

BASIN ELECTRIC POWER COOPERATIVE ONSITE HEALTH CLINIC

(A Component Plan of Plan Number 580)

SUMMARY PLAN DESCRIPTION*

*This document serves as both the Summary Plan Description required under the Employee Retirement Income Security Act of 1974 ("ERISA") and the official plan document.

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BASIN ELECTRIC POWER COOPERATIVE ONSITE HEALTH CLINIC

SUMMARY PLAN DESCRIPTION

THIS SUMMARY PLAN DESCRIPTION is effective for all purposes as of January 1, 2023.

ARTICLE I. INTRODUCTION

1.1 Purpose of Plan. Basin Electric Power Cooperative (the "Employer") has established the Basin Electric Power Cooperative Onsite Health Clinic (the "Clinic" or the "Plan"). The Employer established the Clinic to provide convenient professional medical care for its Employees, Directors, Retirees, Limited Access Retirees, and their Eligible Dependents to address common medical needs, illnesses and injuries. It is intended that the Clinic qualify as an accident and health plan within the meaning of Code Section 105, and the value of benefits provided through the Clinic be eligible for exclusion from your gross income (i.e. these benefits are not taxable to you) if you are an Employee, Director, Retiree, or Limited Access Retiree.

1.2 Purpose of This Document. It is important that you carefully review this document to understand the benefits which are available to you through the Clinic, as well as your responsibilities to ensure that you receive all the benefits available to you through the Clinic and to which you are eligible. This document has been written so that it is not just a summary of the Clinic benefits, but also the legal plan document written so that it can be used by you or the Employer in understanding and administering the benefits provided by the Clinic.

ARTICLE II. DEFINITIONS

2.1 "COBRA Administrator" shall mean WEX, Inc.

2.2 "Clinic" shall mean the Basin Electric Power Cooperative Onsite Health Clinic established by the Employer.

2.3 "Code" shall mean the Internal Revenue Code of 1986, as amended.

2.4 "Director" shall mean a member of the board of directors of the Employer.

2.5 "Eligible Dependent" shall have the meaning assigned in the Health Plan and also includes dependents who are currently covered by a military medical plan. Those dependents will show their medical ID card as proof of insurance.

"Employee" means any person providing services to the 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.

2.6 "Employer" shall mean Basin Electric Power Cooperative and any subsidiaries.

2.7 "Enrollment Date" shall mean the first day of coverage under the General Retiree Medical Program.

2.8 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

2.9 "General Retiree Medical Program" shall mean the program sponsored by the Employer under which qualifying retirees elect to continue coverage under the Health Plan in lieu of COBRA coverage.

2.10 "Health Plan" shall mean the medical plan components of the Basin Electric Power Cooperative Health and Welfare Plan (PN 580).

2.11 "Limited Access Retiree" shall mean a person formerly employed as an Employee by the Employer who (1) terminated employment with the Employer after attaining age 55; (2) is not eligible for coverage under the General Retiree Medical Program; and (3) does not elect to continue coverage under this Plan through COBRA.

2.12 "Participant" is an Employee, Director, Retiree, or Limited Access Retiree, or the Eligible Dependent of any such an individual, who is eligible to use the Clinic in accordance with Section 3.1.

2.13 "Plan" shall mean the Basin Electric Power Cooperative Onsite Health Clinic established by the Employer.

2.14 "Plan Administrator" shall be 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.

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

2.16 "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.

2.17 "Retiree" shall mean a person formerly employed by the Employer as an Employee and who has elected coverage under the General Retiree Medical Program component of the Health Plan.

2.18 "Summary Plan Description" shall mean this document and its attached exhibits.

ARTICLE III. PARTICIPATION

3.1 Eligibility for Participation. All Employees, Directors, and Retirees, and their Eligible Dependents, are Participants in this Plan and entitled to receive any service offered by the Clinic. Limited Access Retirees and their Eligible Dependents are also Participants in the Plan, but only eligible to have their blood drawn at the Clinic.

3.2 When Coverage Begins. All Employees and their Eligible Dependents automatically become Participants in this Plan and eligible to receive services at the Clinic as of the Employee's hire date. Directors and their Eligible Dependents automatically become Participants in this Plan and eligible to receive services at the Clinic as of the date on which the Director becomes a member of the board of directors of the Employer. Retirees and their Eligible Dependents become Participants in this Plan and eligible to receive services at the Clinic as of their Enrollment Date. Limited Access Retirees and their Eligible Dependents are eligible to have their blood drawn at the Clinic as of the day following the date the Limited Access Retiree terminated employment with the Employer.

