in the plan with the lowest premium for the applicable group, to be effective pursuant to the terms of the Order.

i. Effective with the alternate recipient's benefit commencement date, the Plan Administrator shall take the necessary steps to deduct all applicable premiums from the employee-parent's payroll check, either on a pretax or post-tax basis, as applicable.

j. Any health claims submitted to the Insurer for expenses incurred prior to the alternate recipient's effective date of coverage pursuant to the terms of an Order that has been qualified as a QMCSO shall not be considered as eligible expenses under the Plan and no reimbursements shall be made for such expenses under the Plan.

k. Any payment for benefits made by the Insurer pursuant to a medical child support order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

7.28. Other Required Notices.

a. Special Enrollment Rights. If you decline enrollment for yourself or for an eligible Dependent (including your Spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). If you decline enrollment for yourself or for an eligible Dependent (including your Spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your Dependents' coverage ends under Medicaid or a state children's health insurance program. In addition, if you have a new Dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 31 days after the marriage or within 60 days after the birth, adoption, or placement for adoption. Finally, if you or your Dependents (including your Spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your Dependents in this Plan.

You must request enrollment within 60 days after your or your Dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact:

Basin Electric Power Cooperative
Attn: Human Resources Department
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

b. Preexisting Condition Exclusion. Group health plans and insurers may not impose preexisting condition exclusions. However, this prohibition does not apply to certain excepted Benefits. To the extent an excepted Benefit imposes a preexisting condition exclusion with respect to a Participant or Dependent, the Participant will be notified in writing, of –

(i) The existence and terms of any preexisting condition exclusion under the Plan;
(ii) The rights of individuals to demonstrate creditable coverage (and any applicable waiting periods);
(iii) The right of the individual to request a certificate from a prior plan or issuer, if necessary; and
(iv) That the current plan (or issuer) will assist in obtaining a certificate from any prior plan or issuer, if necessary.

c. Newborns' Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not more than 48 hours (or 96 hours).

d. Women's Health and Cancer Rights Act of 1998. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

(i) All stages of reconstruction of the breast on which the mastectomy was performed;
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(iii) Prostheses; and
(iv) Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits,

contact the Plan Administrator.

e. USERRA Rights. Federal law may also afford certain Participants and their Dependents the right to continue their health care coverage during certain periods of military leaves of absence pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). This continuation option is similar in many respects to COBRA continuation coverage. For example, the Benefits affected by this continuation coverage option are the same as described in Section 7.26 above. The maximum time periods for such coverage, however, shall be the lesser of:

(i) the 24-month period beginning on the day the Participant's military leave of absence begins, or
(ii) the period beginning on the day the Participant's military leave of absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment with the Employer pursuant to the Participant's rights under USERRA.

One hundred and two percent (102%) of the applicable premium must be paid for the continuation coverage unless the period of military service is for fewer than 31 days, in which event only the same contributions required from an active employee for similar coverage must be paid. The notice requirements that apply to COBRA in the case of termination of employment also apply in the case of continuation coverage during military leaves.

Upon the reinstatement of coverage after reemployment no waiting period or other exclusions shall apply that would not have otherwise applied if coverage had terminated for any reason other than military service in the

U.S. uniformed services. Furthermore, coverage under this Plan shall not apply to any illness or injury the U.S. Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the U.S. uniformed services.

