ORIGINAL

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

Application of Water Service Corporation of Kentucky for an Adjustment of Rates	)))	Case No. 2005-00325

WATER SERVICE CORPORATION OF KENTUCKY RESPONSE TO COMMISSION STAFF'S SECOND INFORMATION REQUEST

Water Service Corporation of Kentucky (WSCK), by counsel, files the attached responses to the Commission's second data request.

Submitted by:

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Certificate of Service:

A copy of this Response was delivered to David Spenard of the Attorney General's Office, 1024 Capital Center Dr, Frankfort, KY 40601 the 7th day of February, 2006.

John N. Hughes

COMMISSION STAFF'S SECOND INFORMATION REQUEST TO WATER SERVICE CORPORATION OF KENTUCKY

DATA REQUEST #1

List each case before any state public utility regulatory commissions in which Kirsten E. Weeks has testified and describe the subject matter of her testimony in that case.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Ms. Weeks has testified in Illinois, Pennsylvania, North Carolina, South Carolina, Ohio and New Jersey. The subject matter of her testimony was rate proceedings.

DATA REQUEST #2

State whether Ms. Weeks conducted a review of Kentucky statutory and decisional law on rate-making practices prior to the filing of her written testimony. If Ms. Weeks conducted such review, describe the nature and extent of this review.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Yes, a review was conducted. The nature of Ms. Weeks' studies was regarding regulatory proceedings. She conducted a thorough review in order to file the case.

3) At pages 7 and 8 of her testimony, Ms. Ahern quotes Value Line Investment Survey ("Value Line") on the ability of large water companies to withstand the burden of increasing costs associated with an aging infrastructure and the threat of bioterrorism. Value Line describes how larger companies are acquiring smaller ones that are unable to deal with the financial pressures, and focuses on Aqua America, the largest water utility in its survey and one that offers the highest return on equity of the stocks in the water industry. Explain the connection between acquisitions and the return on equity of a water company. Provide all workpapers, sources, and written materials used to develop the response.

Response: (Witness Responsible – Pauline M. Ahern)

Acquisitions allow a company to grow its customer base, and hence, its revenues and earnings while simultaneously reducing expenses through economies of scale thereby increasing its achieved rate of return on common equity. Value Line Investment Survey's statement that Aqua America Inc. offers the highest return on equity of the stocks in the water industry refers to the projected returns on equity for 2005, 2006 and 2008-2010 as shown on pages 8-10 of Schedule PMA-9. In each case, Value Line Investment Survey projects the highest return on equity for Aqua America.

4) At page 8 of her testimony, Ms. Ahern states that the water industry is much more capital-intensive than the electric, natural gas or telephone industries.

a) List all sources and materials that Ms. Ahern relied upon for this statement.

b) Provide all workpapers and written materials Ms. Ahern relied upon for her statement.

c) State Ms. Ahern's opinion as to how much more capital-intensive the water industry is compared to:

1) the electric industry.

2) the telephone industry.

3) the natural gas industry.

Response: (Witness Responsible – Pauline M. Ahern)

a) See attachment 4-a.

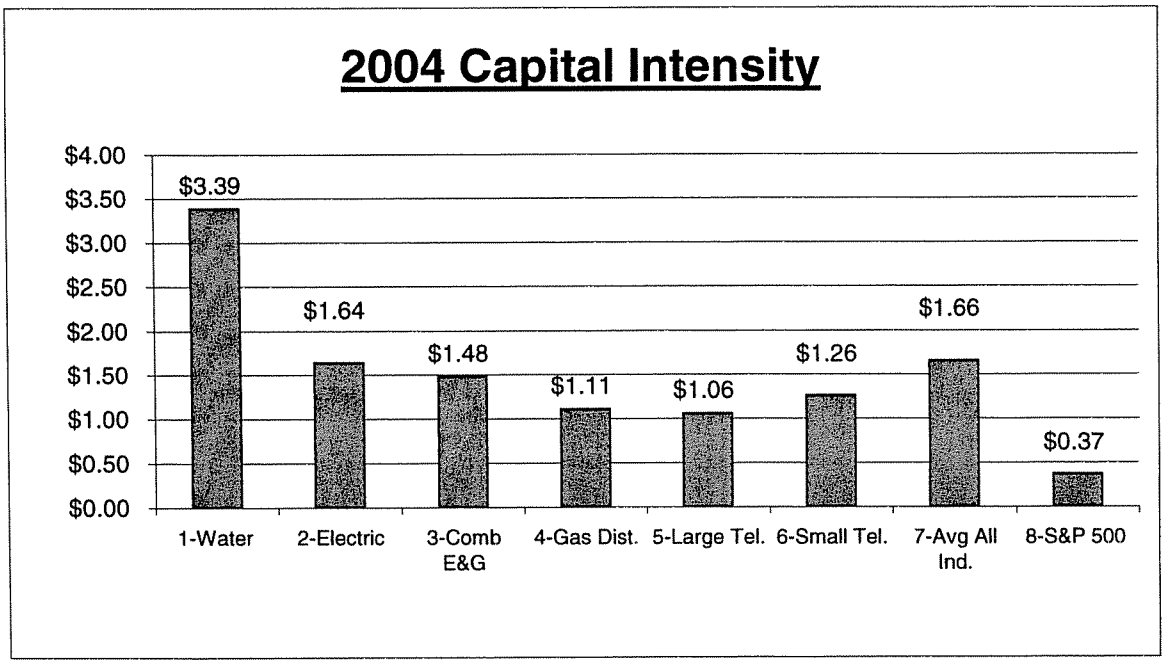
b) See attachment 4-a.

c) See attachment 4-a.

Attachment 4-a

2004
CAPITAL INTENSITY
AUS UTILITY REPORTS
UTILITY AND TELECOMMUNICATIONS INDUSTRIES
AND S&P 500 INDUSTRY AVERAGE

	Average Net Plant ($ mill)	Average Total Operating Revenue ($ mill)	Capital Intensity ($)	Capital Intensity of Water Industry v. Other Industries
Water Industry Average	$ 524.07	$ 154.51	$ 3.39	- -
Electric Industry Average	$ 6,744.09	$ 4,106.92	$ 1.64	106.71%
Combination Elec. & Gas Industry Average	$ 8,453.79	$ 5,728.75	$ 1.48	129.05%
Gas Distribution Average	$ 1,842.73	$ 1,665.73	$ 1.11	205.41%
Large Telephone Cos. Ind. Average	$ 15,852.20	$ 14,976.19	$ 1.06	219.81%
Small Telephone Cos. Ind. Average	$ 141.39	$ 112.27	$ 1.26	169.05%
Average All AUS Utility Reports Groups	**$ 5,593.04**	**$ 4,457.39**	**$ 1.66**	104.63%
S&P 500 Industry Average	**$ 5,276.82**	**$ 14,164.87**	**$ 0.37**	816.22%



Group 1 - Water Industry Average
Group 2 - Electric Industry Average
Group 3 - Combination Electric & Gas Industry Average
Group 4 - Gas Distribution Industry Average
Group 5 - Large Telephone Cos. Industry Average
Group 6 - Small Telephone Cos. Industry Average
Group 7 - Average For All AUS Utility Reports Companies
Group 8 - Average S&P 500 Industry Average

Notes:

Capital Intensity is equal to Net Plant divided by Total Operating Revenue.

Distribution Group excludes El Paso Energy and The Williams Companies. Two transmission companies, which were formerly part of the AUS Utility Reports Transmission Group. That group has been eliminated. Also, due to the nature of their business, they have been eliminated from the averages.

Large Telephone group excludes Qwest Communications. The company shows Not Meaningul Figures.

The S&P 500 Group excludes 13 companies, which S&P Compustate Services, Inc. reports as having "Not Meaningful" or "Not Available" data.

Source of Information:
Standard & Poor's Compustat Service, Inc.
PC Plus/Research Insight Database

AUS Utility Reports - January 2006
Published By AUS Consultants

WATER COMPANIES

	Ticker	Name of Company	Fiscal Year	Net Plant	Total Oper. Rev.
1	AWR	AMERICAN STATES WATER CO	Y04	664.165	228.005
2	WTR	AQUA AMERICA INC	Y04	2,069.812	442.039
3	ARTNA	ARTESIAN RESOURCES -CL A	Y04	212.489	39.582
4	CWT	CALIFORNIA WATER SERVICE GP	Y04	800.305	315.567
5	CTWS	CONNECTICUT WATER SVC INC	Y04	241.776	48.493
6	MSEX	MIDDLESEX WATER CO	Y04	256.366	70.991
7	PNNW	PENNICHUCK CORP	Y04	90.886	23.025
8	SJW	SJW CORP	Y04	462.356	166.911
9	SWWC	SOUTHWEST WATER CO	Y04	302.596	187.952
10	YORW	YORK WATER CO	Y04	139.961	22.504
	Average		**2004**	**524.071**	**154.507**

ELECTRIC COMPANIES

	Ticker	Name of Company	Fiscal Year	Net Plant	Total Oper. Rev.
1	ALE	ALLETE INC	Y04	883.100	751.400
2	AYE	ALLEGHENY ENERGY INC	Y04	6303.018	2756.121
3	AEP	AMERICAN ELECTRIC POWER	Y04	22,801.000	14,057.000
4	CV	CENTRAL VERMONT PUB SERV	Y04	299.460	302.200
5	CNL	CLECO CORP	Y04	1,060.045	745.817
6	DPL	DPL INC	Y04	2,530.100	1,199.900
7	DQE	DUQUESNE LIGHT HOLDINGS INC	Y04	1,459.400	897.300
8	EIX	EDISON INTERNATIONAL	Y04	13,475.000	10,199.000
9	EE	EL PASO ELECTRIC CO	Y04	1,283.047	708.628
10	EDE	EMPIRE DISTRICT ELECTRIC CO	Y04	857.035	325.540
11	FE	FIRSTENERGY CORP	Y04	13,478.356	12,453.046
12	FPL	FPL GROUP INC	Y04	21,226.000	10,522.000
13	GXP	GREAT PLAINS ENERGY INC	Y04	2,734.450	2,464.018
14	GMP	GREEN MOUNTAIN POWER CORP	Y04	232.712	228.816
15	HE	HAWAIIAN ELECTRIC INDS	Y04	2,186.798	1,924.057
16	IDA	IDACORP INC	Y04	2,163.754	844.491
17	MAM	MAINE & MARITIMES CORP	Y04	61.117	37.138
18	OGE	OGE ENERGY CORP	Y04	3,581.000	4,926.600
19	OTTR	OTTER TAIL CORP	Y04	682.098	882.324
20	PNW	PINNACLE WEST CAPITAL CORP	Y04	7,430.001	2,899.725
21	PGN	PROGRESS ENERGY INC	Y04	14,363.000	9,772.000
22	SO	SOUTHERN CO	Y04	28,361.000	11,902.000
23	TXU	TXU CORP	Y04	16,676.000	9,308.000
24	UIL	UIL HOLDINGS CORP	Y04	563.852	1,101.287
25	WR	WESTAR ENERGY INC	Y04	3,910.908	1,464.489
	Average		**2004**	**6,744.090**	**4,106.916**

COMBINATION ELEC. & GAS COMPANIES

	Ticker	Name of Company	Fiscal Year	Net Plant	Total Oper. Rev.
1	AES	AES CORP. (THE)	Y04	18,788.000	9,486.000
2	LNT	ALLIANT ENERGY CORP	Y04	4672.800	2958.700
3	AEE	AMEREN CORP	Y04	13,297.000	5,160.000
4	ILA	AQUILA INC	Y04	2,777.400	1,711.000
5	AVA	AVISTA CORP	Y04	1,956.063	1,151.580
6	BKH	BLACK HILLS CORP	Y04	1,445.732	1,121.701
7	CNP	CENTERPOINT ENERGY INC	Y04	8,186.393	8,510.428
8	CHG	CH ENERGY GROUP INC	Y04	745.067	791.512
9	CIN	CINERGY CORP	Y04	9,929.465	4,687.950
10	CMS	CMS ENERGY CORP	Y04	8,636.000	5,472.000
11	ED	CONSOLIDATED EDISON INC	Y04	15,168.000	9,882.000
12	CEG	CONSTELLATION ENERGY GRP INC	Y04	10,086.600	12,549.700
13	D	DOMINION RESOURCES INC	Y04	26,716.000	13,972.000
14	DTE	DTE ENERGY CO	Y04	10,491.000	7,114.000
15	DUK	DUKE ENERGY CORP	Y04	33,506.000	22,503.000
16	EAS	ENERGY EAST CORP	Y04	5,662.168	4,756.692
17	ETR	ENTERGY CORP	Y04	18,695.631	10,123.724
18	EXC	EXELON CORP	Y04	21,482.000	14,515.000
19	FPU	FLORIDA PUBLIC UTILITIES CO	Y04	118.723	110.039
20	MDU	MDU RESOURCES GROUP INC	Y04	2,572.705	2,719.257
21	MGEE	MGE ENERGY INC	Y04	607.398	424.881
22	NI	NISOURCE INC	Y04	8,946.500	6,666.200
23	NU	NORTHEAST UTILITIES	Y04	5,864.161	6,686.699
24	NWEC	NORTHWESTERN CORP	Y04	1,379.060	1,038.989
25	NST	NSTAR	Y04	3,425.015	2,954.332
26	POM	PEPCO HOLDINGS INC	Y04	7,088.000	7,221.800
27	PCG	PG&E CORP	Y04	18,989.000	11,080.000
28	PNM	PNM RESOURCES INC	Y04	2,324.586	1,604.792
29	PPL	PPL CORP	Y04	11209.000	5812.000
30	PEG	PUBLIC SERVICE ENTRP GRP INC	Y04	13750.000	10996.000
31	PSD	PUGET ENERGY INC	Y04	4,228.358	2,568.813
32	SCG	SCANA CORP	Y04	6,762.000	3,885.000
33	SRE	SEMPRA ENERGY	Y04	11,086.000	9,410.000
34	SRP	SIERRA PACIFIC RESOURCES	Y04	4,926.926	2,823.839
35	TE	TECO ENERGY INC	Y04	4,657.900	2,669.100
36	UNS	UNISOURCE ENERGY CORP	Y04	2,081.137	1,168.978
37	UTL	UNITIL CORP	Y04	204.003	214.137
38	VVC	VECTREN CORP	Y04	2,156.200	1,689.800
39	WEC	WISCONSIN ENERGY CORP	Y04	5,903.100	3,431.100
40	WPS	WPS RESOURCES CORP	Y04	1,988.400	4,890.600
41	XEL	XCEL ENERGY INC	Y04	14,095.955	8,345.259
	Average		**2004**	**8,453.791**	**5,728.746**

GAS DISTRIBUTION COMPANIES

	Ticker	Name of Company	Fiscal Year	Net Plant	Total Oper. Rev.
1	ATG	AGL RESOURCES INC	Y04	3,178.000	1,832.000
2	ATO	ATMOS ENERGY CORP	Y04	1,722.521	2,920.037
3	CGC	CASCADE NATURAL GAS CORP	Y04	334.574	318.078
4	CPK	CHESAPEAKE UTILITIES CORP	Y04	177.053	177.955
5	DGAS	DELTA NATURAL GAS CO INC	Y04	115.216	79.194
6	EGN	ENERGEN CORP	Y04	568.273	937.384
7	EWST	ENERGY WEST INC	Y04	37.380	73.291
8	ENSI	ENERGYSOUTH INC	Y04	204.597	115.972

Total Industry Averages

Water	**2004**	**524.071**	**154.507**
Electric	**2004**	**6,744.090**	**4,106.916**
Comb. Elec. & Gas	**2004**	**8,453.791**	**5,728.746**
Gas Dist.	**2004**	**1,842.730**	**1,665.727**
Large Telcos	**2004**	**15,852.197**	**14,976.191**
Small Telcos	**2004**	**141.388**	**112.275**
S&P 500	**2004**	**5,276.818**	**14,164.874**