3.3 Participant Contributions. There will be no premium contributions for this Plan (except as described in Section 7.22 below for COBRA participants and any premium a Retiree is required to pay as part of his or her participation in the General Retiree Medical Program), and generally Clinic services for Participants are provided at no cost to the Participant. However, in certain cases, such as when tests are sent to an outside lab for processing, fees for services will be billed. Additional information regarding any costs associated with Clinic services is provided below.

3.4 Cessation and Reinstatement of Participation. Participation in this Plan and eligibility to use the Clinic shall terminate on the earliest of the following:

- a. The day an Employee is no longer employed as an Employee by the Employer;
- b. The day a Director is no longer a member of the Employer's board of directors;
- c. The day a Retiree is no longer covered by the General Retiree Medical Program;
- d. The day a Participant is no longer an Eligible Dependent;
- e. The day a Limited Access Retiree dies;
- f. The date specified in any Plan amendment resulting in a Participant's loss of eligibility to participate in this Plan;
- g. The date this Plan is terminated; or
- h. The date a Participant behaves in an abusive manner toward Clinic staff or otherwise violates the Policy on Terminating the Physician-Patient Relationship for Threatening, Abusive, or Disruptive Patient Behavior adopted by the Employer or any Clinic provider policies governing behavior on Clinic premises.

ARTICLE IV. BENEFITS

4.1 No Cost Benefits. Participants may receive the types of services shown in the following chart from the Clinic during its regularly scheduled office hours at no cost, but only to the extent (i) such care is within the professional capabilities and qualifications of the Clinic staff, and (ii) equipment and pharmaceutical and over-the-counter drugs are available at the Clinic. Not every type of service listed in the chart is available at each Clinic location and the types of services offered by the Clinic or any Clinic location may change without notice being provided to you. In addition, when appropriate the Clinic may also refer a Participant to his or her primary care physicians for follow-up care and/or arrange for a Participant's transfer to a hospital emergency room if additional treatment is required.

Basin Electric Power Cooperative Onsite Health Clinic Services	
Condition	Clinic Services
Emergency Response within the Clinic	• Basic Life Support, including CPR, AED, oxygen therapy (DGC only), nasal & oral airways, injectable benadryl and epinephrine, IV insertion • Choking/shortness of breath • Transfer to hospital emergency room, if required *The Clinic is not equipped to handle emergencies that occur outside of its normal operating hours. You should call 911 or go to the nearest hospital emergency room if you

	have an emergency outside of the Clinic's normal operating hours.	
Laceration/Wound Care	• Minor wounds and lacerations • Facial wounds • Specialist referral for deep or multi-system wounds • Minor puncture wounds • 1st and 2nd degree burns • Treatment, including steri-strip, dermabond, sutures, and staples	
Suture Removal	• Minor lacerations • Surgical and plastic sutures	
Infection	• Fever • Skin • Sinus • Ear • Fingernail/toenail (includes simple trimming and ingrown nail care)	• Eye • Wound • Throat • Toe
Sprains and Strains	• Minor of the knees • Foot • Ankle • Wrist • Elbow • Splinting/Casting - DGC Only	• Shoulder • Neck • Back • Fingers • Toes • X-rays can be done
Gastro-intestinal Disorders	• Upset stomach • Nausea and vomiting • Indigestion and reflux • Diarrhea, food poisoning • Food allergies • Diverticulitis	• Constipation • Abdominal pain • Increase abdominal gas/flatulence • Hemorrhoids • Rectal itching
Rashes and Skin Disorders	• Eczema • Psoriasis • Poison ivy • Contact dermatitis • Sun and sand rashes • Bug/insect bites/stings/reactions • Bruising • Chickenpox	• Hives • Impetigo • Lice • Warts • Scabies • Mole checks and biopsies • Skin lesions • Skin tag removal