If you are a pre-service member returning from service in the uniformed services, you are entitled to reemployment from the Employer if you meet the following criteria:

(i) you held the job prior to service;
(ii) you gave advance notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
(iii) your cumulative period of service did not exceed five years (with some exceptions);
(iv) you were not released from service under dishonorable or other

punitive conditions; and

(v) you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

(i) For fewer than 31 days of service—by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight-hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;

(ii) For 31 to 180 days of service—you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;

(iii) For 181 days or more of service—you must apply for reemployment no later than 90 days after completion of military service; or

(iv) For service-connected injury or illness—reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

f. Compliance with Laws. To the extent applicable, the Plan will provide coverage and Benefits in accordance with the requirements of all applicable laws. Any Benefit maximums, minimums, copayments, deductibles, or other limits are intended to comply with applicable law. To the extent any amounts conflict with applicable law, the amounts required by applicable law will control. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law, the Mental Health Parity and Addiction Equity Act of 2008, the Genetic Information Nondiscrimination Act, the HITECH Act, the Patient Protection and Affordable Care Act of 2010, and the Health Care Education Reconciliation Act of 2010. An Insurance Contract that provides both medical and surgical Benefits and mental health and/or substance abuse Benefits shall not impose any limits on mental health or substance abuse Benefits that violate the requirements of ERISA Section 712.

g. HIPAA Notice of Privacy Practices. You have been furnished a Notice of Privacy Practices located in Exhibit C describing the practices the Plan will follow regarding your "protected health information." If you would like to receive another copy, please contact:

Basin Electric Power Cooperative
Attn: Human Resources Department
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

BASIN ELECTRIC POWER COOPERATIVE HEALTH AND WELFARE PLAN
SUMMARY PLAN DESCRIPTION

EXHIBIT A

CERTIFICATES OF COVERAGE/BOOKLETS
(Certificates/Booklets will be separately provided to you)

Exhibit	Document
A-1	Health Plan • Administered by UMR, Inc.
A-2	Dental Plan • Administered by Delta Dental of Minnesota
A-3	Vision Plan (Basin Cooperative Services) • Blue Cross Blue Shield of North Dakota
A-4	Vision Plan • Vision Services Plan
A-5	Eye Exam Reimbursements under the Prescription Safety Eyewear Program
A-6	Long-Term Disability • The Prudential Insurance Company of America
A-7	Individual Disability Insurance • Unum Life Insurance Company of America
A-8	Life Insurance • The Prudential Insurance Company of America
A-9	Split-Dollar Life Insurance • The Lincoln National Life Insurance Company
A-10	Business Travel Accident Insurance • Hartford Life and Accident Insurance
A-11	Accidental Death and Dismemberment • The Prudential Insurance Company of America
A-12	Dakota Gasification Company Severance Pay Plan
A-13	Basin Electric Power Cooperative Severance Pay Plan
A-14	Health Flexible Spending benefits under the Basin Electric Power Cooperative Cafeteria Plan • WEX, Inc.
A-15	Employee Assistance Program • Acentra Health
A-16	The Basin Electric Accrued Sick Leave Payout Plan
A-17	Basin Electric Power Cooperative On-Site Medical Services
A-18	Medicare Supplement Plan • Blue Cross Blue Shield of North Dakota
A-19	Medicare Supplement Plan • The Hartford Financial Services Group, Inc.

ISSUER RESPONSIBILITY:

NAME & ADDRESS OF ISSUER	EXTENT TO WHICH BENEFITS ARE GUARANTEED BY ISSUER	ADMINISTRATIVE SERVICES PROVIDED BY ISSUER
UMR, Inc. 115 W. Wausau Ave Wausau, WI 54401	None	Claims Administration
Delta Dental of Minnesota National Dedicated Service Center P.O. Box 59238 Minneapolis, Minnesota 55459	None	Claims Administration
WEX, Inc. 4321 20th Avenue S. Fargo, ND 58103	None	Cafeteria Plan and COBRA Administration
Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	Fully Insured Business Travel Accident Plan	Claims Administration
Unum Life Insurance Company of America 2211 Congress Avenue Portland, ME 04122	Fully Insured Individual Disability Insurance	Claims Administration
The Lincoln National Life Insurance Company 100 North Greene Street Greensboro, NC 27401	Fully Insured Split Dollar Life Plan	Claims Administration
The Prudential Insurance Company of American 751 Broad Street Neward, NJ 07102	Fully Insured Life, Accidental Death & Dismemberment, Dependent Life, Dependent Accidental Death & Disability, and Long-Term Disability Plan	Claims Administration
Blue Cross Blue Shield of North Dakota 4510 13th Avenue S Fargo, ND 58121	Fully Insured Vision (Basin Cooperative Services)	Claims Administration
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	Fully Insured Vision	Claims Administration
Acentra Health 777 East Park Drive Harrisburg, PA 17111-2754	None	Employee Assistance Program (EAP) Services