9	EQT	EQUITABLE RESOURCES INC	Y04	1,879.787	1,191.609
10	KSE	KEYSPAN CORP	Y04	7,059.181	6,650.466
11	KMI	KINDER MORGAN INC	Y04	5,851.965	1,164.933
12	LG	LACLEDE GROUP INC	Y04	646.875	1,250.320
13	NFG	NATIONAL FUEL GAS CO	Y04	3,006.764	2,031.393
14	NJR	NEW JERSEY RESOURCES CORP	Y04	861.719	2,533.607
15	GAS	NICOR INC	Y04	2,549.800	2,739.700
16	NWN	NORTHWEST NATURAL GAS CO	Y04	1,289.686	707.604
17	OKE	ONEOK INC	Y04	3,786.821	5,988.080
18	PGL	PEOPLES ENERGY CORP	Y04	1,904.185	2,260.199
19	PNY	PIEDMONT NATURAL GAS CO	Y04	1,849.823	1,529.739
20	STR	QUESTAR CORP	Y04	2,984.660	1,901.431
21	RGCO	RGC RESOURCES INC	Y04	69.999	103.147
22	SEN	SEMCO ENERGY INC	Y04	559.674	508.336
23	SJI	SOUTH JERSEY INDUSTRIES INC	Y04	732.781	819.076
24	SUG	SOUTHERN UNION CO	Y04	3,207.513	1,799.974
25	SWX	SOUTHWEST GAS CORP	Y04	2,335.992	1,477.060
26	SWN	SOUTHWESTERN ENERGY CO	Y04	984.156	477.137
27	UGI	UGI CORP	Y04	1,781.900	3,784.700
28	WGL	WGL HOLDINGS INC	Y04	1,915.551	1,267.948
	Average		**2004**	**1,842.730**	**1,665.727**

LARGE TELEPHONE COMPANIES

	Ticker	Name of Company	Fiscal Year	Net Plant	Total Oper. Rev.
1	AT	ALLTEL CORP	Y04	7,548.100	8,246.100
2	T	AT&T INC	Y04	50,046.000	40,787.000
3	BCE	BCE INC	Y04	17,781.285	15,948.978
4	BLS	BELLSOUTH CORP	Y04	22,039.000	20,350.000
5	CTL	CENTURYTEL INC	Y04	3,341.401	2,410.885
6	CBB	CINCINNATI BELL INC	Y04	851.100	1,207.100
7	CZN	CITIZENS COMMUNICATIONS CO	Y04	3,338.300	2,192.980
8	CTCO	COMMONWLTH TELE ENTER	Y04	382.523	335.051
9	GNCMA	GENERAL COMMUNICATION -CL A	Y04	454.754	424.826
10	S	SPRINT NEXTEL CORP	Y04	22,628.000	27,428.000
11	TDS	TELEPHONE & DATA SYSTEMS INC	Y04	3,385.481	3,720.389
12	CLEC	US LEC CORP	Y04	158.617	356.181
13	VZ	VERIZON COMMUNICATIONS INC	Y04	74,124.000	71,283.000
	Average		**2004**	**15,852.197**	**14,976.191**

SMALL TELEPHONE COMPANIES

	Ticker	Name of Company	Fiscal Year	Net Plant	Total Oper. Rev.
1	ANK	ATLANTIC TELE-NETWORK INC	Y04	100.092	88.252
2	CTCI	CT COMMUNICATIONS INC	Y04	207.072	163.680
3	DECC	D & E COMMUNICATIONS INC	Y04	182.573	176.271
4	HCT	HECTOR COMMUNICATIONS CORP	Y04	40.041	31.570
5	HTCO	HICKORY TECH CORP	Y04	114.692	90.515
6	NPSI	NORTH PITTSBURGH SYSTEMS	Y04	80.046	108.469
7	SURW	SUREWEST COMMUNICATIONS	Y04	365.613	211.763
8	WWVY	WARWICK VALLEY TELEPHONE CO	Y04	40.971	27.678
	Average		**2004**	**141.388**	**112.275**

S&P 500

	Ticker				
1	A	AGILENT TECHNOLOGIES INC	Y04	1258.000	7181.000
2	AA	ALCOA INC	Y04	12592.000	23478.000
3	AAPL	APPLE COMPUTER INC	Y04	707.000	8279.000
4	ABC	AMERISOURCEBERGEN CORP	Y04	465.264	53178.953
5	ABI	APPLERA CORP APPLIED BIOSYS	Y04	402.908	1741.098
6	ABS	ALBERTSONS INC	Y04	10472.000	39897.000
7	ABT	ABBOTT LABORATORIES	Y04	6007.874	19680.016
8	ACS	AFFILIATED COMP SVCS -CL A	Y04	521.772	4106.393
9	ACV	ALBERTO-CULVER CO	Y04	293.901	3257.996
10	ADBE	ADOBE SYSTEMS INC	Y04	99.675	1666.581
11	ADCT	ADC TELECOMMUNICATIONS INC	Y04	233.000	784.300
12	ADI	ANALOG DEVICES	Y04	667.779	2633.800
13	ADM	ARCHER-DANIELS-MIDLAND CO	Y04	5254.738	36151.395
14	ADP	AUTOMATIC DATA PROCESSING	Y04	642.353	7754.942
15	ADSK	AUTODESK INC	Y04	69.566	1234.267
16	AEE	AMEREN CORP	Y04	13297.000	5160.000
17	AEP	AMERICAN ELECTRIC POWER	Y04	22801.000	14057.000
18	AES	AES CORP. (THE)	Y04	18788.000	9486.000
19	AET	AETNA INC	Y04	233.600	19904.100
20	AFL	AFLAC INC	Y04	515.000	13275.000
21	AGN	ALLERGAN INC	Y04	468.500	2045.600
22	AHC	AMERADA HESS CORP	Y04	8505.000	16733.000
23	AIG	AMERICAN INTERNATIONAL GROUP	Y04	38897.000	97152.000
24	AIV	APARTMENT INVT &MGMT -CL A	Y04	8785.046	1499.617
25	ALL	ALLSTATE CORP	Y04	1018.000	33936.000
26	ALTR	ALTERA CORP	Y04	159.587	1016.364
27	AMAT	APPLIED MATERIALS INC	Y04	1345.528	8013.053
28	AMCC	APPLIED MICRO CIRCUITS CORP	Y04	44.461	253.756
29	AMD	ADVANCED MICRO DEVICES	Y04	4233.807	5001.435
30	AMGN	AMGEN INC	Y04	4712.000	10550.000
31	AMP	AMERIPRISE FINANCIAL INC	Y04	677.000	7245.000
32	AMZN	AMAZON.COM INC	Y04	246.156	6921.124
33	AN	AUTONATION INC	Y04	1836.300	19424.699
34	ANDW	ANDREW CORP	Y04	225.366	1838.749
35	AOC	AON CORP	Y04	664.000	10172.000
36	APA	APACHE CORP	Y04	13860.359	5308.017
37	APC	ANADARKO PETROLEUM CORP	Y04	15913.000	6067.000
38	APCC	AMERICAN POWER CONVERSION CP	Y04	154.851	1699.877
39	APD	AIR PRODUCTS & CHEMICALS INC	Y04	5702.200	7411.400
40	APOL	APOLLO GROUP INC -CL A	Y04	169.377	1798.423
41	ASD	AMERICAN STANDARD COS INC	Y04	1616.600	9508.800
42	ASH	ASHLAND INC	Y04	1256.000	8349.000
43	ASN	ARCHSTONE-SMITH TRUST	Y04	8547.496	891.231
44	ASO	AMSOUTH BANCORPORATION	Y04	1060.574	3031.700
45	AT	ALLTEL CORP	Y04	7548.100	8246.100

46	ATI	ALLEGHENY TECHNOLOGIES INC	Y04	718.300	2733.000
47	AV	AVAYA INC	Y04	509.000	4057.000
48	AVP	AVON PRODUCTS	Y04	1014.800	7747.800
49	AVY	AVERY DENNISON CORP	Y04	1381.000	5340.900
50	AW	ALLIED WASTE INDUSTRIES INC	Y04	4129.900	5362.000
51	AXP	AMERICAN EXPRESS CO	Y04	3083.000	29907.000
52	AYE	ALLEGHENY ENERGY INC	Y04	6303.018	2756.121
53	AZO	AUTOZONE INC	Y04	1790.089	5637.025
54	BA	BOEING CO	Y04	8443.000	52457.000
55	BAC	BANK OF AMERICA CORP	Y04	7517.000	65447.000
56	BAX	BAXTER INTERNATIONAL INC	Y04	4369.000	9509.000
57	BBBY	BED BATH & BEYOND INC	Y04	609.631	5147.678
58	BBT	BB&T CORP	Y04	1283.546	6665.966
59	BBY	BEST BUY CO INC	Y04	2464.000	27433.000
60	BC	BRUNSWICK CORP	Y04	876.400	5229.300
61	BCR	BARD (C.R.) INC	Y04	260.800	1656.100
62	BDK	BLACK & DECKER CORP	Y04	754.600	5398.400
63	BDX	BECTON DICKINSON & CO	Y04	1880.997	4934.745
64	BEN	FRANKLIN RESOURCES INC	Y04	470.578	3492.897
65	BF.B	BROWN-FORMAN -CL B	Y04	501.000	2312.000
66	BHI	BAKER HUGHES INC	Y04	1334.100	6103.800
67	BIIB	BIOGEN IDEC INC	Y04	1525.225	2211.562
68	BJS	BJ SERVICES CO	Y04	913.713	2600.986
69	BK	BANK OF NEW YORK CO INC	Y04	1097.000	7093.000
70	BLI	BIG LOTS INC	Y04	648.741	4375.072
71	BLL	BALL CORP	Y04	1532.400	5440.200
72	BLS	BELLSOUTH CORP	Y04	22039.000	20350.000
73	BMC	BMC SOFTWARE INC	Y04	383.700	1463.000
74	BMET	BIOMET INC	Y04	322.887	1879.950
75	BMS	BEMIS CO INC	Y04	938.574	2834.394
76	BMY	BRISTOL-MYERS SQUIBB CO	Y04	5765.000	19380.000
77	BNI	BURLINGTON NORTHERN SANTA FE	Y04	25814.000	10946.000
78	BOL	BAUSCH & LOMB INC	Y04	580.900	2232.300
79	BR	BURLINGTON RESOURCES INC	Y04	11033.000	5618.000
80	BRCM	BROADCOM CORP -CL A	Y04	107.160	2400.610
81	BSC	BEAR STEARNS COMPANIES INC	Y04	381.403	8399.902
82	BSX	BOSTON SCIENTIFIC CORP	Y04	870.000	5624.000
83	BUD	ANHEUSER-BUSCH COS INC	Y04	8847.400	14934.200
84	CA	COMPUTER ASSOCIATES INTL INC	Y04	622.000	3560.000
85	CAG	CONAGRA FOODS INC	Y04	2848.300	14566.900
86	CAH	CARDINAL HEALTH INC	Y04	2364.000	65053.500
87	CAT	CATERPILLAR INC	Y04	7682.000	30251.000
88	CB	CHUBB CORP	Y04	883.800	13152.500
89	CBE	COOPER INDUSTRIES LTD	Y04	696.400	4462.900
90	CBSS	COMPASS BANCSHARES INC	Y04	537.466	1891.116
91	CC	CIRCUIT CITY STORES INC	Y04	738.802	10477.928
92	CCE	COCA-COLA ENTERPRISES INC	Y04	6913.000	18158.000
93	CCL	CARNIVAL CORP	Y04	20823.000	9727.000
94	CCU	CLEAR CHANNEL COMMUNICATIONS	Y04	4124.274	9418.459
95	CD	CENDANT CORP	Y04	13098.000	19665.000
96	CEG	CONSTELLATION ENERGY GRP INC	Y04	10086.600	12549.700
97	CFC	COUNTRYWIDE FINANCIAL CORP	Y04	985.350	13835.334
98	CHIR	CHIRON CORP	Y04	799.415	1605.109
99	CI	CIGNA CORP	Y04	777.000	17877.000
100	CIEN	CIENA CORP	Y04	51.252	298.707
101	CIN	CINERGY CORP	Y04	9929.465	4687.950
102	CINF	CINCINNATI FINANCIAL CORP	Y04	156.000	3614.000
103	CIT	CIT GROUP INC	Y04	8290.900	4672.800
104	CL	COLGATE-PALMOLIVE CO	Y04	2647.700	10584.200
105	CLX	CLOROX CO/DE	Y04	1052.000	4324.000
106	CMA	COMERICA INC.	Y04	415.000	3087.000
107	CMCSA	COMCAST CORP	Y04	18711.000	20307.000
108	CMI	CUMMINS INC	Y04	1648.000	8438.000
109	CMS	CMS ENERGY CORP	Y04	8636.000	5472.000
110	CMVT	COMVERSE TECHNOLOGY INC	Y04	122.174	959.442
111	CMX	CAREMARK RX INC	Y04	285.214	25801.121
112	CNP	CENTERPOINT ENERGY INC	Y04	8186.393	8510.428
113	COF	CAPITAL ONE FINANCIAL CORP	Y04	817.704	10694.577
114	COH	COACH INC	Y04	148.524	1321.106
115	COL	ROCKWELL COLLINS INC	Y04	418.000	2930.000
116	COP	CONOCOPHILLIPS	Y04	50902.000	118719.000
117	COST	COSTCO WHOLESALE CORP	Y04	7263.697	48106.992
118	CPB	CAMPBELL SOUP CO	Y04	1901.000	7109.000
119	CPWR	COMPUWARE CORP	Y04	418.241	1231.839
120	CSC	COMPUTER SCIENCES CORP	Y04	2365.400	14058.600
121	CSCO	CISCO SYSTEMS INC	Y04	3290.000	22045.000
122	CSX	CSX CORP	Y04	19945.000	8020.000
123	CTAS	CINTAS CORP	Y04	817.198	3067.283
124	CTB	COOPER TIRE & RUBBER CO	Y04	729.420	2081.609
125	CTL	CENTURYTEL INC	Y04	3341.401	2410.885
126	CTX	CENTEX CORP	Y04	162.305	12859.695
127	CTXS	CITRIX SYSTEMS INC	Y04	69.281	741.157
128	CVG	CONVERGYS CORP	Y04	416.600	2487.700
129	CVH	COVENTRY HEALTH CARE INC	Y04	32.193	5311.969
130	CVS	CVS CORP	Y04	3505.900	30594.301
131	CVX	CHEVRON CORP	Y04	44458.000	142897.000
132	CZN	CITIZENS COMMUNICATIONS CO	Y04	3338.300	2192.980
133	D	DOMINION RESOURCES INC	Y04	26716.000	13972.000
134	DCN	DANA CORP	Y04	2153.000	9078.000
135	DD	DU PONT (E I) DE NEMOURS	Y04	10224.000	27491.000
136	DDS	DILLARDS INC -CL A	Y04	3180.756	7732.371
137	DE	DEERE & CO	Y04	3458.500	19731.100
138	DELL	DELL INC	Y04	1691.000	49205.000
139	DG	DOLLAR GENERAL CORP	Y04	1080.838	7660.927
140	DGX	QUEST DIAGNOSTICS INC	Y04	619.485	5126.601
141	DHI	D R HORTON INC	Y04	91.900	10840.800
142	DHR	DANAHER CORP	Y04	752.966	6889.301
143	DIS	DISNEY (WALT) CO	Y04	22420.000	30752.000