	• Peritoneal irritation • Frostbite	• Toe nail removal
Eye Problems	• Infections • Stys	• Foreign body in the eye • Vision screening
Respiratory Problems	• Asthma • Cough and chest congestion • Bad breath • Foreign body in the nose • Sore throat • Laryngitis • Hoarseness • Shortness of breath	• Mouth or oral/tooth problems • Nose bleed • Nose injury • Wheezing • Sinus problems • Tongue problems • Common cold/flu symptoms
Genito-urinary Problems	• Bladder infections • Pain on urination • Blood in urine • Menstrual problems	• Vaginal discharge/pain/itching • STD testing can be ordered • Testicle problems • Genital lesions
Laboratory testing	• Common lab tests ordered by Clinic Nurse Practitioner or Medical Doctor • Common lab tests ordered by outside physician (can be drawn/collected at the clinic and sent to a laboratory)	
Miscellaneous Symptoms/Complaints	• Headaches • Allergic reactions • Anxiety • Chest pain • Minor traumas • Electrical shock • Fainting • Fevers • Swollen glands • Allergies • Depression • Dizziness • Domestic violence • Patient education programs • Head injury	• Drug and alcohol problems • Heat exhaustion • HIV exposure/blood and body fluid exposure • Pain • Health risk assessments • Screening programs: blood pressure checks, cholesterol checks, nutrition, diabetes, vision and hearing screenings, depression screenings, stress management screenings, breast exams, testicular exams, prostate screenings,

		electrocardiograms (EKG), Spirometry (breathing test)
Vaccinations	• Influenza • Hepatitis B (only offered to employees at each facility that are on the Fire & Rescue Team)	• Tetanus (TD) • Tetanus, Diphtheria, Pertussis (Tdap) • Pneumonia • Shingles • Covid
Wellness Coaching	• Blood draws • Engage Participants in coaching programs • Meet with individual employees weekly or bi-weekly for 3-6 months or until goals are met; sessions are typically 30 minutes • Assess Participant's readiness for behavior change in the areas of weight management, nutrition, physical fitness, smoking cessation, and stress management • Help the Participant understand the benefits of behavior change and correct misinformation • Co-create individual wellness plans • Identify motivators and barriers to behavior change • Guide the employee into exploring new behaviors to substitute for those which have not been effective • Set short and long-term goals • Celebrate success and develop strategies to overcome barriers	

Other services not listed above may also be available at the Clinic and the services offered by the Clinic are subject to change. Any medical care provided by the Clinic which is not described above or which is not of a type deductible under Code Section 213(d) is not covered under the Plan. A Participant's receipt of medical care from the Clinic is subject to availability. In no event will the Plan make any payments to a third-party for medical care provided to a Participant.

4.2 For Cost Benefits. Participants may receive the types of services shown in the following chart from the Clinic during its regularly scheduled office hours at an additional cost specified below, but only to the extent (i) such care is within the professional capabilities and qualifications of the Clinic staff, and (ii) equipment and pharmaceutical and over-the-counter drugs are available at the Clinic. In addition, when appropriate the Clinic may also refer a Participant to his or her primary care physicians for follow-up care and/or arrange for a Participant's transfer to a hospital emergency room if additional treatment is required.

Basin Electric Power Cooperative Onsite Health Clinic Services		
Condition	Clinic Services	Cost

Miscellaneous Symptoms/Complaints	Transportation to another treatment facility	
	Additional Laboratory Tests	

Other services not listed above may also be available at the Clinic at an additional cost and the services offered at the Clinic at an additional cost are subject to change. Any medical care which is not described above or which is not of a type deductible under Code Section 213(d) is not covered under the Plan. A Participant's receipt of medical care from the Clinic is subject to availability. In no event will the Plan make any payments to a third-party for medical care provided to a Participant.

4.3 Using the Clinic. Participants may visit the Clinic at any time during regularly scheduled Clinic hours, with an appointment.

ARTICLE V. ADMINISTRATION OF PLAN

5.1 Limitation of Rights. Nothing herein will be construed to require the Employer or the Plan Administrator 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. Nothing in this Plan shall give any Employee any right to continue employment.

5.2 Funding. The Clinic is funded by the Employer.

5.3 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. 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);
- 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);
- d. To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and
- e. 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.

All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

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 at any time.

ARTICLE VII. ERISA INFORMATION

7.1 Plan Name. The name of the Plan is the Basin Electric Power Cooperative Onsite Health Clinic.

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). This Plan is a component of Plan Number 580, the Basin Electric Power Cooperative Health and Welfare Plan.

7.5 Type of Plan. The Plan is a welfare benefit plan which provides medical benefits.

7.6 Type of Administration. The Plan Administrator administers the non-clinical aspects of the Clinic's day-to-day operation.

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

7.11 Summary of Benefits. The benefits provided under this Plan are summarized in Section 4.1.

7.12 Qualified Medical Child Support Orders ("QMCSOs"). The procedures governing QMCSOs are set forth in Section 7.23.

7.13 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 3.4.