Blue Cross Blue Shield of North Dakota 4510 13th Avenue S Fargo, ND 58121	Fully Insured Medicare Supplement	Claims Administration
The Hartford Financial Services Group, Inc. One Hartford Plaza Hartford, CT 06155	Fully Insured Medicare Supplement	Claims Administration

BASIN ELECTRIC POWER COOPERATIVE HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

EXHIBIT B

CLAIMS AND APPEALS PROCEDURES

Note: To the extent the Applicable Insurance Contract does not contain ERISA compliant claims and appeals procedures, the Claims and Appeals Procedures in this Exhibit B will control. In such cases, if the claims administrator is specified in the Applicable Insurance Contract that party shall serve as the claims administrator when applying the Claims and Appeals Procedures in this Exhibit B. If the claims administrator is not specified in the Applicable Insurance Contract, the Plan Administrator shall serve as the claims administrator.

I. Definitions.

A. "**Adverse Benefit Determination**" shall mean any of the following:

1. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit, including a decision based on a determination of a Participant's or Beneficiary's eligibility to participate in the Plan (including determinations made in accordance with Section 4980H of the Code);

2. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review;

3. a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigative or not medically necessary or appropriate;

4. a Concurrent Care Reduction; and

5. with respect to a Disability Claim (in addition to the events, above), any rescission of disability coverage with respect to a Participant or Beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time). For this purpose, "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

B. "**Appeal**" or "**Internal Appeal**" shall mean review by the Plan of an Adverse Benefit Determination.

C. "**Claim**" shall mean any request for a Plan Benefit or Benefits made in accordance with these Claims and Appeals Procedures.

D. "**Claimant**" shall mean a Participant or Beneficiary of the Plan who submits a

Claim.

E. "**Concurrent Care Claim**" shall mean, with respect to an ongoing course of treatment to be provided over a period of time or number of treatments approved by the Plan, (i) any reduction or termination by the Plan of such course of treatment before the end of such period of time or number of treatments (a "**Concurrent Care Reduction**"), or (ii) any request by a Claimant to extend the course of treatment (a "**Concurrent Care Extension Request**").

F. "**Disability Claim**" shall mean any Claim, the receipt of which is conditioned upon a finding of disability. It does not matter how the Benefit is characterized by this Plan; if the Plan Administrator (or, if applicable, the claims administrator under an Applicable Insurance Contract) must make a determination of disability in order to decide a Claim, the Claim will be treated as a Disability Claim for purposes of these Claims and Appeals Procedures. However, if receipt of a Benefit is conditioned upon a finding of disability, and that finding is made by a party other than the Plan for purposes other than making a Benefit determination under the Plan (i.e., a disability determination by the Social Security Administration), then the Claim will not be treated as a Disability Claim for purposes of these Claims and Appeals Procedures.

G. "**Employer**" shall mean Basin Electric Power Cooperative and its subsidiaries.

H. "**Non-Health Claim**" shall mean Claims that are neither group health claims nor Disability Claims. A Non-Health Claim includes Claims for Benefits under life insurance plans, accidental death and dismemberment plans, long term care, and business travel accident insurance plans.