144	DJ	DOW JONES & CO INC	Y04	660.024	1671.458
145	DOV	DOVER CORP	Y04	756.680	5488.112
146	DOW	DOW CHEMICAL	Y04	13828.000	40161.000
147	DRI	DARDEN RESTAURANTS INC	Y04	2351.454	5278.110
148	DTE	DTE ENERGY CO	Y04	10491.000	7114.000
149	DUK	DUKE ENERGY CORP	Y04	33506.000	22503.000
150	DVN	DEVON ENERGY CORP	Y04	19346.000	9189.000
151	DYN	DYNEGY INC	Y04	6130.000	6153.000
152	EBAY	EBAY INC	Y04	709.773	3271.309
153	EC	ENGELHARD CORP	Y04	911.029	4166.420
154	ECL	ECOLAB INC	Y04	834.730	4184.933
155	ED	CONSOLIDATED EDISON INC	Y04	15168.000	9882.000
156	EDS	ELECTRONIC DATA SYSTEMS CORP	Y04	2216.000	20669.000
157	EFX	EQUIFAX INC	Y04	141.800	1272.800
158	EIX	EDISON INTERNATIONAL	Y04	13475.000	10199.000
159	EK	EASTMAN KODAK CO	Y04	4512.000	13517.000
160	EMC	EMC CORP/MA	Y04	1571.810	8229.488
161	EMN	EASTMAN CHEMICAL CO	Y04	3192.000	6580.000
162	EMR	EMERSON ELECTRIC CO	Y04	2937.000	15615.000
163	EOG	EOG RESOURCES INC	Y04	5101.603	2268.892
164	EOP	EQUITY OFFICE PROPERTIES TR	Y04	22140.176	3254.457
165	EP	EL PASO CORP	Y04	18812.000	5874.000
166	EQR	EQUITY RESIDENTIAL	Y04	12252.794	1892.861
167	ERTS	ELECTRONIC ARTS INC	Y04	353.000	3129.000
168	ESRX	EXPRESS SCRIPTS INC	Y04	181.166	15109.228
169	ET	E TRADE FINANCIAL CORP	Y04	302.291	2083.254
170	ETN	EATON CORP	Y04	2147.000	9817.000
171	ETR	ENTERGY CORP	Y04	18695.631	10123.724
172	EXC	EXELON CORP	Y04	21482.000	14515.000
173	F	FORD MOTOR CO	Y04	44551.000	171652.000
174	FCX	FREEPRT MCMOR COP&GLD -CL B	Y04	3199.292	2371.866
175	FD	FEDERATED DEPT STORES	Y04	6018.000	16084.000
176	FDC	FIRST DATA CORP	Y04	854.800	10013.200
177	FDO	FAMILY DOLLAR STORES	Y04	918.449	5281.888
178	FDX	FEDEX CORP	Y04	9643.000	29363.000
179	FE	FIRSTENERGY CORP	Y04	13478.356	12453.046
180	FHN	FIRST HORIZON NATIONAL CORP	Y04	379.359	2529.988
181	FII	FEDERATED INVESTORS INC	Y04	27.166	846.964
182	FISV	FISERV INC	Y04	213.799	3729.746
183	FITB	FIFTH THIRD BANCORP	Y04	1619.000	6422.000
184	FLR	FLUOR CORP	Y04	527.808	9380.277
185	FO	FORTUNE BRANDS INC	Y04	1378.100	7021.200
186	FPL	FPL GROUP INC	Y04	21226.000	10522.000
187	FRX	FOREST LABORATORIES -CL A	Y04	362.028	3113.777
188	FSH	FISHER SCIENTIFIC INTL INC	Y04	788.600	4662.700
189	FSL.B	FREESCALE SEMICONDUCTOR INC	Y04	2207.000	5715.000
190	GAS	NICOR INC	Y04	2549.800	2739.700
191	GCI	GANNETT CO	Y04	2753.445	7381.283
192	GD	GENERAL DYNAMICS CORP	Y04	2169.000	19178.000
193	GDT	GUIDANT CORP	Y04	808.900	3765.600
194	GDW	GOLDEN WEST FINANCIAL CORP	Y04	391.523	4472.779
195	GE	GENERAL ELECTRIC CO	Y04	63334.000	151802.000
196	GENZ	GENZYME CORP	Y04	1310.256	2201.145
197	GILD	GILEAD SCIENCES INC	Y04	223.106	1324.621
198	GIS	GENERAL MILLS INC	Y04	3007.000	11248.000
199	GLW	CORNING INC	Y04	3941.000	3854.000
200	GM	GENERAL MOTORS CORP	Y04	75084.000	190812.000
201	GPC	GENUINE PARTS CO	Y04	379.388	9097.267
202	GPS	GAP INC	Y04	3376.000	16267.000
203	GR	GOODRICH CORP	Y04	1165.000	4724.500
204	GS	GOLDMAN SACHS GROUP INC	Y04	4083.000	29839.000
205	GT	GOODYEAR TIRE & RUBBER CO	Y04	5455.200	18370.400
206	GTW	GATEWAY INC	Y04	102.657	3649.734
207	GWW	GRAINGER (W W) INC	Y04	761.573	5049.785
208	HAL	HALLIBURTON CO	Y04	2553.000	20464.000
209	HAS	HASBRO INC	Y04	206.934	2997.510
210	HBAN	HUNTINGTON BANCSHARES	Y04	355.115	2165.913
211	HCA	HCA INC	Y04	11396.000	23502.000
212	HCR	MANOR CARE INC	Y04	1495.152	3208.867
213	HD	HOME DEPOT INC	Y04	22726.000	73094.000
214	HDI	HARLEY-DAVIDSON INC	Y04	1024.665	5320.452
215	HET	HARRAHS ENTERTAINMENT INC	Y04	4744.977	4548.326
216	HIG	HARTFORD FINANCIAL SERVICES	Y04	643.000	22693.000
217	HLT	HILTON HOTELS CORP	Y04	3510.000	4146.000
218	HMA	HEALTH MANAGEMENT ASSOC	Y04	1692.701	3205.885
219	HNZ	HEINZ (H J) CO	Y04	2163.938	8912.297
220	HON	HONEYWELL INTERNATIONAL INC	Y04	4331.000	25601.000
221	HOT	STARWOOD HOTELS&RESORTS WRLD	Y04	6997.000	5368.000
222	HPC	HERCULES INC	Y04	695.000	1997.000
223	HPQ	HEWLETT-PACKARD CO	Y04	6649.000	79905.000
224	HRB	BLOCK H & R INC	Y04	330.150	4420.019
225	HSP	HOSPIRA INC	Y04	946.304	2645.036
226	HSY	HERSHEY CO	Y04	1682.698	4429.248
227	HUM	HUMANA INC	Y04	399.506	13088.325
228	IBM	INTL BUSINESS MACHINES CORP	Y04	15175.000	96293.000
229	IFF	INTL FLAVORS & FRAGRANCES	Y04	501.334	2033.653
230	IGT	INTL GAME TECHNOLOGY	Y04	329.058	2484.752
231	INTC	INTEL CORP	Y04	15768.000	34209.000
232	INTU	INTUIT INC	Y04	233.101	1867.663
233	IP	INTL PAPER CO	Y04	17368.000	25548.000
234	IPG	INTERPUBLIC GROUP OF COS	Y04	722.900	6387.000
235	IR	INGERSOLL-RAND CO LTD	Y04	1013.200	9393.600
236	ITT	ITT INDUSTRIES INC	Y04	980.900	6764.100
237	ITW	ILLINOIS TOOL WORKS	Y04	1876.875	11731.425
238	JBL	JABIL CIRCUIT INC	Y04	776.353	6252.897
239	JCI	JOHNSON CONTROLS INC	Y04	3529.400	26553.400
240	JCP	PENNEY (J C) CO	Y04	3638.000	18424.000
241	JDSU	JDS UNIPHASE CORP	Y04	195.600	635.900

242	JNJ	JOHNSON & JOHNSON	Y04	10436.000	47348.000
243	JNS	JANUS CAPITAL GROUP INC	Y04	62.000	1010.800
244	JNY	JONES APPAREL GROUP INC	Y04	303.600	4649.700
245	JPM	JPMORGAN CHASE & CO	Y04	9145.000	56931.000
246	JWN	NORDSTROM INC	Y04	1780.366	7304.330
247	K	KELLOGG CO	Y04	2715.100	9613.900
248	KEY	KEYCORP	Y04	603.000	5587.000
249	KG	KING PHARMACEUTICALS INC	Y04	280.731	1304.364
250	KLAC	KLA-TENCOR CORP	Y04	376.052	1496.718
251	KMB	KIMBERLY-CLARK CORP	Y04	7990.500	15083.200
252	KMG	KERR-MCGEE CORP	Y04	10827.000	5157.000
253	KMI	KINDER MORGAN INC	Y04	5851.965	1164.933
254	KO	COCA-COLA CO	Y04	6091.000	21962.000
255	KR	KROGER CO	Y04	11497.000	56434.000
256	KRB	MBNA CORP	Y04	2787.755	12327.005
257	KRI	KNIGHT-RIDDER INC	Y04	947.146	3014.149
258	KSE	KEYSPAN CORP	Y04	7059.181	6650.466
259	KSS	KOHL'S CORP	Y04	3987.945	11700.619
260	LEG	LEGGETT & PLATT INC	Y04	960.700	5085.500
261	LEH	LEHMAN BROTHERS HOLDINGS INC	Y04	2988.000	21250.000
262	LEN	LENNAR CORP	Y04	39.672	10504.899
263	LH	LABORATORY CP OF AMER HLDGS	Y04	360.000	3084.800
264	LIZ	LIZ CLAIBORNE INC	Y04	474.573	4632.828
265	LLL	L-3 COMMUNICATIONS HLDGS INC	Y04	556.972	6896.997
266	LLTC	LINEAR TECHNOLOGY CORP	Y04	201.080	807.281
267	LLY	LILLY (ELI) & CO	Y04	7550.900	13857.900
268	LMT	LOCKHEED MARTIN CORP	Y04	3599.000	35526.000
269	LNC	LINCOLN NATIONAL CORP	Y04	207.118	5236.274
270	LOW	LOWE'S COMPANIES INC	Y04	13911.000	36464.000
271	LPX	LOUISIANA-PACIFIC CORP	Y04	867.400	2849.400
272	LSI	LSI LOGIC CORP	Y04	311.916	1700.164
273	LTD	LIMITED BRANDS INC	Y04	1484.000	9408.000
274	LTR	LOEWS CORP	Y04	4840.700	15202.800
275	LU	LUCENT TECHNOLOGIES INC	Y04	1376.000	9045.000
276	LUV	SOUTHWEST AIRLINES	Y04	8723.000	6530.000
277	LXK	LEXMARK INTL INC -CL A	Y04	792.200	5313.800
278	MAR	MARRIOTT INTL INC	Y04	2389.000	10099.000
279	MAS	MASCO CORP	Y04	2272.000	12074.000
280	MAT	MATTEL INC	Y04	586.526	5102.786
281	MBI	MBIA INC	Y04	114.692	2010.530
282	MCD	MCDONALD'S CORP	Y04	20703.100	19064.699
283	MCK	MCKESSON CORP	Y04	630.500	80514.602
284	MCO	MOODY'S CORP	Y04	45.200	1438.300
285	MDP	MEREDITH CORP	Y04	195.799	1161.652
286	MDT	MEDTRONIC INC	Y04	1859.300	10054.600
287	MEDI	MEDIMMUNE INC	Y04	310.900	1141.100
288	MEL	MELLON FINANCIAL CORP	Y04	688.000	4833.000
289	MER	MERRILL LYNCH & CO INC	Y04	2508.000	32467.000
290	MERQE	MERCURY INTERACTIVE CORP	Y04	78.415	685.547
291	MHP	MCGRAW-HILL COMPANIES	Y04	513.066	5250.538
292	MHS	MEDCO HEALTH SOLUTIONS INC	Y04	657.800	35351.898
293	MI	MARSHALL & ILSLEY CORP	Y04	467.225	3112.285
294	MIL	MILLIPORE CORP	Y04	351.004	883.263
295	MKC	MCCORMICK & COMPANY INC	Y04	486.600	2526.200
296	MMC	MARSH & MCLENNAN COS	Y04	1387.000	12121.000
297	MMM	3M CO	Y04	5711.000	20011.000
298	MNST	MONSTER WORLDWIDE INC	Y04	94.558	845.519
299	MO	ALTRIA GROUP INC	Y04	16305.000	63963.000
300	MOLX	MOLEX INC	Y04	1022.378	2246.715
301	MON	MONSANTO CO	Y04	2087.000	5457.000
302	MOT	MOTOROLA INC	Y04	2332.000	31323.000
303	MRK	MERCK & CO	Y04	14713.700	23430.199
304	MRO	MARATHON OIL CORP	Y04	11810.000	45135.000
305	MSFT	MICROSOFT CORP	Y04	2326.000	36835.000
306	MTB	M & T BANK CORP	Y04	367.204	3236.701
307	MTG	MGIC INVESTMENT CORP/WI	Y04	36.382	1612.693
308	MU	MICRON TECHNOLOGY INC	Y04	4712.700	4404.200
309	MUR	MURPHY OIL CORP	Y04	3685.594	8299.147
310	MWD	MORGAN STANLEY	Y04	6531.000	39549.000
311	MWV	MEADWESTVACO CORP	Y04	6583.000	8227.000
312	MXIM	MAXIM INTEGRATED PRODUCTS	Y04	942.186	1439.263
313	MYG	MAYTAG CORP	Y04	921.162	4721.538
314	MYL	MYLAN LABORATORIES INC	Y04	336.719	1253.374
315	NAV	NAVISTAR INTERNATIONAL CORP	Y04	1444.000	9713.000
316	NBR	NABORS INDUSTRIES LTD	Y04	3275.495	2394.031
317	NCC	NATIONAL CITY CORP	Y04	2319.475	9769.734
318	NCR	NCR CORP	Y04	670.000	5984.000
319	NE	NOBLE CORP	Y04	2743.620	1066.231
320	NEM	NEWMONT MINING CORP	Y04	5360.892	4590.009
321	NFB	NORTH FORK BANCORPORATION	Y04	416.003	1826.655
322	NI	NISOURCE INC	Y04	8946.500	6666.200
323	NKE	NIKE INC -CL B	Y04	1605.800	13739.700
324	NOC	NORTHROP GRUMMAN CORP	Y04	4210.000	29853.000
325	NOV	NATIONAL OILWELL VARCO INC	Y04	255.100	2318.100
326	NOVL	NOVELL INC	Y04	231.468	1152.417
327	NSC	NORFOLK SOUTHERN CORP	Y04	20526.000	7312.000
328	NSM	NATIONAL SEMICONDUCTOR CORP	Y04	605.100	1913.100
329	NTAP	NETWORK APPLIANCE INC	Y04	418.749	1598.131
330	NTRS	NORTHERN TRUST CORP	Y04	465.100	2829.100
331	NUE	NUCOR CORP	Y04	2818.307	11376.828
332	NVDA	NVIDIA CORP	Y04	178.955	2010.033
333	NVLS	NOVELLUS SYSTEMS INC	Y04	476.492	1357.288
334	NWL	NEWELL RUBBERMAID INC	Y04	1308.200	6748.400
335	NWS.A	NEWS CORP	Y04	3868.788	20458.346
336	NYT	NEW YORK TIMES CO -CL A	Y04	1367.384	3303.642
337	ODP	OFFICE DEPOT INC	Y04	1463.028	13564.699
338	OMC	OMNICOM GROUP	Y04	636.400	9747.200
339	OMX	OFFICEMAX INC	Y04	541.452	13270.196