7.14 COBRA. 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 7.22. Coverage under this Plan for Retirees and Limited Access Retirees is alternative coverage offered in lieu of COBRA continuation coverage. If you are a Retiree or Limited Access Retiree, you cannot elect both COBRA continuation under this Plan due to your termination of

employment with the Employer and coverage under this Plan as a Retiree or Limited Access Retiree. If, prior to the expiration of the Election Period, you elect COBRA continuation coverage under this Plan in lieu of coverage under this Plan as a Retiree or Limited Access Retiree, you will have forever waived your right to be covered under this Plan as a Retiree or a Limited Access Retiree. If you elect to be covered under this Plan as a Retiree or Limited Access Retiree in lieu of COBRA continuation coverage, you will have forever waived your right to COBRA continuation coverage under this Plan and you will never be entitled to elect COBRA continuation coverage under this Plan.

7.15 Plan Funding. The benefits offered by the Plan are funded by contributions from the Employer and, in the case of for cost benefits, Participants.

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

7.17 Claims and Appeals Procedures. The claims and appeals procedures under this Plan are set forth respectively in Exhibit A.

7.18 Further Information. An Employee, Director, Retiree, Limited Access Retiree or Eligible Dependent may obtain further information about the Plan and Clinic by contacting the Plan Administrator.

7.19 Inspection of Plan. The Employer will make the Plan and all related documents incorporated herein by reference available for inspection at its offices at no cost upon reasonable notice.

7.20 Copy of Plan. Upon reasonable notice and written request a copy of this Plan may be obtained from the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

7.21 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

- Examine, without charge, at the Plan Administrator's office 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 updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- 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 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.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- 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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the claim procedures available to you under the Plan (see section 7.18) 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.

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.

7.22 Continuation of Group Health Coverage Under COBRA.

Introduction

You are receiving this notice because you are covered under the Basin Electric Power Cooperative Onsite Health Clinic (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 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 get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. This section is intended to inform you of your rights and obligations under COBRA. It does not fully describe all continuation coverage rights.

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 doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it 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 Plan 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 Eligible 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.)

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.

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 or Director, 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 employment or service as a Director ends for any reason other than your gross misconduct.

If you are the spouse of an Employee or Director, 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 employment ends for any reason other than his or her gross misconduct;
- c. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- d. 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 Eligible Dependent child of an Employee or Director, 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 or parent-Director dies;
- b. Your parent-Employee's or parent-Director's employment or service as a Director ends for any reason other than his or her gross misconduct;
- c. Your parent-Employee or parent-Director becomes entitled to Medicare benefits (under Part A, Part B, or both);
- d. Your parents become divorced or legally separated; or
- e. You stop being eligible for coverage under the Plan as an "Eligible 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 Retiree or Limited Access Retiree covered under the Plan, the Retiree or Limited Access Retiree is a qualified beneficiary with respect to the bankruptcy. The Retiree's or Limited Access Retiree's spouse, surviving spouse, and Eligible Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Outside of a filing of bankruptcy, Retirees and Limited Access Retirees will not be qualified beneficiaries.

If you are the Eligible Dependent child of a Retiree or Limited Access Retiree, you may be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- a. The latter of: (i) your parent-Retiree or parent-Limited Access Retiree or (ii) his or her spouse becoming entitled to Medicare benefits (under Part A, Part B, or both), provided that if the spouse of your parent-Retiree or parent-Limited Access Retiree becomes entitled to Medicare benefits second, such an entitlement occurs with 36 months of your parent-Retiree or parent-Limited Access Retiree becoming entitled to such benefits;
- b. The death of your parent-Retiree or parent-Limited Access Retiree and the remarriage of his or her spouse within 36 months of your parent-Retiree or parent-Limited Access Retiree's death; or
- c. You stop being eligible for coverage under the Plan as an "Eligible Dependent child."

If you are the spouse of a Retiree or Limited Access Retiree, you may be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- a. You become divorced or legally separated from your spouse. Also, if your spouse (the Retiree or Limited Access Retiree) 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; or
- b. Your remarriage within 36 months of the death of your Retiree or Limited Access Retiree spouse.

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 Plan 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 PLAN 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 Plan 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 both the Plan Administrator and the COBRA Administrator have been notified that a qualifying event has occurred. When the qualifying event is the end of employment, death of the Employee, 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 Plan Administrator of any of these qualifying events.