I. "**Plan**" shall mean Basin Electric Power Cooperative Health and Welfare Plan.

J. "**Plan Administrator**" shall mean the Employer. For purposes of submitting an initial Claim or an Appeal, the Plan Administrator can be contacted as follows:

Basin Electric Power Cooperative
Attn: Human Resources Department
1717 East Interstate Avenue
Bismarck, ND 58503
(701) 223-0441

K. "**Post-Service Claim**" shall mean any Claim for a Benefit under the Plan other than an Urgent Care Claim, Pre-Service Claim, Disability Claim, or Non-Health Claim.

L. "**Pre-Service Claim**" shall mean any Claim upon which the Plan conditions receipt of such Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care. A Pre-Service Claim does not include a Disability Claim, Non-Health Claim, Post-Service Claims, or Urgent Care Claim.

M. "**Urgent Care Claim**" shall mean any Claim for medical care or treatment with respect to which medical care decisions, if made on non-urgent care timeframe, (i) could seriously jeopardize the life or health of the Claimant, (ii) could seriously

jeopardize the Claimant's ability to regain maximum function, or (iii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. Whether a Claim is an Urgent Care Claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any Claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim shall be treated as such.

II. Initial Claim.

A. Submitting the Claim. Upon request, the Plan Administrator shall provide any Claimant with a claim form which may be used to request Benefits. In addition, an authorized representative may act on behalf of the Claimant with respect to a Claim or Appeal under these Procedures. Any reference in these Procedures to the Claimant is intended to include the authorized representative of such Claimant. The Plan Administrator will consider any written request for Benefits under the Plan to be a Claim. A Claim will not be considered for payment unless it is received within twelve (12) months after the date the expense incurred.

B. Deadline to File Claim. To be considered timely, a Claim must be filed within one year after the Claimant knew or reasonably should have known of the principal facts upon which the Claim is based. Knowledge of all facts that the Participant knew or reasonably should have known shall be imputed to the claimant for the purpose of applying the deadline.

C. How Incorrectly Filed Claims are Treated. These Claims and Appeals Procedures do not apply to any request for Benefits that is not made in accordance with these Claims and Appeals Procedures, except that (a) in the case of an incorrectly-filed Pre-Service Claim, the Claimant shall be notified as soon as possible but no later than five (5) days following receipt by the Plan Administrator of the incorrectly-filed Claim; and (b) in the case of an incorrectly- filed Urgent Care Claim, the Claimant shall be notified as soon as possible but no later than 24 hours following receipt by the Plan Administrator of the incorrectly- filed Claim. The notice shall explain that the request is not a Claim and describe the proper procedures for filing a Claim. The notice may be oral unless written notice is specifically requested by the Claimant.

D. Full and Fair Review. With respect to Disability Claims, the Plan will ensure all Claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational

expert) will not be made based upon the likelihood that the individual will support a denial of Benefits.

E. Denial of Initial Claim. If a Claim for Benefits is denied (in whole or in part) by the Plan Administrator, the Plan Administrator shall provide the Claimant with written or electronic notification of such Adverse Benefit Determination. The notice shall include:

1. The specific reason(s) for the Adverse Benefit Determination.

2. A reference to the specific Plan provision(s) on which the Adverse Benefit Determination is based.

3. A description of any additional material or information necessary to perfect the Claim, and an explanation of why this material or information is necessary.

4. A description of the Plan's appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA § 502(a) if the Claim is denied on Appeal.

5. In the case of a Claim for Benefits except Non-Health Claims (in addition to the above requirements in Section II.E.1-4):

    a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request.

    b. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

6. In the case of an Urgent Care Claim, (in addition to the above requirements in Section II.E.1-5), a description of the expedited appeal procedures. For Urgent Care Claims, notification of the Adverse Benefit Determination may be provided to the Claimant orally, provided that a written or electronic notification is furnished not later than 3 days after the oral notification.

7. In the case of a Disability Claim (in addition to the above requirements in Section II.E.1-5):

    a. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Benefit determination; and

- A disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and

b. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for Benefits. Whether a document, record, or other information is relevant to a Claim shall be determined by reference to 29 CFR § 2560.503-1(m)(8).