340	ORCL	ORACLE CORP	Y04	1442.000	11799.000
341	OXY	OCCIDENTAL PETROLEUM CORP	Y04	14633.000	11368.000
342	PAYX	PAYCHEX INC	Y04	205.319	1445.143
343	PBG	PEPSI BOTTLING GROUP INC	Y04	3581.000	10906.000
344	PBI	PITNEY BOWES INC	Y04	1123.481	4957.440
345	PCAR	PACCAR INC	Y04	2226.300	11396.300
346	PCG	PG&E CORP	Y04	18989.000	11080.000
347	PCL	PLUM CREEK TIMBER CO INC	Y04	253.000	1528.000
348	PD	PHELPS DODGE CORP	Y04	5318.900	7089.300
349	PDCO	PATTERSON COMPANIES INC	Y04	97.178	2421.457
350	PEG	PUBLIC SERVICE ENTRP GRP INC	Y04	13750.000	10996.000
351	PEP	PEPSICO INC	Y04	8149.000	29261.000
352	PFE	PFIZER INC	Y04	18385.000	52516.000
353	PFG	PRINCIPAL FINANCIAL GRP INC	Y04	429.400	8303.700
354	PG	PROCTER & GAMBLE CO	Y04	14108.000	51407.000
355	PGL	PEOPLES ENERGY CORP	Y04	1904.185	2260.199
356	PGN	PROGRESS ENERGY INC	Y04	14363.000	9772.000
357	PGR	PROGRESSIVE CORP-OHIO	Y04	666.500	13768.200
358	PH	PARKER-HANNIFIN CORP	Y04	1591.853	7106.907
359	PHM	PULTE HOMES INC	Y04	130.700	11711.216
360	PKI	PERKINELMER INC	Y04	235.916	1687.231
361	PLD	PROLOGIS	Y04	5344.510	601.146
362	PLL	PALL CORP	Y04	600.383	1770.747
363	PMCS	PMC-SIERRA INC	Y04	16.177	297.383
364	PMTC	PARAMETRIC TECHNOLOGY CORP	Y04	55.780	660.029
365	PNC	PNC FINANCIAL SVCS GROUP INC	Y04	1482.000	6258.000
366	PNW	PINNACLE WEST CAPITAL CORP	Y04	7430.001	2899.725
367	PPG	PPG INDUSTRIES INC	Y04	2471.000	9513.000
368	PPL	PPL CORP	Y04	11209.000	5812.000
369	PSA	PUBLIC STORAGE INC	Y04	4246.710	950.540
370	PTV	PACTIV CORP	Y04	1445.000	3382.000
371	PX	PRAXAIR INC	Y04	5946.000	6594.000
372	Q	QWEST COMMUNICATION INTL INC	Y04	16853.000	13809.000
373	QCOM	QUALCOMM INC	Y04	675.000	4880.000
374	QLGC	QLOGIC CORP	Y04	77.464	571.903
375	R	RYDER SYSTEM INC	Y04	3811.309	5150.278
376	RAI	REYNOLDS AMERICAN INC	Y04	1129.000	6437.000
377	RBK	REEBOK INTERNATIONAL LTD	Y04	183.799	3785.284
378	RDC	ROWAN COS INC	Y04	1661.898	708.501
379	RF	REGIONS FINANCIAL CORP	Y04	1089.094	4610.039
380	RHI	ROBERT HALF INTL INC	Y04	95.783	2675.696
381	RIG	TRANSOCEAN INC	Y04	7005.200	2613.900
382	ROH	ROHM AND HAAS CO	Y04	2929.000	7300.000
383	ROK	ROCKWELL AUTOMATION	Y04	804.500	4411.100
384	RRD	DONNELLEY (R R) & SONS CO	Y04	1924.500	7156.400
385	RSH	RADIOSHACK CORP	Y04	652.000	4841.200
386	RTN	RAYTHEON CO	Y04	2738.000	20245.000
387	RX	IMS HEALTH INC	Y04	145.214	1569.045
388	S	SPRINT NEXTEL CORP	Y04	22628.000	27428.000
389	SAFC	SAFECO CORP	Y04	380.900	6195.400
390	SANM	SANMINA-SCI CORP	Y04	782.642	12204.607
391	SBL	SYMBOL TECHNOLOGIES	Y04	241.508	1732.123
392	SBUX	STARBUCKS CORP	Y04	1551.416	5294.247
393	SCHW	SCHWAB (CHARLES) CORP	Y04	903.000	4465.000
394	SEBL	SIEBEL SYSTEMS INC	Y04	83.908	1339.793
395	SEE	SEALED AIR CORP	Y04	1008.600	3798.100
396	SFA	SCIENTIFIC-ATLANTA INC	Y04	184.584	1708.004
397	SGP	SCHERING-PLOUGH	Y04	4593.000	8272.000
398	SHLD	SEARS HOLDINGS CORP	Y04	315.000	19701.000
399	SHW	SHERWIN-WILLIAMS CO	Y04	720.360	6123.579
400	SIAL	SIGMA-ALDRICH CORP	Y04	584.400	1409.200
401	SLB	SCHLUMBERGER LTD	Y04	4108.251	11480.165
402	SLE	SARA LEE CORP	Y04	3271.000	19566.000
403	SLM	SLM CORP	Y04	0.000	4368.486
404	SLR	SOLECTRON CORP	Y04	726.600	11638.300
405	SNA	SNAP-ON INC	Y04	313.600	2407.200
406	SNV	SYNOVUS FINANCIAL CP	Y04	638.407	2664.231
407	SO	SOUTHERN CO	Y04	28361.000	11902.000
408	SOV	SOVEREIGN BANCORP INC	Y04	353.337	2706.442
409	SPLS	STAPLES INC	Y04	1600.874	14448.378
410	SRE	SEMPRA ENERGY	Y04	11086.000	9410.000
411	SSP	EW SCRIPPS -CL A	Y04	496.241	2167.503
412	STI	SUNTRUST BANKS INC	Y04	1860.415	7822.828
413	STJ	ST JUDE MEDICAL INC	Y04	326.981	2294.173
414	STT	STATE STREET CORP	Y04	1444.000	5861.000
415	STZ	CONSTELLATION BRANDS -CL A	Y04	1596.367	4087.638
416	SUN	SUNOCO INC	Y04	4966.000	23186.000
417	SUNW	SUN MICROSYSTEMS INC	Y04	1996.000	11185.000
418	SVU	SUPERVALU INC	Y04	2201.005	19528.914
419	SWK	STANLEY WORKS	Y04	398.900	3043.400
420	SWY	SAFEWAY INC	Y04	8689.400	35822.898
421	SYK	STRYKER CORP	Y04	700.500	4262.300
422	SYMC	SYMANTEC CORP	Y04	382.689	2582.849
423	SYY	SYSCO CORP	Y04	2166.809	29335.402
424	T	AT&T INC	Y04	50046.000	40787.000
425	TAP	MOLSON COORS BREWING CO	Y04	1445.584	4305.816
426	TE	TECO ENERGY INC	Y04	4657.900	2669.100
427	TEK	TEKTRONIX INC	Y04	120.546	1034.654
428	TER	TERADYNE INC	Y04	547.075	1791.880
429	TGT	TARGET CORP	Y04	16860.000	46839.000
430	THC	TENET HEALTHCARE CORP	Y04	4820.000	9919.000
431	TIF	TIFFANY & CO	Y04	917.853	2204.831
432	TIN	TEMPLE-INLAND INC	Y04	2401.000	4750.000
433	TJX	TJX COMPANIES INC	Y04	1861.127	14913.483
434	TLAB	TELLABS INC	Y04	328.800	1231.800
435	TMK	TORCHMARK CORP	Y04	29.500	3071.500
436	TMO	THERMO ELECTRON CORP	Y04	261.041	2205.995
437	TRB	TRIBUNE CO	Y04	1782.368	5726.247

438	TROW	PRICE (T. ROWE) GROUP	Y04	203.807	1280.349
439	TSG	SABRE HOLDINGS CORP -CL A	Y04	387.341	2125.773
440	TSN	TYSON FOODS INC -CL A	Y04	3964.000	26441.000
441	TWX	TIME WARNER INC	Y04	17509.000	42089.000
442	TXN	TEXAS INSTRUMENTS INC	Y04	3918.000	12580.000
443	TXT	TEXTRON INC	Y04	1922.000	10242.000
444	TXU	TXU CORP	Y04	16676.000	9308.000
445	TYC	TYCO INTERNATIONAL LTD	Y04	9635.000	40153.000
446	UIS	UNISYS CORP	Y04	424.100	5820.700
447	UNH	UNITEDHEALTH GROUP INC	Y04	1139.000	37218.000
448	UNM	UNUMPROVIDENT CORP	Y04	398.500	10450.900
449	UNP	UNION PACIFIC CORP	Y04	31014.000	12215.000
450	UPS	UNITED PARCEL SERVICE INC	Y04	13973.000	36582.000
451	USB	U S BANCORP	Y04	1890.000	14705.700
452	UST	UST INC	Y04	421.848	1788.954
453	UTX	UNITED TECHNOLOGIES CORP	Y04	5231.000	36977.000
454	UVN	UNIVISION COMMUNICATIONS INC	Y04	551.138	1786.935
455	VC	VISTEON CORP	Y04	5303.000	18657.000
456	VFC	VF CORP	Y04	572.254	6054.536
457	VIA.B	VIACOM INC -CL B	Y04	4657.100	22525.900
458	VLO	VALERO ENERGY CORP	Y04	10317.400	53918.602
459	VMC	VULCAN MATERIALS CO	Y04	1536.493	2454.335
460	VNO	VORNADO REALTY TRUST	Y04	8314.404	1963.218
461	VZ	VERIZON COMMUNICATIONS INC	Y04	74124.000	71283.000
462	WAG	WALGREEN CO	Y04	5446.400	37508.199
463	WAT	WATERS CORP	Y04	135.908	1104.536
464	WB	WACHOVIA CORP	Y04	5268.000	28067.000
465	WEN	WENDY'S INTERNATIONAL INC	Y04	2349.820	3635.438
466	WFC	WELLS FARGO & CO	Y04	3850.000	33876.000
467	WFT	WEATHERFORD INTL LTD	Y04	1377.182	3131.774
468	WHR	WHIRLPOOL CORP	Y04	2583.000	13220.000
469	WLP	WELLPOINT INC	Y04	1045.200	20815.100
470	WM	WASHINGTON MUTUAL INC	Y04	3140.000	16199.000
471	WMB	WILLIAMS COS INC	Y04	11886.800	12461.300
472	WMI	WASTE MANAGEMENT INC	Y04	11476.000	12516.000
473	WMT	WAL-MART STORES	Y04	68567.000	286103.000
474	WPI	WATSON PHARMACEUTICALS INC	Y04	427.377	1640.551
475	WWY	WRIGLEY (WM) JR CO	Y04	1142.620	3648.592
476	WY	WEYERHAEUSER CO	Y04	16324.000	22665.000
477	WYE	WYETH	Y04	9524.350	17358.027
478	X	UNITED STATES STEEL CORP	Y04	3627.000	13969.000
479	XEL	XCEL ENERGY INC	Y04	14095.955	8345.259
480	XLNX	XILINX INC	Y04	344.516	1573.233
481	XOM	EXXON MOBIL CORP	Y04	108639.000	263989.000
482	XRX	XEROX CORP	Y04	2157.000	15722.000
483	XTO	XTO ENERGY INC	Y04	5624.378	1950.315
484	YHOO	YAHOO INC	Y04	531.696	3564.517
485	YUM	YUM BRANDS INC	Y04	3439.000	9011.000
486	ZION	ZIONS BANCORPORATION	Y04	409.210	1923.001
487	ZMH	ZIMMER HOLDINGS INC	Y04	628.500	2980.900
			2004	**5,276.818**	**14,164.874**

DATA REQUEST #5

At page 9 of her testimony, Ms. Ahern states that the water utility industry faces a need for increased funds to financial the increasing security costs required to protect the water supply and infrastructure after September 11, 2001. Describe all specific security related projects that Water Services has undertaken since September 11, 2001 and state the dollar amount of those expenditures.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The following are specific security related projects that Water Services has undertaken since September 11, 2001:

- Additional Fencing: $20,000
- Low level tank alarms: $5,000
- Emergency Generators: $160,000
- Additional Chemical Feeders used for chemical absorption: $55,000
- EPA mandated Vulnerability Assessment and Emergency Response Plan: $5,000
- Police and neighbors were included in a neighbor watch program.

6) At page 14 of her testimony, Ms. Ahern describes her criteria for selecting the proxy companies. The third criterion is that the company must have more than 70 percent of the 2004 operating revenues derived from water operations. Explain why 70 percent was chosen.

Response: (Witness Responsible – Pauline M. Ahern)

A water company with 70% or greater of total operating revenues derived from water operations is, in Ms. Ahern's expert opinion, predominantly a regulated water utility suitable to use as a proxy for a regulated operating water utility. On average, the companies in the proxy group of six AUS Utility Reports water companies and the proxy group of three Value Line (Standard Edition) water companies derive 91% and 89% of their operating revenues from water operations, respectively, as reported in the June 2005 AUS Monthly Utility Report used at the time of the selection of the proxy group of six AUS Utility Reports water companies.

7) Refer to page 15 of the Ahern Testimony and PMA-3. PMA-3 is described as containing data for the period 2000-2004. Explain why Ms. Ahern chose this time period.

Response: (Witness Responsible – Pauline M. Ahern)

The period 2000-2004 is the latest five-year period for which financial data were and still are available. In addition, five years is the period of time required by the Securities and Exchange Commission (SEC) for reports filed before the SEC and the time period typically reviewed by analysts.

8) Refer to pages 14 and 15 of the Ahern Testimony and PMA-3 and PMA-4. Both of the proxy groups, the six water companies from AUS Utility Reports and the three water companies from Value Line, including American States Water Co., Aqua America, Inc. and California Water Service Group.

a) State the purpose of developing and using two proxy groups that contain three of the same companies.

b) State whether, since Ms. Ahern believes that Water Services is a small company and should qualify for a small company premium, she considered using the water utility companies in Value Line's Small and Mid-Cap Edition, rather than the large cap water utility companies in the Investment Survey. Explain why.

Response: (Witness Responsible – Pauline M. Ahern)

a) Ms. Ahern used two proxy groups of water companies containing the same three companies because it is Ms. Ahern's opinion that the three company Value Line Investment Survey Water Group, which has now expanded to include Southwest Water Company, is considered representative of the water industry by the many individual investors (see Schedule PMA-8) in water companies. Therefore, it is reasonable to use the group as a proxy for Water Service Corporation of Kentucky as Value Line Investment Survey is a widely subscribed to publication and therefore investor influencing. In addition, Ms. Ahern's proxy group of six AUS was developed as a broader based group to provide added reliability to the development of a recommended cost rate of common equity.

b) As is clear from the inclusion of Middlesex Water Company and York Water Company in the proxy group of six AUS Utility Reports water companies, Ms. Ahern did consider the water utility companies in Value Line's Small and Mid-Cap Edition. The remaining water companies in the Small and Mid-Cap Edition were excluded for the following reasons:

Connecticut Water Services:
No Value Line five-year EPS growth rate projections or Thomson FN/ First Call consensus five-year EPS growth rate projections.

SJW Corporation:
No Value Line five-year EPS growth rate projections or Thomson FN/ First Call consensus five-year EPS growth rate projections.

Response to Data Request No. 8) continued

Southwest Water Company:
37% operating water revenues, i.e., substantially less than 70% operating water revenues as reported in the June 2005 AUS Utility Reports used at the time of the selection of the proxy group.

9) Refer to page 21 of the Ahern Testimony, footnote 10. Provide a copy of the referenced pages.

Response: (Witness Responsible – Pauline M. Ahern)

The requested pages are attached.

The Regulation of Public Utilities

Theory and Practice

CHARLES F. PHILLIPS, JR.

Robert G. Brown
Professor of Economics
Washington and Lee University

1993
PUBLIC UTILITIES REPORTS, INC.
Arlington, Virginia

allowances, however, are not uniform. For example, with respect to call premiums, some commissions have charged such costs of refunding bonds to stockholders,[97] while others have amortized the premiums over a reasonable period;[98] with respect to flotation costs, some commissions deny them unless a new stock issue is planned.[99]

Cost of Equity Capital. The most difficult problem in determining the overall cost of capital arises in estimating the cost of equity capital. The relevant question is: How much must a utility earn to induce investors to hold and to continue to buy common stock? In answering this question, it is important to realize that circular reasoning is involved. In the absence of a fixed, expressed or implied commitment as to the dividend rate, the actual cost of floating a stock issue is indeterminate. Investors' decisions are largely based on a utility's expected earnings and upon their stability, as well as upon alternative uses of investment funds. Yet, since the allowable amount of earnings is the object of a rate case, a commission's decision, in turn, will affect investors' decisions.

There are several approaches for estimating the cost of equity capital, but two principal methods have evolved in recent years: the "market-determined" standard and the "comparable earnings" standard.[100] The former is a market-oriented approach that focuses on investor expectations in terms of a utility's earnings, dividends and market prices. The latter is an alternative investment approach that focuses on what capital can earn in various alternatives with comparable risk.

Market-Determined Standard. The market-determined standard relies upon stock market transactions and estimates of investor expectations. Three major approaches have been, or are being, employed: e/p ratios (earnings-price ratios), the discounted cash flow (DCF) model, and the capital asset pricing model (CAPM).