You Must Notify the Plan Administrator of Certain Qualifying Events

For the other qualifying events ((i) divorce or legal separation of the Employee, Retiree, or Limited Access Retiree, and spouse; (ii) an Eligible Dependent child's losing eligibility for coverage as an Eligible Dependent child; or (iii) the remarriage of the spouse of a Retiree or Limited Access Retiree within 36 months of the death of the Retiree or Limited Access Retiree), a COBRA election will be available to you only if you notify the Plan 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 Plan Administrator during the 60-day notice period, YOU 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 deliver 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 Plan Administrator or 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.**

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account the Health Insurance Marketplace and that you have special enrollment rights under federal law. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the marketplace. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

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

When Plan coverage is lost due to the end 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, Retiree, or Limited Access Retiree; the covered Employee's, Retiree's, or Limited Access Retiree's, divorce or legal separation; the covered Employee, Retiree, or Limited Access Retiree becoming entitled to Medicare benefits; or an Eligible Dependent child's losing eligibility as an Eligible 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

When Plan coverage is lost due to the end 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 until 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 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.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered Employee's termination of employment, 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 in order 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, Retiree's, or Limited Access Retiree's death, divorce, or legal separation or an Eligible 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 Plan Administrator in a timely fashion, all of 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. The disability must have started at some time before the 61st day after

the covered Employee's termination of employment 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 Plan 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; and
- (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.

You must also provide this notice within 18 months after the covered Employee's termination of employment 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 Plan Administrator during the 60-day notice period and within 18 months after the covered Employee's termination of employment, 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 Eligible 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. 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, an Eligible 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 Plan 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 Plan 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).

You must notify the COBRA Administrator if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. You must 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."

You must notify the COBRA Administrator if a qualified beneficiary ceases to be 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 mailed or hand-delivered to the individual at the payment address 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 or hand-deliver 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

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering 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, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) 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 Plan 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 Plan Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your 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 as long as 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 considered to be 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 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 or hand-deliver notices which are required to be provided to the Plan Administrator to the address below:

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

You must mail or hand-deliver notices which are required to be provided to the COBRA Administrator to the address below:

WEX, Inc.
4321 20th Ave S
Fargo, ND 58103

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above 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 Plan 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 Plan 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 Plan 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, Retiree, or Limited Access Retiree (i.e., the person 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.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit 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.

Plan Contact Information

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

The COBRA Administrator can be contacted at:

WEX, Inc.
4321 20th Ave S Fargo,
ND 58103
1-866-451-3399

7.23 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.
- 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 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 Qualified Medical Child Support Order as set forth in ERISA § 609, (ii) if the Order is found to be a Qualified Medical Child Support Order 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 Qualified Medical Child Support Order.
- 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 Summary Plan Description to each alternate recipient under the Order (or his/her designated representative).
- f. Effective with the alternate recipient's benefit commencement date, the Plan Administrator shall take the necessary steps to deduct any applicable premiums from the employee-parent's payroll check, either on a pretax or post-tax basis, as applicable.

7.24 Other Required Notices.

- a. HIPAA Notice of Privacy Practices. You have been furnished a Notice of Privacy Practices describing the practices the Plan will follow with regard to your "protected health information" (see Exhibit B). The Employer will not receive any protected health information with respect to any services provided at the Clinic, except as allowed by law. If you would like to receive another copy of the Notice of Privacy Practices, please contact:

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

**BASIN ELECTRIC POWER COOPERATIVE ONSITE HEALTH
CLINIC SUMMARY PLAN DESCRIPTION**

EXHIBIT A

CLAIMS AND APPEALS PROCEDURES

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 of time 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 by 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 with regard to 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 ONSITE HEALTH CLINIC
SUMMARY PLAN DESCRIPTION**

EXHIBIT B

NOTICE OF PRIVACY PRACTICES

Please see next page for Notice of Privacy Practices

Basin Electric Power Cooperative Group Health Plans Notice of Privacy Practices

Robert Kremers, Privacy Officer
Basin Electric Power Cooperative
1717 East Interstate Avenue
Bismarck, North Dakota 58503-0564
(701) 557-5682



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

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.

continued on next page

Your Rights *continued*

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
- Contact you for fundraising efforts

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
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Do research	• We can use or share your information for health research.
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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.
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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.
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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
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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.
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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 January 1, 2022

This Notice of Privacy Practices applies to the following organizations.

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