The notice required for the denial of an initial Disability Claim will be provided in a culturally and linguistically appropriate manner if required by law.

The Claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to the Plan Administrator. The Claimant may appeal the denial as set forth in the next section of this procedure. If the Claimant fails to appeal such action to the Plan Administrator in writing within the prescribed period described in Section III, the Plan Administrator's denial of a Claim shall be final, binding and conclusive.

A Concurrent Care Reduction will be considered a denial of a Claim, and the Plan Administrator shall provide the Claimant with written or electronic notification as described in this section.

F. **Approval of Initial Claim.** If a Claim is approved, the Plan Administrator shall provide the Claimant with written or electronic notice of such approval. The notice shall include:

1. The amount of benefits to which the Claimant is entitled.

2. The duration of such benefit.

3. The time the benefit is to commence.

4. Other pertinent information concerning the benefit.

Payment of any Benefit will be made to the Claimant unless he or she has previously authorized payment to any entity rendering covered services, treatment, or supplies. If the Claimant dies before all Benefits have been paid, the remaining

Benefits may be paid to any relative of the Claimant or to any person appearing to the Plan Sponsor to be entitled to payment. The Plan Sponsor shall fully discharge its liability by such payments.

G. Timing of Notice of Decision. The Plan Administrator shall render a decision on the Claim and will provide notification to the Claimant within the following time frames, unless special circumstances require an extension of time for processing the Claim. (See Section IV for the procedures concerning extensions of time.)

1. For an Urgent Care Claim – as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the Claim by the Plan. A notice of decision on an Urgent Care Claim may be provided orally within the time frame above, provided that written or electronic notice described in the previous section is provided no less than 3 days after the oral notification. Notice will be provided regardless of whether the Claim is approved or denied.

2. For a Pre-Service Claim – within a reasonable period of time appropriate to the medical circumstances, but no more than 15 days after receipt of the Claim by the Plan. Notice will be provided regardless of whether the Claim is denied.

3. For a Post-Service Claim – within a reasonable period of time, but no more than 30 days after receipt of the Claim by the Plan.

4. For a Concurrent Care Reduction – sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination of the Appeal before the Benefit is reduced or terminated.

5. For a Concurrent Care Extension Request – if the Concurrent Care Extension Request involves urgent care, the notice will be provided as soon as possible, taking into account the medical exigencies. So long as the request is made at least 24 hours prior to the expiration of the course of treatment, the Plan will provide notice no more than 24 hours after receipt of the Claim by the Plan. If the Concurrent Care Extension Request does not involve urgent care, the notice will be provided in the otherwise applicable timeframes for Pre-Service Claims, or Post-Service Claims, as applicable. Notice will be provided regardless of whether the Claim is denied.

6. For a Disability Claim – within a reasonable period of time, but no more than 45 days after receipt of the Claim by the Plan.

7. For a Non-Health Claim – within a reasonable period of time, but no more than 90 days after receipt of the Claim by the Plan.

III. Appeal Procedures

A. Filing the Appeal. In the event that a Claim is denied (in whole or in part), the Claimant has the opportunity to appeal and receive a full and fair review of the

Claim and the Adverse Benefit Determination. The Claimant may appeal the denial of a Claim by giving written notice of the Appeal to the Plan Administrator within 180 days (60 days for Non-Health Claims) after the Claimant receives notice of the Adverse Benefit Determination. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, records, and other information relating to the Claim. The Plan Administrator (or its designee) shall review and consider this information without regard to whether the information was submitted or considered in conjunction with the initial claim.

If the Claimant fails to appeal such action to the Plan Administrator in writing within the prescribed period of time described in this Section III, the Plan Administrator's denial of a Claim shall be final, binding, and conclusive.