The earnings-price ratio approach holds that the cost of equity capital to a utility is equal to the ratio of current earnings per share to the market price per share. Thus, if a utility's annual earnings are $5 per share and the average market price of its common stock for that same period is $38, the earnings-price ratio is 13.16 percent. (The ratio must be increased to allow for flotation costs. An allowance of 5 percent would result in an adjusted ratio of 13.85 percent — 13.16 percent divided by 0.95.) The method was widely used in the 1950s and early 1960s, although there was growing recognition of an underlying theoretical problem: The earnings-price ratio approach ignores the fact that investors purchase common stock for future growth and not for past or current earnings alone.[101] As a result, a growth factor must be added in computing the cost of equity capital.

Finance theory holds that the cost of common equity capital

> is the equity investors' capitalization rate, or required market rate of return, competitively determined in the capital markets, adjusted by

an appropriate allowance for underpricing in connection with sales of additional shares, including allowance for market pressure and for costs of flotation and underwriting. The capitalization rate before the allowance for underpricing is the discount rate that equates all expected dividends in the future plus the market price that investors eventually expect to realize to the present market price. While this is a simple enough concept, it is difficult to measure since measurement requires the estimation of the expectations of the investors who determine the present market price. Such estimates, of course, involve the exercise of informed judgment.[102]

The DCF model represents an attempt to estimate the equity investors' capitalization rate. Mathematically,

$$K=\frac{d}{p}+g$$

where: k is the investor's capitalization or discount rate (i.e., the cost of capital)
d is the current dividend per share
p is the current market price per share
g is the expected rate of growth in dividends per share.[103]

Thus, if the stock of a particular utility pays a $3 dividend, which is expected to grow at a rate of 4.5 percent per year, and if investors are willing to pay $38 for the stock, the required return on common equity (assuming a 5 percent allowance for flotation costs) is 12.81 percent.[104] However, use of the DCF model for regulatory purposes involves both theoretical and practical difficulties.

The theoretical issues include the assumption of a constant retention ratio (i.e., a fixed payout ratio) and the assumption that dividends will continue to grow at rate g in perpetuity. Neither of these assumptions has any validity, particularly in recent years. Further, the investors' capitalization rate and the cost of equity capital to a utility for application to book value (i.e., an original cost rate base) are identical only when market price is equal to book value.[105] Indeed, DCF advocates assume that if the market price of a utility's common stock exceeds its book value, the allowable rate of return on common equity is too high and should be lowered — and vice versa.[106] Many question the assumption that market price should equal book value, believing that "the earnings of utilities should be sufficiently high to achieve market-to-book ratios which are consistent with those prevailing for stocks of unregulated companies."[107]

Most frequently, the major practical issue involves the determination of the growth rate, a determination that is highly complex and that requires

considerable judgment.[108] The crux of the measurement problem is this: How can investors' expectations of *future* growth be measured? When past growth rates are used as a proxy for future growth rates, it is far from obvious as to (1) which time periods have the most relevance to investors and (2) whether the prospective growth rate should be determined by using trends in dividends per share, earnings per share and/or book value per share, and exactly how the information contained in these various measures is used by investors.[109] Indeed, one study showed that the expectations of security analysts outperformed the extrapolation of historical trends in explaining share prices.[110] But when future growth rates are used, it is not clear whether the prospective growth rate should be determined by using analysts' estimates, surveys of institutional investors or the expected return on common equity times the retention ratio.[111] And, even when all of these issues have been settled, there remains the circularity problem: Since regulation establishes a level of authorized earnings, which, in turn, implicitly influences dividends per share, estimation of the growth rate from such data is an inherently circular process. For these reasons, the DCF model "suggests a degree of precision which is in fact not present"[112] and leaves "wide room for controversy and argument about the level of k."[113]

The CAPM[114] holds that the cost of equity capital or expected return on a utility's common equity is equivalent to that on a riskless security plus a risk premium related to the risk inherent in a particular utility's stock; that is, the model combines risk and return in a single measure.[115] The formula is as follows:

$$R = R_f + (R_m - R_f)\ \beta$$

where: R is the total return
R_f is the risk free return
R_m is the stock market return (or the expected return on a stock market portfolio)
β is the beta coefficient (or the utility's relevant market risk).

Thus, assuming a stock market return of 13.9 percent, a risk-free return (Treasury bonds) of 7.8 percent, and a beta of 0.90, the total return or cost of equity capital would be 13.29 percent.[116]

Despite its appeal, the CAPM also has both theoretical and practical problems. The theoretical issues include the reliability of the model's basic assumptions[117] and the static nature of the model.[118] The practical problems surround the beta coefficient, "the only variable in the CAPM equation that is unique to the particular firm for which the cost of equity capital is being determined."[119] They include: How should beta be measured — stock market price alone or total return on investment (i.e., dividends plus capital gains)?

What period of time should be used for such measurement? What is the proper measure of stock market performance (e.g., Dow Jones index, Standard & Poor's index, etc.)? What is the proper measure of the risk-free return (e.g., Treasury notes or Treasury bonds)? Finally, the evidence suggests that betas are unstable over time and that they move in the opposite direction from investors' perceptions of risk.[120] These issues have led some to conclude that the CAPM, at least at this stage in its development, "is inaccurate, incomplete, and unreliable as a measure of a firm's equity cost of capital."[121]

Comparable Earnings Standard. The comparable earnings standard[122] recognizes a fundamental economic concept; namely, opportunity cost. This concept states that the cost of using any resource — land, labor and/or capital — for a specific purpose is the return that could have been earned in the next best alternative use. The opportunity cost of a farmer using his land for beef grazing is what the land would yield after expenses if used for raising tobacco or for growing wheat; the opportunity cost to a worker in accepting one job is what he forgoes by not accepting the next best alternative. Likewise, the opportunity cost to an investor in a utility's common stock is what that capital would yield in an alternative investment — in another utility's or industrial's common stock; in utility, corporate or government bonds; in real estate; etc. Stated another way, the opportunity cost of capital concept holds that "capital should not be committed to any venture unless it can earn a return commensurate with that prospectively available in alternative employments of similar risk."[123]

The relevance of the opportunity cost concept was recognized by Judge Hand in a 1920 case:

> The recurrent appeal to a just rate and a fair value assumes that the effort is to insure such a profit as would induce the venture originally and that the public will keep its faith so impliedly given. That, I think, involves a tacit comparison of the profit possible under the rate with profits available elsewhere; i.e., under those competitive enterprises which offer an alternative investment. The implication is that the original adventurer would compare future rates, varying as they would with the going profit, and would find them enough, but no more than enough, to induce him to choose this investment. By insuring such a return it is assumed that the supply of capital will be secured necessary to the public service. As the profits in the supposed alternative investment will themselves vary, so it is assumed to be a condition of the investors' bargain that their profit shall measurably follow the general rates. It is, of course, not relevant here to discuss these presuppositions, since they have now the support of authoritative law.[124]

The comparable earnings approach is implemented by examining earnings on book common equity for enterprises that have comparable risks *or*

by examining earnings on book common equity for enterprises that have different risks and then making an allowance for those risk differences. Earnings on book common equity are used since the resulting cost of common equity is to be applied to an original cost rate base (in most jurisdictions).[125] The comparable earnings approach, further, requires that comparisons be made with both regulated and nonregulated alternatives, if the results are to have any validity, for two basic reasons. First, the alternatives confronting investors include both regulated and nonregulated enterprises. There is active competition for investor capital; no company enjoys a monopoly of the capital markets. Investors will seek the opportunity that provides the greatest profit, commensurate with the risks involved. Second, returns of regulated firms must always be used with extreme caution. At best, they reflect what the informed judgments of regulatory commissions have permitted such utilities to earn and may not be indicative of what could have been earned in the competitive market.[126]

The most difficult problem in applying the comparable earnings standard is the determination of relative risk. Prior to the 1970s, it was frequently argued that regulation tended to eliminate some of the risks to which nonregulated enterprises are subject, so that utilities' overall or business risk tended to be less than the corresponding business risk of industrial firms. As a result, utilities were financed with larger amounts of senior capital (i.e., they had significantly higher debt ratios). But there is clear evidence that the risk of public utilities has increased in more recent years, particularly with the introduction of competition and significant disallowances,[127] and there is also support for the proposition that regulation itself is a risk.[128] Yet, the fact remains that there is no accepted method of measuring relative risk. Some have argued that risk can be measured by instability of earnings; this may be derived statistically by use of the standard deviation or coefficient of variation. Some advocate the use of market price-book value ratios and/or market price-earnings ratios to reflect how investors appraise relative risk.[129] Beta has received attention in some cases, although, as noted earlier, betas tend to be unstable over time. Still others maintain that the higher debt ratios of utilities serve to offset their overall lower business risk, with the result that the financial or equity risks of utilities and industrials are similar under current economic conditions. And, finally, some rely upon the various indexes published by Merrill Lynch (Merrill Lynch Suitability Rating), Standard & Poor's (S&P's Quality Rating) and/or Value Line (Value Line Safety and Timeliness Ratings).[130]

Despite the difficulty of measuring relative risk, the comparable earnings standard is no harder to apply than is the market-determined standard. The DCF method, to illustrate, requires a subjective determination of the growth rate the market is contemplating. Moreover, as Leventhal has argued: "Unless the utility is permitted to earn a return comparable to that available elsewhere on similar risk, it will not be able in the long run to attract capital."[131]

10) Refer to page 22 of the Ahern Testimony, footnote 11. Provide a copy of the referenced pages.

Response: (Witness Responsible – Pauline M. Ahern)

The requested pages are attached.

REGULATORY FINANCE:

UTILITIES' COST OF CAPITAL

Roger A. Morin, PhD

in collaboration with
Lisa Todd Hillman

1994
PUBLIC UTILITIES REPORTS, INC.
Arlington, Virginia

Chapter 9
Reflections on Cost of Capital Methodology

9.1 Sole Reliance on the DCF Methodology

While the DCF model is presently fashionable in regulatory proceedings, although not nearly as much in financial theory circles, uncritical acceptance of the standard DCF equation vests the model with a degree of accuracy that simply is not there. One of the leading experts on regulation, Dr. C. F. Phillips discussed the dangers of relying on the DCF model:

> [U]se of the DCF model for regulatory purposes involves both theoretical and practical difficulties. The theoretical issues include the assumption of a constant retention ratio (i.e., a fixed payout ratio) and the assumption that dividends will continue to grow at a rate g in perpetuity. Neither of these assumptions has any validity, particularly in recent years. Further, the investors' capitalization rate and the cost of equity capital to a utility for application to book value (i.e., an original cost rate base) are identical only when market price is equal to book value. Indeed, DCF advocates assume that if the market price of a utility's common stock exceeds its book value, the allowable rate of return on common equity is too high and should be lowered; and vice versa. Many question the assumption that market price should equal book value, believing that the earnings of utilities should be sufficiently high to achieve market-to-book ratios which are consistent with those prevailing for stocks of unregulated companies.
>
> . . . [T]here remains the circularity problem: Since regulation establishes a level of authorized earnings which, in turn, implicitly influences dividends per share, estimation of the growth rate from such data is an inherently circular process. For all of these reasons, the DCF model suggests a degree of precision which is in fact not present' and leaves 'wide room for controversy about the level of k [cost of equity].[1]

Sole reliance on the DCF model ignores the capital market evidence and financial theory formalized in the CAPM and other risk premium methods. The DCF model is one of many tools to be employed in conjunction

[1] See Phillips (1993), pp. 395-96.

with other methods to estimate the cost of equity. It is not a superior methodology that supplants other financial theory and market evidence. The broad usage of the DCF methodology in regulatory proceedings does not make it superior to other methods.

9.2 Reservations on DCF

Notwithstanding the fundamental thesis that several methods and/or variants of such methods should be used in measuring equity costs, the DCF methodology can be particularly fragile in a given capital market environment. Two reservations concerning the application of the DCF method are in order. The first reservation concerns the applicability of the DCF model to utility stocks in general at this time in the current capital market environment. The second reservation concerns the estimation of the expected growth component required by the DCF model.

Applicability of the DCF Model

Caution has to be used in applying the DCF model to utility stocks for three reasons. The first reason is that the stock price used as input in the dividend yield component may be unduly influenced by structural changes and changing investor expectations in the utility industry. Stock prices can also be influenced by mergers and acquisitions possibilities, by speculation concerning asset restructurings and deregulation of certain assets, and by corporate takeover rumors.

The second reason is that the traditional DCF model is based on a number of assumptions, some of which are unrealistic in a given capital market environment. For example, the standard infinite growth DCF model assumes a constant market valuation multiple, that is, a constant price/earnings (P/E) ratio. In other words, the model assumes that investors expect the ratio of market price to dividends (or earnings) in any given year to be the same as the current price/dividend (or earnings) ratio. This must be true if the infinite growth assumption is made. This is somewhat unrealistic under current conditions. The DCF model is not equipped to deal with sudden surges in market-to-book (M/B) and price/earnings (P/E) ratios, as was experienced by several utility stocks in recent years. Figures 9-1A and 9-1B show the volatile behavior of price/earnings and market-to-book ratios for gas distribution utility stocks in the last 10 years.

Each methodology requires the exercise of considerable judgment on the reasonableness of the assumptions underlying the methodology and on the reasonableness of the proxies used to validate the theory. The failure of the traditional infinite growth DCF model to account for changes in relative market valuation, discussed above, is a vivid example of the potential shortcomings of the DCF model when applied to a given company. It follows that more than one methodology should be employed in arriving at a judgment on the cost of equity and that these methodologies should be applied across a series of comparable risk companies.

There is no single model that conclusively determines or estimates the expected return for an individual firm. Each methodology possesses its own way of examining investor behavior, its own premises, and its own set of simplifications of reality. Each method proceeds from different fundamental premises that cannot be validated empirically. Investors do not necessarily subscribe to any one method, nor does the stock price reflect the application of any one single method by the price-setting investor. There is no monopoly as to which method is used by investors. In the absence of any hard evidence as to which method outdoes the other, all relevant evidence should be used and weighted equally, in order to minimize judgmental error, measurement error, and conceptual infirmities. A regulator should rely on the results of a variety of methods applied to a variety of comparable groups, and not on one particular method. There is no guarantee that a single DCF result is necessarily the ideal predictor of the stock price and of the cost of equity reflected in that price, just as there is no guarantee that a single CAPM or Risk Premium result constitutes the perfect explanation of that stock price.

If a regulatory commission relies solely on a single cost of equity estimate, the commission greatly limits its flexibility and increases the risk of authorizing unreasonable rates of return. The results from a one-company sample are likely to contain a high degree of measurement error and may be distorted by short-term aberrations. The commission's hands should not be bound to one single company-specific estimate of equity costs, nor should the commission ignore relevant evidence and back itself into a corner.

Financial literature supports the use of multiple methods. Professor Eugene Brigham, a widely respected scholar and finance academician, asserted:

> In practical work, it is often best to use all three methods—CAPM, bond yield plus risk premium, and DCF—and then apply judgement when the methods produce different results. People experienced in estimating capital costs recognize that both careful analysis and some very fine judgements are required. It would be nice to pretend that these judgements are

> unnecessary and to specify an easy, precise way of determining the exact cost of equity capital. Unfortunately, this is not possible.[2]

Another prominent finance scholar, Professor Stewart Myers, in his best-selling corporate finance textbook, stated:

> The constant growth formula and the capital asset pricing model are two different ways of getting a handle on the same problem.[3]

In an earlier article, Professor Myers explained the point more fully:

> Use more than one model when you can. Because estimating the opportunity cost of capital is difficult, only a fool throws away useful information. That means you should not use any one model or measure mechanically and exclusively. Beta is helpful as one tool in a kit, to be used in parallel with DCF models or other techniques for interpreting capital market data.[4]

9.4 Financial Integrity and DCF

According to the seminal standards underlying the notion of fair return, as laid down in the landmark *Hope* and *Bluefield* cases, the return allowed by the regulator must be such as (1) to permit the utility to attract capital and maintain integrity, and (2) to be comparable with returns on similar risk investments.

It is transparent that return on equity and interest coverage, which is a pivotal standard used by capital markets with respect to the attraction of debt capital, are related. A return on equity that produces inadequate interest coverages, endangers debt capital attraction. If the coverage implied by a recommended return on equity is below current bond rating benchmarks, then an anemic coverage would almost guarantee a further downgrading of a company's bonds, particularly if coverages were already marginal. This can be further damaging if the company is pursuing a substantial construction expenditure program and requires external financing in a volatile and quality-conscious capital market. If the coverage ratio implied by any cost of equity estimate is well outside that of its peers, then this should attest to the inadequacy of the estimate. As a result, existing bondholders would be inflicted a capital loss, and the cost

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[2] See Brigham and Gapenski (1991), p. 256.
[3] See Brealey and Myers (1991), p. 182.
[4] See Myers (1978), p. 67.

11) Refer to page 31 of the Ahern Testimony. Explain why Ms. Ahern chose June 20, 2005 as the spot date to calculate an average for the dividend yield.

Response: (Witness Responsible – Pauline M. Ahern)

At the time of the preparation of Ms. Ahern's testimony and accompanying financial exhibit, June 20, 2005 was the most recently available date for which the market prices of the companies in the two proxy groups were available.

12) Refer to page 42 of the Ahern Testimony.

a) Explain why Ms. Ahern average three months of data to derive her market equity risk premium.

b) Explain why the three months of data was then averaged with a spot market price from June 17, 2005.

c) Explain why Ms. Ahern chose June 17, 2005 as the spot price.

Response: (Witness Responsible – Pauline M. Ahern)

a) As stated on page 42, lines 15 through 17, using three months of data to derive a market equity risk premium "is consistent with the use of the 3-month and spot dividend yields in [her] application of the DCF model."

b) See Ms. Ahern's response to part a) above. In addition, although the most relevant stock price to use in the estimation of the cost of common equity is the spot price consistent with the Efficient Market Hypothesis that current stock prices reflect the most recent information, a spot market price may reflect abnormal conditions or a temporary aberration. Since one goal of regulation is rate stability and normalization of costs, it is reasonable to utilize an average of three months of recent data and spot data in calculating both a dividend yield and a projected market equity risk premium so as not to influence the estimation of the cost of common equity with any possible temporary aberrations or abnormal conditions in the capital markets.

c) At the time of the preparation of Ms. Ahern's testimony and accompanying financial exhibit, June 17, 2005 was the most recently available Value Line Summary & Index which reports the median market price appreciation potential utilized, in part, by Ms. Ahern to derive the forecasted market equity risk premium.

13) Refer to PMA-1, pages 3, 4 and 15.

a) Footnote 11 on page 4 indicates that the size premium displayed on page 3 for the Proxy Group of Three Value Line Water Companies should be from the sixth decile of the NYSE/AMEX/NASDAQ as shown on page 15. Table 7-5 on page 15, however, indicates that the sixth decile size premium is 1.75 percent, rather than 1.61 percent. Explain the discrepancy and provide any corrected workpapers.

b) State whether Ms. Ahern is stating that the size premium should be between 442 and 480 basis point(sic), but is recommending only 60 and 65 basis points as the adjustment.

c) Describe how Ms. Ahern developed her estimates of 60 and 65 basis points.

Response: (Witness Responsible – Pauline M. Ahern)

a) Line No. 3, Column 4 should read 1.75%. Please see the attached corrected page 3 of Schedule PMA-1.

b) As shown on Line No. 6 on page 2 of Schedule PMA-1 and stated by Ms. Ahern at lines 21 through 27 on page 61 of her direct testimony:

"Consequently, business risk adjustments of 4.42% and 4.80% [4.66% corrected] are indicated for the six water companies and the three Value Line (Std. Ed.) water companies, respectively. However, I will make conservatively reasonable business risk adjustments of 0.60% (60 basis points) and 0.65% (65 basis points) to the indicated common equity cost rates of 10.70% and 10.90% for the six AUS Utility Reports water companies and the three Value Line (Std. Ed.) water companies, respectively."

c) See Ms. Ahern's response to b) above.

14) At page 60, Table 4, of her testimony, Ms. Ahern presents the results of her four models and states that the Indicated Common Equity Cost Rate Before Business Risk Adjustment is 10.7 percent for the AUS proxy group and 10.9 percent for the Value Line proxy group. Explain how Ms. Ahern developed the percentages.

Response: (Witness Responsible – Pauline M. Ahern)

Based upon Ms. Ahern's informed expert judgment, as stated on page 60 of her direct testimony, Ms. Ahern concluded that based upon the common equity cost rate results of the four cost of common equity cost rate models she employed, i.e., Discounted Cash Flow, Risk Premium, Capital Asset Pricing and Comparable Earnings Models, she concluded that common equity cost rates of 10.70% and 10.90% were indicated for each proxy group, respectively, before adjustment for business risk. It is clear that Ms. Ahern gave less reliance to the results of the Comparable Earnings Model than those of the other three models because, had she relied upon the results of all four models the indicated common equity cost rates for the two proxy groups would have been 11.30% and 11.50%, respectively.

DATA REQUEST #15

Refer to Exhibit 4 of the Application, Schedule B, Income Statement and w/p(c), Revised Allocations.

a. The first column in the pro forma income statement is the restated test-period operations. Provide a revised pro forma income statement using Microsoft Excel 97 format ("Excel") that includes the columns for the actual test-period operations and the restatement adjustments.

b. Provide a copy of the revised pro forma income statement requested in 15(a) on a computer disk.

c. The restatement adjustments listed on w/p(c) are by expense sub-accounts, but the restatement adjustments that will be included on revised pro forma income statement requested in 15(a) will be by major expense accounts. Provide a schedule reconciling the restatement adjustments on w/p(c) with the adjustments on the revised pro forma income statement requested in 15(a).

d. For each restatement adjustment shown on w/p(c), provide the allocation factor that was used and the calculation of the restatement adjustment.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

See enclosed CD.

Water Service Corporation of Kentucky
Income Statement
December 31, 2004
Item 15a

		Per Restatement	Restatement Adjustments		Actual Test-Period
Operating Revenues					
	Service Revenues - Water	$ 1,378,947	$ 0		$ 1,378,947
	Service Revenues - Sewer	0	0		0
	Miscellaneous Revenues	36,738	0		36,738
	Uncollectible Accounts	(16,783)	(17)	(1)	(16,800)
Total Operating Revenues		$ 1,398,901	$ (17)		$ 1,398,884
Maintenance Expenses					
	Salaries and Wages	$ 391,796	0		$ 391,796
	Purchased Power	42,517	0		42,517
	Purchased Water	85,614	0		85,614
	Maintenance and Repair	120,028	43	(4)	120,071
	Maintenance Testing	16,320	0		16,320
	Meter Reading	0	0		0
	Chemicals	79,315	0		79,315
	Transportation	26,615	0		26,615
	Operating Exp. Charged to Plant	(121,266)	0		(121,266)
	Outside Services - Other	18,261	609	(2)	18,870
	Total	$ 659,199	$ 652		$ 659,851
General Expenses					
	Salaries and Wages	$ 127,678	0		$ 127,678
	Office Supplies & Other Office Exp.	44,800	474	(7)	45,274
	Regulatory Commission Exp.	0	0		0
	Pension & Other Benefits	103,251	0		103,251
	Rent	18,492	0		18,492
	Insurance	67,228	1,093	(3)	68,321
	Office Utilities	32,001	58	(5)	32,059
	Miscellaneous	(18)	452	(8)	434
	Total	$ 393,433	$ 2,077		$ 395,510
Depreciation		$ 183,354	0		$ 183,354
Taxes Other Than Income		136,302	86	(6)	136,388
Income Taxes - Federal		(5,795)	0		(5,795)
Income Taxes - State		12,270	0		12,270
Expense Reduction Related to Clinton Sewer Operations		(102,670)	-		(102,670)
Amortization of PAA		0	(3,660)	**	(3,660)
Amortization of CIAC and AIAC		(1,628)	0		(1,628)
	Total	$ 221,832	$ (3,574)		$ 218,258

Total Operating Expenses	$ 1,274,464	$ (844)		$ 1,273,619
Net Operating Income	$ 124,437	$ 828		$ 125,265
Interest During Construction	$ (5,618)	0		$ (5,618)
Interest on Debt	136,089	426	(9)	136,515
Net Income	$ (6,034)	$ 402		$ (5,632)

** The amortization of Plant Acquisition Adjustment was not included in the Income Statement because it does not represent a rate base item.

WATER SERVICE CORPORATION OF KENTUCKY w/p [c]
Revised Allocations
Item 15c and d

SE.51

Account Number	Account Name	Original Allocation to WSCK	Revised Allocation to WSCK	Difference	Comments	Allocation Factor
6019045	Computer Salaries	9,730	9,730	-	allocation based on code 4	
6369007	Computer Maint	2,727	2,727	-	allocation based on code 4	
6369009	Computer-Amort & Prog. Cost	1,021	1,021	-	allocation based on code 4	
6369012	Internet Supplier	385	385	-	allocation based on code 4	
6759003	Computer Supplies	949	949	-	allocation based on code 4	
6759016	Microfilming	734	734	-	allocation based on code 4	
6759051	Computer Supplies - Billing	1,141	1,141	-	allocation based on code 4	
6759115	Office Comp Phone Line	-	-	-	allocation based on code 4	
4032098	Depreciation - Computer	2,602	2,435	167 *	in w/p [f]	Distribution code 5 - distribution of computer costs
		19,289	19,122	167		

SE.51

Account Number	Account Name	Original Allocation to WSCK	Revised Allocation to WSCK	Difference	Comments	
6599090	Other Insurance	68,321	67,228	1,093 (3)	in TB - insurance	Distribution code 11 - distribution of insurance

SE.60

Account Number	Account Name	Original Allocation to WSCK	Revised Allocation to WSCK	Difference	Comments	
6019000	Non-Utility Salaries	-	-	-	N/A	
6019030	Cap Sal - Admin	-	-	-	N/A	
6019045	Sal-Computer	-	-	-	N/A	
6019053	Sal-IL Office	-	-	-	N/A	
6019050	Salaries - Office	32,097	29,306	2,791 *	in w/p [b]	Distribution code 1 - distribution based on customer equivalent %
6019070	Sal-IL Customer Service	-	-	-	N/A	
6019071	Sal-IL Office Exempt	-	-	-	N/A	
6708001	Agency Expense	202	185	17 (1)	in TB - uncollectible	Distribution code 1 - distribution based on customer equivalent %
6338001	Legal Fees	77	70	7 (2)	in TB - outside services	Distribution code 1 - distribution based on customer equivalent %
6329002	Audit Fees	3,985	3,638	347 (2)	in TB - outside services	Distribution code 1 - distribution based on customer equivalent %
6369003	Temp Empl.	34	31	3 (2)	in TB - outside services	Distribution code 1 - distribution based on customer equivalent %
6369005	Payroll Services	880	804	76 (2)	in TB - outside services	Distribution code 1 - distribution based on customer equivalent %
6369006	Employ Finder Fees	1,066	973	93 (2)	in TB - outside services	Distribution code 1 - distribution based on customer equivalent %
6369007	Computer Maint	-	-	-	N/A	
6369008	Director Fees	-	-	-	N/A	
6369009	Computer-Amort & Prog. Cost	-	-	-	N/A	
6319011	Engineering Fees	3	3	-	N/A	
6329013	Accounting Studies	-	-	-	N/A	
6329014	Tax Return Review	952	869	83 (2)	in TB - outside services	Distribution code 1 - distribution based on customer equivalent %
6369012	Internet Supplier	-	-	-	N/A	
6369090	Other Outside Services	-	-	-	N/A	

6049010	Health Ins. Reimb	3,216	3.009	207	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049011	Employee Ins. Deductions	(951)	(890)	(61)	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049012	Health Costs & Other	78	73	5	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049015	Dental Ins. Reimbursements	272	254	18	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049020	Pension Contributions	1,462	1.364	98	*	in w/p [b]	Distribution code 6 - indirect expense allocation percentage
6049050	Health Ins. Premiums	672	629	43	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049055	Dental Premiums	19	18	1	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049060	Term Life Ins.	135	127	8	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049065	Term Life Ins. - OPT	3	3	-		N/A	
6049066	Depend Life Ins.- OPT & AFLAC	-	-	-		N/A	
6049067	AFLAC	1	1	-		N/A	
6049070	ESOP Contributions	1,925	1.796	129	*	in w/p [b]	Distribution code 6 - indirect expense allocation percentage
6049080	Disability Insurance	56	53	3	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6049090	Other Emp Pens & Benefits	105	98	7	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
6599090	Other Insurance	-	-	-		N/A	
6759001	Publ Subscriptions & Tapes	157	143	14	(7)	in TB - office supplies	Distribution code 1 - distribution based on customer equivalent %
6759002	Answering Serv	-	-	-		N/A	
6759003	Computer Supplies	-	-	-		N/A	
6759004	Printing & Blueprints	350	328	22	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759005	Postage	(224)	(224)	-		N/A	
6759006	UPS & Air Freight	553	553	-		N/A	
6759008	Xerox	319	298	21	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759009	Off Supply Stores	488	457	31	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759010	Reim of Off Emp Exp.	38	35	3	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759011	Envelopes	2,880	2.695	185	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759013	Cleaning Supplies	48	45	3	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759014	Memberships	12	11	1	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759016	Microfilming	-	-	-		N/A	
6759007	Printing Customer Service	128	120	8	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759012	Bill Stock	1,084	1.014	70	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759051	Computer Supplies - Billing	-	-	-		N/A	
6759090	Other Office Expense	122	114	8	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759110	Office Telephone	81	76	5	(5)	in TB - office utilities	Distribution code 5 - indirect expense allocation percentage
6759111	Office Telephone - Long Dist	-	-	-		N/A	
6759115	Office Comp Phone Line	-	-	-		N/A	
6759120	Office Electric	533	499	34	(5)	in TB - office utilities	Distribution code 5 - indirect expense allocation percentage
6759125	Office Water	116	108	8	(5)	in TB - office utilities	Distribution code 5 - indirect expense allocation percentage
6759130	Office Gas	168	157	11	(5)	in TB - office utilities	Distribution code 5 - indirect expense allocation percentage
6759160	Office Fax Phone Line	-	-	-		N/A	
6759190	Office Utilities - Other	-	-	-		N/A	
6759135	Operators Telephones	-	-	-		N/A	
6759210	Office Cleaning Serv	576	539	37	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759220	Landscaping, Mowing,Snow	621	581	40	(4)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759230	Office Garbage Removal	38	35	3	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759250	Decor & Repaint Structures	-	-	-		N/A	
6759260	Repair Off Mach & Heating	54	51	3	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759290	Other Office Maint	1,027	962	65	(7)	in TB - office supplies	Distribution code 5 - indirect expense allocation percentage
6759330	Memberships - Company	18	17	1	(8)	in TB - miscellaneous	Distribution code 5 - indirect expense allocation percentage
7048050	Employees ED Expenses	58	54	4	(8)	in TB - miscellaneous	Distribution code 5 - indirect expense allocation percentage
7048055	Office Education/Train Exp	527	493	34	(8)	in TB - miscellaneous	Distribution code 5 - indirect expense allocation percentage
7758370	Meals & Related Exp	119	109	10	(8)	in TB - miscellaneous	Distribution code 1 - distribution based on customer equivalent %
7758380	Bank Serv Charges	4,570	4.172	398	(8)	in TB - miscellaneous	Distribution code 1 - distribution based on customer equivalent %
7758390	Other Misc General	303	276	27	(8)	in TB - miscellaneous	Distribution code 1 - distribution based on customer equivalent %
6759018	Operators - Other Office Exp	57	54	3	(4)	in TB - maintenance and repair	Distribution code 5 - indirect expense allocation percentage
6759430	Sales/Use Tax Exp.	-	-	-		N/A	
6509090	Other Trans. Exp.	-	-	-		N/A	
4032090	Depreciation - Office Struct.	1,476	1.381	95	*	in w/p [f]	Distribution code 5 - indirect expense allocation percentage

4032091	Depreciation - Office Furn.	1,460	1,367	93	*	in w/p [f]	Distribution code 5 - indirect expense allocation percentage
4032093	Depreciation - Telephones	59	56	3	*	in w/p [f]	Distribution code 5 - indirect expense allocation percentage
4032098	Depreciation - Computer	-	-	-		N/A	
4081303	Franchise Tax	3	3	-		N/A	
4081121	Real Estate Tax	1,343	1,257	86	(6)	in TB - taxes other than income	Distribution code 5 - indirect expense allocation percentage
4081201	FICA Expense	3,400	3,182	218	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
4091060	SUTA-IL	148	139	9	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
4091128	SUTA-NC	-	-	-		N/A	
4091050	FUTA	46	43	3	*	in w/p [b]	Distribution code 5 - indirect expense allocation percentage
4091000	Income Taxes - Federal	-	-	-		N/A	
4101000	Deferred Inc. Taxes - Federal	-	-	-		N/A	
4191010	Interest Income	-	-	-		N/A	
4131020	Rental Income	-	-	-		N/A	
4141040	Sale of Trans Equipment	-	-	-		N/A	
4192000	Interest - Interco.	8,881	8,450	431	(9)	in TB - interest	Distribution code WSC RB - WSC rate base allocation
4201000	Interest During Const	-	-	-		N/A	
4261000	Misc. Income	(346)	(324)	(22)	(8)	in TB - miscellaneous	Distribution code 5 - indirect expense allocation percentage
4272090	S/T Int Exp Other	(62)	(58)	(4)	(9)	in TB - interest	Distribution code 5 - indirect expense allocation percentage
		77,518	71,682	5,836			

Grouping of Allocation Adjustments

(1)	Uncollectible Accounts	$ 17
(2)	Outside Services - Other	609
(3)	Insurance	1,093
(4)	Maintenance and Repair	43
(5)	Office Utilities	58
(6)	Taxes Other Than Income	86
(7)	Office Supplies & Other Office Exp.	474
(8)	Miscellaneous	452
(9)	Interest on Debt	426
**	Amortization of PAA	$ (3,660)
	Total	$ (402)

* These allocations are located in the indicated work papers.