B. General Appeal Procedure. The Plan Administrator (or its designee) may hold a hearing or otherwise ascertain such facts as it deems necessary and shall render a decision which shall be binding upon both parties. In deciding the Appeal:

All Claims

1. The Claimant may submit written comments, documents, records, and other information relating to the Claim.

2. All comments, documents, records, and other information submitted by the Claimant relating to the Claim, shall be considered without regard to whether the information was submitted or considered in conjunction with the initial Claim.

3. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. Whether a document, record, or other information is relevant to a Claim shall be determined be reference to 29 C.F.R. § 2560.503-1(m)(8).

All Claims Except Non-Health Claims

In addition to III.B.1-3:

4. No deference shall be given to the initial decision resulting in the Adverse Benefit Determination.

5. The Appeal shall be decided by an appropriate named fiduciary who did not make the initial Adverse Benefit Determination, and who is not a subordinate of anyone that decided the initial Adverse Benefit Determination.

6. If the Appeal is based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary deciding the Appeal shall consult with a health care professional who has appropriate training and experience in the relevant

field of medicine involved in the medical judgment. The health care professional must not be an individual who participated in the Adverse Benefit Determination and must not be the subordinate of any such individual.

7. If the Plan Administrator obtained advice from any medical or vocational experts in conjunction with the Adverse Benefit Determination, then such experts must be identified to the Claimant. This identification must occur even if the Plan Administrator did not rely on the advice obtained.

C. Special Appeal Procedure for Urgent Care Claims. In addition to the procedures set forth in Section III.B. ("General Appeal Procedures"), an expedited Appeal process shall be available in the case of an Urgent Care Claim, and the following shall apply:

1. A request for an expedited Appeal of an Adverse Benefit Determination must be made to the Plan Administrator but may be made either orally or in writing.

2. All necessary information will be transmitted from the Plan to the Claimant by telephone, facsimile or similarly expeditious means.

D. Special Appeal Procedure for Disability Claims. In addition to the procedures set forth in Section III.B ("General Appeal Procedure"), the following procedures shall apply in the case of a Disability Claim:

1. Before the Plan can issue an Adverse Benefit Determination on review on a Disability Claim, the Plan Administrator shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Insurer, or other person making the benefit determination (or at the direction of the Plan, Insurer or such other person) in connection with the Claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date; and

2. Before the Plan can issue an Adverse Benefit Determination on review on a Disability Claim based on a new or additional rationale, the Plan Administrator shall provide the Claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

E. Notice of Decision on Appeal. The Appeal decision of the Plan Administrator shall be provided in written or electronic form to the Claimant. In the case of an Adverse Benefit Determination, the notification shall include the following:

1. The specific reason(s) for the Adverse Benefit Determination.

2. Reference to the specific Plan provision(s) on which the Adverse Benefit Determination was based.

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for Benefits. (Whether a document, record, or other information is relevant to a Claim for Benefits shall be determined by reference to 29 C.F.R. § 2560.503-1(m)(8).)

4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures and a statement of the Claimant's right to bring an action under § 502(a) of the Employee Retirement Income Security Act.

5. In the case of an Adverse Benefit Determination on review with respect to a Claim for benefits except a Non-Health Claim (in addition to the above requirements in Section III.E.1-4):

    a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request.

    b. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

6. In the case of an Adverse Benefit Determination on review with respect to a Claim for Benefits except a Non-Health Claim or Disability Claim (in addition to the above requirements in this Section E.1-5), the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

7. In the case of an Adverse Benefit Determination on review with respect to a Disability Claim, the notification shall include (in addition to the above requirements in Section III.E.1-4 and 5.a. and 5.b.):

    a. The statement described in III.E.4, above, shall also describe any applicable contractual limitations period that applies to the Claimant's right to bring an action under § 502(a) of the Employee Retirement Income Security Act, including the calendar date on which the contractual limitations period expires for the Claim.

b. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Benefit determination; and

- A disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration.

The notice required for the denial of a Disability Claim on review will be provided in a culturally and linguistically appropriate manner if required by law.

F. Timing of Notice of Decision on Appeal. The Plan Administrator shall render a decision on Appeal and will notify the Claimant within the following time frames.

1. For an Urgent Care Claim – as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the Appeal by the Plan.

2. For a Pre-Service Claim – within a reasonable period of time appropriate to the medical circumstances, but no more than 30 days after receipt of the Appeal by the Plan.

3. For a Post-Service Claim – within a reasonable period of time, but no more than 60 days after receipt of the Appeal by the Plan.

4. For a Concurrent Care Reduction – before the proposed reduction or termination of treatment.

5. For a Concurrent Care Extension Request – in the appropriate time frame described above for an Urgent Care Claim, Pre-Service Claim, or Post-Service Claim.

6. For a Disability Claim – within a reasonable period of time, but no more than 45 days after receipt of the Appeal by the Plan.

7. For a Non-Health Claim – within a reasonable period of time, but no more than 60 days after receipt of the Appeal by the Plan.

G. Incomplete Appeals. Where an Appeal's submission date is within the appropriate deadline, and the Appeal is later supplemented or resubmitted (either because the initial submission was incomplete, or for any other reason), the initial Appeal

submission date does not apply to the later supplementation or resubmission. The intent of this Section is to require the resubmitted Appeal to be filed within the deadlines described above. In the case of an incomplete Appeal, however, in no event shall the Plan refuse to accept for processing a resubmission or supplementation of such an Appeal that is resubmitted or supplemented within the deadline described in the preceding paragraph.

IV. Extensions of Time

A. Permissible Extensions. Extensions of time are available, subject to the following limitations:

1. For an initial Pre-Service Claim – No more than one extension of 15 days.

2. For an initial Post-Service Claim – No more than one extension of 15 days.

3. For an initial Disability Claim – No more than two extensions of 30 days each.

4. For a Disability Claim Appeal– No more than one extension of 45 days.

5. For an initial Non-Health Claim – No more than one extension of 90 days.

6. For a Non-Health Claim Appeal – No more than one extension of 60 days.

7. Incomplete Claims.

   a. For an Incomplete Urgent Care Claim – If the Claimant fails to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the Plan Administrator shall notify the Claimant, as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Claimant shall be permitted not less than 48 hours to provide the specified information. The Plan Administrator shall notify the Claimant of the grant or denial of the Claim as soon as possible, but not later than 48 hours after the earlier of: (a) the end of the time period given to the Claimant to provide the specified information or (b) the Plan's receipt of the specified information.

   b. For Other Incomplete Claims – If a Pre-Service or Post-Service Claim is incomplete, the Plan Administrator may deny the Claim or may take an extension of time, as described above. If the Plan Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the Claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is

provided to the Plan Administrator. If the requested information is provided, the Plan Administrator shall decide the Claim within 15 days of receiving the missing necessary information. If the requested information is not provided within the time specified, the Claim may be decided without that information.

B. Notice of Extension. If the Plan requires an extension of time, the Plan Administrator shall provide the Claimant with written or electronic notice of the extension before the expiration of the original Claim review period. The notice of the extension shall include:

1. An explanation of the circumstances requiring the extension. These circumstances must be matters beyond the control of the Plan.

2. The date by which the Plan expects to render a decision.

3. For Claims other than Non-Health Claims, if the extension is necessary due to a failure by the Claimant to submit the information necessary to decide the Claim, a description of the information needed to resolve those issues. In the event that such information is needed:

    a. The Claimant shall have at least 45 days in which to provide the specified information.

    b. The time for determining an initial Claim shall be tolled from the date on which the notice of extension is sent to the Claimant, until the date on which the Claimant responds to the request for additional information.

4. For Disability Claims (in addition to the requirements in this Section IV.B.1-3), the standard on which the Claimant's entitlement to a Benefit is based.