DATA REQUEST #16

In response to Question 14 of her direct testimony, Kirsten E. Weeks states that "[a]ll other maintenance and general expenses were adjusted by 5.518 percent to account for the increase in the consumer price index since acquisition."

a. Explain the phrase "[t]o account for the increase in the consumer price index since acquisition."

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Since the acquisition of Aqua/KWS, Inc. and Utilities of Kentucky, Inc. in September 2002, the cost of all goods and services to a customer, or consumer price index, has increased and increases each year. The 5.518 percent increase in other maintenance and general expenses represents the increase in consumer price index from September 2002 (acquisition date) until December 31, 2004 (test year).

DATA REQUEST #16

In response to Question 14 of her direct testimony, Kirsten E. Weeks states that "[a]ll other maintenance and general expenses were adjusted by 5.518 percent to account for the increase in the consumer price index since acquisition."

b. Administrative Regulation 807 KAR 5:001, Section 10(7), provides that, "[u]pon good cause shown, a utility may request pro forma adjustments for known and measurable changes to ensure fair, just and reasonable rates based on the historical test period." Explain how an inflationary expense adjustment based upon a consumer price index is a known and measurable change.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The inflationary expense adjustment is based on an increase in the consumer price index from the date of acquisition of Aqua/KWS, Inc. and Utilities of Kentucky, Inc. in September 2002 until the date of the test year, December 31, 2004. The consumer price index is measurable, since it is a known statistic from the U.S. Department of Labor.

DATA REQUEST #17

Refer to Water Services response to Commission Staff's First Data Request, Items 12 and 18.

a. Provide an employee schedule in the format provided in Schedule 17 in Excel. Include a copy of the employee schedule on a computer disk.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

See enclosed CD.

DATA REQUEST #17

Refer to Water Services response to Commission Staff's First Data Request, Items 12 and 18.

b. In calendar year 2004 Water Service capitalized $125,579 of employee salaries, benefits, and payroll taxes. Explain how Water Service calculated the amount that was capitalized in 2004. Provide a breakdown of the $125,579 between the three components.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

See enclosed CD.

DATA REQUEST #17

Refer to Water Services response to Commission Staff's First Data Request, Items 12 and 18.

c. Provide the percentage wage increases that were granted in calendar year 2003 by employee.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

See enclosed CD.

WATER SERVICE CORPORATION OF KENTUCKY
Operating Expense Charged to Plant
Item 17 b

Operator Salaries	391,795.82	75.42%
Office Salaries	127,678.13	24.58%
Total Salaries	519,473.95	100.00%
Payroll Taxes:	47,658.56	
Operator Portion	35,944.87	
Office Portion	11,713.69	
Insurance, Pension & Other Benefits:	103,251.00	
Operator Portion	77,873.61	
Office Portion	25,377.39	
Percentage of Operator Salaries Charged to Plant:		
Salaries Charged to Plant	121,266.00	
Operator Salaries	391,795.82	
Operator Portion of Payroll Taxes	35,944.87	
Operator Portion of Insurance, Pension, & Other Benefits	77,873.61	
	505,614.30	
Percentage Charged to Plant	23.98%	
Breakdown of Components:		
Salaries	93,967.90	
Payroll Taxes	8,620.98	
Insurance, Pension, & Other Benefits	18,677.12	
Total Operating Expense Charged to Plant	121,266.00	

Water Service Corporation of Kentucky
Case No. 2005-00325
Employee Schedule
Item 17 c

Employee Reference	Title	2002 Wage Rates	2003 Wage Rates	% Increase
Bolt, Gregory C	Operator	$ 26,315	$ 27,091	3%
Heck, Travis N	Meter Reader	$ 17,300	$ 21,025	22%
Johnson, Harvey H	Operator	$ 27,876	$ 28,726	3%
Leonard, James R	Regional Manager	$ 43,000	$ 50,000	16%
Mills, Wendell G	Operator	$ 29,120	$ 30,680	5%
Onkst, James H	Meter Reader	$ 18,620	$ 23,295	25%
Partin, Michael W	Operator	N/A	$ 24,000	N/A
Pickard, Michael A	Area Manger - started 6/3/04	N/A	N/A	N/A
Russell, R D	Area Manger	$ 35,000	$ 36,200	3%
Spurlock, Charles F	Operator	$ 29,816	$ 30,516	2%
Turner, John R	Operator	$ 19,520	$ 24,220	24%
Yates Jr., Bobby E	Area Manger	$ 42,000	$ 43,200	3%
Cox, David T	Laborer - started and terminated 04	N/A	N/A	N/A
Daniel, Carl	Vice President & Regional Director	$ 143,000	$ 145,900	2%
Petrey, Vivian A	Customer Service Representative	$ 19,940	$ 23,000	15%
Standifer, Reba F	Office Manager	$ 30,752	$ 34,500	12%
Thomas, Pamela	Customer Service Representative	$ 23,992	$ 25,000	4%
Camaren, Jim	CEO			
Schumacher, Lawrence	President & CFO			
Crossett, Lisa	Director of Operations			
Lubertozzi, Steven	Director of Regulatory Accounting			
Arnoux, Diane	Payroll			
Cohn, Michelle	Senior Accountant			
Delgado, Daniel	Manager, Planning & Analysis			
Friedman, Avelina	Account Manager			
Luppino, Nancy	Account Manager			
Haynes, John	Director of Corporate Accounting			
Silvey, Justine	Human Resource Generalist			
Aylin, Sue	Executive Assistant			
McGrain, Pamela	Account Manager			
Kocan, Chris	Senior Accountant			
Guidice, Joyce	Benefits Coordinator			
Weeks, Kirsten	Senior Regulatory Accountant			
Turov, Igor	Accountant			
Bernardi, Brad	Senior Analyst, Planning & Analysis			
Dihel, Steven	Regulatory Accountant			
Luppino, Phyllis	Account Manager			
Baratz, Daniel	Regulatory Accountant			
Cabugason, Art	Operations Analyst			
Gingery, Todd	Administrative Clerk			
Lawrence, Brent	Administrative Services			
Matthews, Mary Ellen	Billing Manger			
Schiopu, Mircea	Mail Room Services			
Parrish, Marge	Receptionist			
Paulie, Nancy	Receptionist			
Lowman, Adrienne	Corporate Customer Services Manager			
Owens, Patricia	Director of Customer Relations & Administrative Services			
Casados, Jim	MIS Manger			
Gingery, Karen	Data Processing Coordinator			
Berlet, Erica	Network Administrator			
Gomez, Sam	Data Entry			
Friedlander, Larry	Assistant MIS Manager			

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

a. Provide a detailed calculation of each salary listed in the column "Total Annualized Salary."

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

See enclosed CD.

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

b. Explain in detail how the 2004 employee health insurance premium of $4,332 was derived.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The utility calculates the total costs incurred for all Water Service Corporation employees during the test year for health costs. This total number is then divided by the number of full time employees for the year. The result is the base amount given to each employee for these costs, which during 2004 is $4,332.

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

c. Provide a comparison of 2003, 2004, 2005, and 2006 employee insurance premiums.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

WATER SERVICE CORPORATION OF KENTUCKY
Calculation of Salary and Benefits
Item 18 a

		Total Annualized Salary	Increase 4 %	Total Annualized Salary	Percentage Allocated USSC	Salary Allocation
Maintenance						
Bolt, Gregory		$ 30,671	$ 1,180	$ 29,491	100%	$ 30,671
Heck, Travis		23,885	919	22,966	100%	23,885
Johnson, Harvey		35,095	1,350	33,745	100%	35,095
Leonard, James		54,972	2,114	52,858	100%	54,972
Mills, Wendell		40,289	1,550	38,739	100%	40,289
Onkst, James		26,182	1,007	25,175	100%	26,182
Partin, Michael		28,169	1,083	27,086	100%	28,169
Pickard, Michael		24,224	932	23,292	100%	24,224
Russell, R		38,325	1,474	36,851	100%	38,325
Spurlock Charles		37,957	1,460	36,497	100%	37,957
Turner, John		30,164	1,160	29,004	100%	30,164
Yates Jr., Bobby		18,247	702	17,545	100%	18,247
Cox, David (PT)		6,292	242	6,050	100%	6,292
Other		2,559	98	2,461	100%	2,559
Supervisory						
Daniel, Carl		$ 153,920	$ 5,920	$ 148,000	6.22%	$ 9,574
Total Operator Salary		$ 550,950	$ 21,190	$ 529,760		$ 406,604
Office						
Berry, Sandra	(1) (2)	$ 66,724	$ 2,566	$ 64,158	6.22%	$ 4,149
Petrey, Vivian		24,628	947	23,681	100.00%	24,628
Standifer, Reba		36,984	1,422	35,562	100.00%	36,984
Stanis, Veronica	(2)	46,016	1,770	44,246	6.22%	2,861
Thomas, Pamela		26,884	1,034	25,850	100.00%	26,884
Other		$ 788	$ 30	$ 758	100.00%	$ 788
Total Kentucky Office Salary		$ 202,025	$ 7,770	$ 194,255		$ 96,295

(1) Note: in the original filing the total Kentucky Office Salary is $135,301 which mistakenly did not include Sandra Berry's salary of $66,724.

(2) Note: in the original filing these two employees' salary was allocated 100% instead of 6.22% to the total Kentucky Office Salary.

WATER SERVICE CORPORATION OF KENTUCKY
Calculation of Salary and Benefits
Item 18 c

	2003 Health Insurance Premiums	2004 Health Insurance Premiums	2005 Health Insurance Premiums	2,006 Health Insurance Premiums
Maintenance				
Bolt, Gregory	$ 5,350	$ 4,332	$ 4,124	$ 4,268
Heck, Travis	5,350	4,332	4,124	4,268
Johnson, Harvey	5,350	4,332	4,124	4,268
Leonard, James	5,350	4,332	4,124	4,268
Mills, Wendell	5,350	4,332	4,124	4,268
Onkst, James	5,350	4,332	4,124	4,268
Partin, Michael	5,350	4,332	4,124	4,268
Pickard, Michael	5,350	4,332	4,124	4,268
Russell, R	5,350	4,332	4,124	4,268
Spurlock Charles	5,350	4,332	-	-
Turner, John	5,350	4,332	4,124	4,268
Yates Jr., Bobby	5,350	4,332	4,124	4,268
Cox, David (PT)				
Supervisory				
Daniel, Carl	5,350	4,332	4,124	4,268
Total Operator Health Insurance Premiums	$ 69,550	$ 56,316	$ 49,488	$ 51,220
Office				
Berry, Sandra				
Petrey, Vivian	5,350	4,332	4,124	4,268
Standifer, Reba	5,350	4,332	4,124	4,268
Stanis, Veronica				
Thomas, Pamela	5,350	4,332	4,124	4,268
Total Office Health Insurance Premiums	$ 16,050	$ 12,996	$ 12,372	$ 12,804

Note: 2006 insurance premiums are based on a 3.5% increase in total medical costs from 2005, based on a renewal analysis recently available for 2006.

RESPONSE:

See enclosed CD.

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

d. In response to 12(b) of the Commission Staff's First Data Request, Water Service provided its Employee Manual. According to the Employee Manual, the employee is responsible for a portion of the premiums for the health and dental insurance coverages. State whether the 2004 employee health insurance premium of $4,332 exclude, the amount of the premium that the employee paid.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The 2004 health insurance premium of $4,332 represents company paid health costs only.

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

e. Provide the gross amount of the insurance premium for each employee listed, the amount of the premium that was paid by each employee, and how the employee portion of the premium was calculated.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

This question does not apply based on the response to the previous question in18 d.

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

f. Provide a complete description of the "WSC Salary Allocation, including bonus" of $29,306. Separate the amount between the salary and the bonus with an explanation of the purpose of the bonus. Identify the expense account that the $29,306 was allocated.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The $29,306 represents WSC salaries allocated from SE.60 based on the revised allocation. The bonus amount included in the total $29,306 is $201. The $29,306 was allocated to salaries (non-operations).

DATA REQUEST #18

Refer to the Revised w/p(b), Calculation of Salary and Benefits, that was filed December 21, 2005.

g. According to the w/p(b), "Salaries at the WSC level were increased by $70,000 to account for two new hires in HR." Identify the amount allocated to Water Service for the new HR hires and the expense account in which it is recorded. State the date the positions were filed and new employees' actual salaries.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The $70,000 in salaries accounts for one new HR hire who started working on December 27, 2005 and one additional HR hire who will be hired as soon as possible. Both positions are in the human resources field, and the expense account in which the allocation of $1,285.90 (70,000*0.01837) is located, is salaries (non-operations).

DATA REQUEST #19

In response to question 14 of her direct testimony, Ms. Weeks states that, "[s]alaries and wages for operators and office personnel were adjusted by 4 percent to reflect the anticipated raises for employees." However, the rate at the bottom of Revised w/p(b), Calculation of Salary and Benefits, states the salaries include adjustments of 3.5 percent. Explain the discrepancy between the two statements.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

A 4 percent increase in salaries and wages for operators and office personnel should have been used. The 3.5 percent stated in the footnotes is incorrect.

DATA REQUEST #20

According to the revised w/p(b-2), Calculation of Pro Forma Operating Expenses Charged to Plant, the amount of operating expenses charged to plant in 2004 was $121,266. However, in its response the Commission Staff's First Data Request, item 12(a), Water Service states that in 2004 the capitalized amount was $125,579. Explain the discrepancy between the two statements.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The correct amount of operating expenses charged to plant in 2004 is $121,266. The $125,579 stated in the Commission Staff's First Data Request is incorrect.

DATA REQUEST #21

In response to Question 16 of her direct testimony, Ms. Weeks states that in recalculating accumulated depreciation a composite rate of 2 percent was used for water plant and a 25 percent depreciation rate was used for computer and transportation equipment. In its filing of November 3, 2005, Water Service provided "[t]the appropriate useful lives for classes of plant accounts."

a. Recalculate accumulated depreciation, depreciation expense, amortization of CIAC and AIAC, the deferred income taxes using the depreciation lives filed on November, 3, 2004.
b. Determine the effect of the revisions requested in Item 21(a) on Water Service's pro forma operations, rate base, and revenue requirement.
c. Provide copies of all work papers, calculations, and assumptions used in the responses to 21(a) and 21(b).

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

No such document exists.