C. New or Additional Evidence. The time in which a decision will be provided may be tolled if new or additional evidence is received so late that it would be impossible to provide it to the Claimant (or his or her personal representative) in time for the Claimant to have a reasonable opportunity to respond. After the Claimant responds, or has had a reasonable opportunity to do so, the Plan will notify the Claimant of its decision.

V. External Review

Any right to an external review by an independent review organization as provided in the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and the regulations and guidance issued thereunder, will be governed by the Applicable Insurance Contract(s).

VI. Judicial Review

A. Exhaustion of Administrative Remedies. The exhaustion of the Claims and Appeals Procedures is mandatory for resolving every Claim and dispute arising under this Plan. As to such Claims and disputes: (a) no Claimant shall be permitted to commence any legal action to recover Plan Benefits or to enforce or clarify rights under the Plan under Section 502 or Section 510 of ERISA or under any other provision of law, whether or not statutory, until the Claims and Appeals Procedures have been exhausted in their entirety; and (b) in any such legal action all explicit and all implicit determinations by the Plan Administrator (including, but not limited to, determinations as to whether the claim, or a request for a review of a denied claim, was timely filed) shall be afforded the maximum deference permitted by law.

B. Deadline to File Action. No legal action to recover Plan Benefits or to enforce or clarify rights under the Plan under Section 502 or Section 510 of ERISA or under any other provision of law, whether or not statutory, may be brought by any Claimant on any matter pertaining to this Plan unless the legal action is commenced in the proper forum before the earlier of: (a) 30 months after the Claimant knew or reasonably should have known of the principal facts on which the Claim is based, or (b) six months after the Claimant has exhausted the Claims and Appeals Procedure under this Plan. Knowledge of all facts that the Participant knew or reasonably should have known shall be imputed to every Claimant who is or claims to be a Beneficiary of the Participant or otherwise claims to derive an entitlement by reference to the Participant for the purpose of applying the previously specified periods.

C. Plan Administrator Discretion; Court Review. The Plan Administrator and all persons determining or reviewing claims have full discretion to determine Benefit Claims under the Plan. Any interpretation, determination or other action of such persons shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the persons reviewing a Claim shall be based only on such evidence presented to or considered by such persons at the time they made the decision that is the subject of review.

VII. Deemed Exhaustion of Claims Procedures for Claims for Disability Benefits

In the case of a Disability Claim, if the Plan fails to adhere to these Claims and Appeals Procedures with respect to a Claim, the Claimant is deemed to have exhausted these Claims and Appeals Procedures, except as provided below. Accordingly, the Claimant is entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the Claim. If a Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the Claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding the foregoing, these Claims and Appeals Procedures will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was

not part of a pattern or practice of violations by the Plan, and was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. The Claimant may request a written explanation of the violation from the Plan, and the Plan will provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause these procedures to be deemed exhausted. If a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception under this Section VII, the Claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan shall provide the Claimant with notice of the resubmission.

BASIN ELECTRIC POWER COOPERATIVE HEALTH AND WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Exhibit C

NOTICE OF PRIVACY PRACTICES

Please see next page for Notice of Privacy Practices.

Basin Electric Power Cooperative Group Health Plans Notice of Privacy Practices

Alicia Lundberg, Privacy Officer
Basin Electric Power Cooperative
1717 E Interstate Ave, Bismarck, ND 58503-0564
alundberg@bepc.com / 701-557-5594

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective 01/01/2025

This Notice of Privacy Practices applies to the following organizations.

Basin Electric Power Cooperative, Dakota Gasification Company, and Montana Limestone Company

Alicia Lundberg, Privacy Officer
alundberg@bepc.com / 701.557.5594

BASIN ELECTRIC POWER COOPERATIVE HEALTH AND WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Exhibit D

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSRANCE PROGRAM (CHIP)

Please see next page for more details.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawk Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565