DATA REQUEST #22

In response to Question 16 in her direct testimony, Ms. Weeks states that , "[t]he rate filing also includes $36,282.69 of organizational costs in utility plant in service that was not booked at the time of acquisition." State the purpose of the organizational costs, why they were not booked at the time of acquisition, and why they should be included in Water Service's rate base.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The purpose of the organizational costs is to organize the Company. These costs were capitalized by the previous companies, Aqua/KWS, Inc. and Utilities of Kentucky, Inc., which were acquired by WSC on August 18, 1992. These organizational costs were overlooked at the time of the booking of the acquisition. These organizational costs should be included in Water Service's rate base because they represent an additional benefit received by customers

DATA REQUEST #23

In response to Question 15 of her direct testimony, Ms. Weeks states that Water Service has invested nearly $1,000,000 in utility plant in service since acquisition. However, in Case No. 2005-00433, Water Service states that "Utilities has infused over $200,000 to fund over 40 capital projects undertaken and completed by Water Service during the short time that Water Service has owned and operated the Kentucky facilities." Explain the discrepancy between these statements.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

There is no discrepancy between these statements, as they relate to different things. Water Service had invested nearly $1,000,000 by the end of the test year. The $200,000 infusion relates to money that Utilities, Inc. has infused to cover capital expenditures.

DATA REQUEST #24

In response to Question 16 of her direct testimony, is Ms. Weeks explains the column entitles "Per Restatement" on Schedule C. Identify the assets that are now being recorded, the date they were placed into service, and explain why they were not originally recorded by Water Service.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The assets being recorded were previously provided with the filing in w/p [p] of exhibit (4) of the application. This schedule will also show the date they were placed in service. All assets recorded on this schedule were originally recorded on the books of Water Service at the time of acquisition, with the exception of an organization entry in the amount of $36,282.69. This entry was inadvertently left out when the original acquisition entry was booked.

DATA REQUEST #25

Refer to Exhibit 10 of the Application, Schedule C, Rate Base and Rate of Return.

a. The first column in the rate base is entitled "Per Restatement." Provide a revised pro forma income statement using Excel that includes the columns for the actual test-period operations and the restatement adjustments.
b. Provide a copy of the revised rate base requested in 25(a) on a computer disk.
c. Accumulated depreciation, CIAC, and AIAC has been restated to reflect a 2 percent depreciation rate from the date the assets were placed in service. State the effect of these adjustments on deferred income taxes. State all assumptions, show all calculations, and provide all work papers used to determine these effects.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

25(a) Please see the enclosed schedule.
25(b) Please see the enclosed disk.
25(c) No such document exists.

WATER SERVICE CORPORATION OF KENTUCKY
CASE NO. 2005-00325
COMMISSION STAFF'S SECOND INFORMATION REQUEST
RESPONSE TO 25(a)

	Per Books	Per Restatement	Change
Gross Plant In Service	$ 6,955,807	$ 6,994,408	$ 38,601
Accumulated Depreciation	(3,084,261)	(2,581,408)	502,853
Net Plant In Service	3,871,546	4,413,000	541,454
Cash Working Capital	149,287	148,617	(670)
Contributions In Aid of Construction	(77,880)	(58,029)	19,851
Advances in Aid of Construction	(113,081)	(92,599)	20,481
Accumulated Deferred Income Taxes	(358,146)	(358,146)	-
Customer Deposits	(114,589)	(114,589)	-
Capitalized Time	-	-	-
Reduction for Transportation Equipment	-	-	-
Water Service Corporation	43,029	43,029	-
Pro Forma Plant	-	-	-
Pro Forma Plant Retirements	-	-	-
Total Rate Base	$ 3,400,167	$ 3,981,283	$ 581,116

DATA REQUEST #26

Refer Water Service's response to Commission Staff's First Data Request, Item 3 and 14, "Pro Forma Plant to be included in Rate Case." The total cost for the project to replace the 100 year old clear well tank is $419,622. Explain why Water Service did not request a Certificate of Public Convenience and Necessity before it began construction of the project.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Water Service obtained all the necessary approvals from the KY Division of Water for the construction and replacement of the 100 year old clear well tank. It is the operator's experience that the Certificate of Convenience & Necessity is usually a request to the commission for a utility company to provide service to a new area. Enclosed is the communication letter that shows that the Commission was notified via letter dated 6/14/05 with support information that the 100 year old well tank was going to be replaced.

#26 (Staff)

Water Service Corp. of Kentucky

An Affiliate of: Utilities, Inc.

Corporate Office
2335 Sanders Road
Northbrook, IL 60062
Telephone 847-498-6440
Fax: 847-498-2066

Local Office
1221 E. Cumberland Avenue
Middlesboro, KY 40965
Telephone 606-248-5730
Fax: 606-248-5736

Regional Office
P.O. Box 240908
Charlotte, NC. 28224
Telephone: 704-525-7990
Fax: 704-525-8174

June 14, 2005

Mr. W. Wakim, P.E.
Water/ Wastewater Manager
Public Service Commission of Kentucky
P.O. Box 615
Frankfort, Kentucky 40602-0615

Re: Response to Periodic Facility Inspection (WSCK- Clinton) on May 18,2005

Dear Mr. Wakim:

In response to the above referenced inspection, the following is the plan of action we have taken to correct the noted deficiency.

1. In July 2004, the Utility completed a clearwell cleaning and inspection, which justified the planning and construction of a new 60,000-gal clearwell. WSCK believes most of its water loss is a direct result of the 100-year old brick lined clear well. Attached is a report from Wet or Dry Tank Inspections of the 100-year old clear well inspection.

2. Attached is a contract between Water Service Corporation of Kentucky & Buckner Engineering Company, 414 South Fourth Street, Union City, Obion County, Tennessee to construct a new 60,000 gal clear well, electrical controls, chemical building, aeration unit, etc.

Water Service Corporation of KY, takes great pride in our past inspection record with the Commission, as well as the May 21st 2003 inspection report which noted " zero deficiencies". We will continue to strive to achieve the same results for future inspections.

If you should have any questions regarding these resolutions, please call me at 606-248-5730.

Sincerely,

James Leonard
Regional Manager

PSC DTR# JA-051605-01

Deficiency Tracking Report

Deficiency Detail (grey sections filled in by PSC)

Utility	Date of Investigation	Investigator
Water Service Corp. of Kentucky (Clinton)	5/16/2005	Jim Laddock

Regulation or Statute found to be deficient:
807 KAR 5:066, Sec. 7 The utility's facilities shall be operated so as to provide adequate and safe service to its customers.

Finding:
Unaccounted water loss of 18% for 2004

If this is a repeat deficiency, date of last Deficiency Report:

Response (attach additional pages as necessary)

1) Explain why the deficiency occurred Include information about what caused the deficiency and why it was not detected by the utility.

100 year old brick-lined clearwell has cracks in floor and sidewall where we believe leakage is occuring. The clearwell repair was placed on hold by past owners for financial reasons; however, under the new owners, this important portion of the Clinton infrastructure was placed in the capital plan by the new owners in 2004 and is currently being engineered to be replaced.

2) Explain actions taken to correct the deficiency, including utility's responsible person, actions taken, and when it was (or will be) done

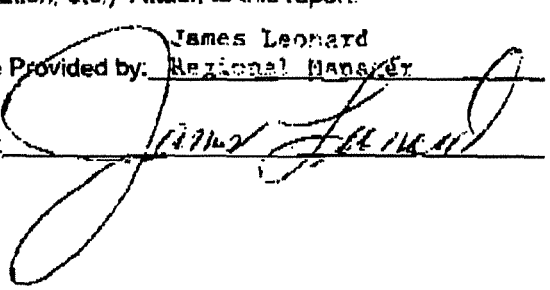
Approval was granted by Water Service Corp. of Ky in 2005 to replace the existing 100-year old clearwell and all other major components at the water treatment facility. James Leonard, WSCK Regional Manager, is responsible for the completion of this project, and upon DOW approval of the engineer's plans, construction will begin immediately. Completion of the project is scheduled for the fall of 2005.

3) Explain actions taken to prevent the deficiency from occurring again, including utility's responsible person, actions taken, and when it was (or will be) done.

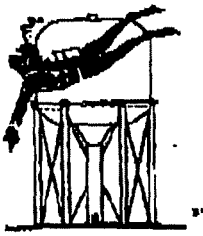
Under the utility's new ownership (WSCK), as well as its local management under the direction of James Leonard, Regional Manager, much more care and planning, as well as capital improvements will be made to ensure continued compliance.

Provide evidence of the implementation of the corrective actions (invoices, photographs, work logs, updated documentation, etc.) Attach to this report.

Response Provided by: James Leonard, Regional Manager Date: June 14, 2005

Signature: 

WET or DRY



Tank Inspection Services

Member: NACE, SSPC, ASTM, AWWA, NFPA
National Association of Corrosion Engineers Coatings Inspectors and Staff

16 July 2004
Water Service Corporation
Of Kentucky
Mr. James Leonard Regional Manager
P. O. Box 818
Middlesboro, KY 40965

Re: Clinton Water Treatment Clear well

Mr. Leonard,

Below are our findings during the cleaning and evaluation of the existing clear well located in Clinton, Ky.

The historical info that we have suggests that the structure was constructed sometime during the 1940's or early 50's. Its construction appears to be brick with a cement veneer sidewalls and floor that was originally built without a roof. Sometime over the years a roof was added with a main center support column constructed of mortar and fieldstones, with two pumps, a chlorine & fluoride injection system.

We discovered that the structure is in need structural of attention and most likely replacement a large portion of the cement veneer mixture used during construction has since deteriorated and is most likely contributing to water loss in the system. Also after significant precipitation events could lead to infiltration into the tank itself.

In our opinion the tank should be replaced, if repair is undertaken we suggest that all voids be filled with a high performance cement/epoxy mixture that is allowed to fully cure followed by the application of a NSF 61 approved lining material formulated for application to concrete.

Thank you,
Jay L. Hoffman
Jay L. Hoffman
VP Operations

1609 Hillsboro Road Campbellsburg, KY 40011
502-532-6190 Office 502-532-7136 Fax
diver@aye.net

AGREEMENT FOR ENGINEERING SERVICES

THIS Agreement, made this 17th day of March, 2005, by and between Water Service Corp. of Kentucky, hereafter referred to as the OWNER, and BUCKNER ENGINEERING COMPANY, 414 SOUTH FOURTH STREET, UNION CITY, OBION COUNTY, TENNESSEE. hereinafter referred to as the ENGINEER.

THE OWNER intends to construct a 60,000 gallon clear well, electrical controls, chemical building, aeration unit, etc.

in Hickman County, State of Kentucky, the ENGINEER agrees to perform the various professional ENGINEERING services for the design and construction of said system.

WITNESSETH:

That for and in consideration of the mutual covenants and promises between the parties hereto, it is hereby agreed:

ENGINEERING SERVICES

The ENGINEER shall furnish ENGINEERING services as follows:

1. The ENGINEER will conduct preliminary investigations, prepare preliminary drawings, prepare a project schedule and provide a preliminary itemized list of probable construction costs.
2. The ENGINEER will attend conferences with the OWNER or other interested parties as may be reasonably necessary.
3. After the OWNER'S approval of the preliminary and project design. The ENGINEER shall prepare construction drawings, specifications and contract documents, and a final cost estimate based on the detailed plans and specifications for the project. It is also understood that if subsurface explorations (such as bores, soil tests, rock sounding and the like) are required, the ENGINEER will furnished coordination of said explorations without additional charge, but the costs of such exploration shall be paid for by the OWNER.
4. Prior to the advertisement for bids, the ENGINEER will provide for the construction contract, not to exceed 4 copies of detailed drawings, specifications, and contract documents for use by the appropriate Federal, State, and local agencies from whom approval of the project must by obtained. Review and approval fees required by the reviewing agency shall be the responsibility of the OWNER; The cost of such drawings, specifications, and contract documents shall be included in the compensation paid to the ENGINEER.
5. The ENGINEER will furnish additional copies of the drawings, specifications and contact documents as required by prospective bidders, material supplies, and other interested parties, but may charge them for the reasonable cost of such copies. Upon award of the contract, the ENGINEER will furnish to the OWNER four (4) sets of executed contract documents. The cost of these sets shall be included in the compensation paid to the ENGINEER. Original documents, survey notes, tracings, and the like except those furnished to the ENGINEER by the OWNER, are

Ernie Fletcher
Governor

LaJuana S. Wilcher, Secretary
Environmental and Public
Protection Cabinet

Christopher L. Lilly
Commissioner
Department of Public Protection

Commonwealth of Kentucky
Public Service Commission
211 Sower Blvd.
P.O. Box 615
Frankfort, Kentucky 40602-0615
Telephone: (502) 564-3940
Fax: (502) 564-3460

Mark David Goss
Chairman

Gregory Coker
Commissioner

May 26, 2005

Mr. Mike Pickard, Manager
Water Service Corp. of Kentucky
P. O. Box 178
Clinton, KY 42031

Re: Periodic Facilities Inspection

Dear Mr. Pickard:

On May 18, 2005, Mr. Jim Adcock conducted a periodic compliance inspection of the Water Service Corp. of Kentucky (Clinton). Mr. Adcock noted one area of your operation that needs improvement. The previous inspection was conducted on May 18, 2004 noting two deficiencies.

Please review the enclosed inspection report and complete and return the Deficiency Tracking Report by June 23, 2005. If you have any questions or need further assistance, please contact Mr. Adcock at (502) 564-3940, Ext. 415.

Sincerely,

George W. Wakim, P.E.
Manager
Water and Sewer Branch

GWW:JA:jep
Enclosures E:\Inspections\Adcock\JA-051805.xls
C: Julie W. Roney, Supervisor, Drinking Water Branch, DOW

Public Service Commission

UTILITY INSPECTION REPORT
Water Service Corp. of Kentucky (Clinton)
Clinton, Kentucky

Utility operations, utility maintenance, utility management and their effect on utility services are a primary concern of the Commission and this Division. Our ongoing inspection program is intended to ensure that the utility's office procedures and its facilities operation are in compliance with the Kentucky Revised Statutes (KRS 278) and the Kentucky Administrative Regulations (807 KAR). During each inspection, I am stressing: (1) the importance of periodic testing of all meters, (2) the importance of accounting for all water purchased, produced, and sold, (3) the importance of having and maintaining a water loss prevention program, (4) the need for surveillance of system operations, and (5) the significance of good operating records.

The subject inspection was made May 18, 2005. The utility consists of a distribution system and treatment plant facility operating in Hickman County, Kentucky. It has approximately 666 customers on its system. The utility representative providing information and assistance during this inspection was Mike Pickard, Manager.

During the office inspection, I reviewed records, including but not limited to: pressure charts/records, meter testing, flushing, service interruptions, complaints, facilities inspections and procedures, facilities maintenance, safety guidelines, and a copy of a water shortage response plan, etc. Further, during the field inspection, I visited the following facilities: the Pruitt Road tank, Washington tank, Short and Depot tank and treatment plant. I also attended an on-site water main break caused by the county road department.

In addition, 12 of the utility's customers were contacted in an informal survey as to the general overall service they were receiving from this utility. These 12 customers rated this utility's service as good.

The noted deficiency is enclosed.

Recommendations

Water Service Corp. of Kentucky (Clinton) should, no later than June 23, 2005, submit to the Public Service Commission a detailed written response indicating the actions taken or planned to correct each noted deficiency with applicable supporting documentation (such as bids, ads, invoices, etc), and the dates each action will be started and completed. Failure to submit such a response to the Commission may result in the initiation of a formal proceeding to investigate Water Service Corp. of Kentucky (Clinton)'s maintenance and operating practices.

Submitted,
May 25, 2005

GW Jim Adcock

Jim Adcock
Utility Investigator

PSC DTR# JA-051805-01

Deficiency Tracking Report

Deficiency Detail: (grey sections filled in by PSC)

Utility:	Date of Investigation:	Investigator:
Water Service Corp. of Kentucky (Clinton)	5/18/2005	Jim Adcock

Regulation or Statute found to be deficient:

807 KAR 5:066 Sec 2: The utility's facilities shall be operated so as to provide adequate and safe service to its customers.

Finding:

Unaccounted water loss of 18% for 2004.

This is a repeat deficiency, date of last deficiency report:

Response (attach additional pages as necessary)

1) Explain why the deficiency occurred. Include information about what caused the deficiency and why it was not detected by the utility.

2) Explain actions taken to correct the deficiency, including utility's responsible person, actions taken, and when it was (or will be) done.

3) Explain actions taken to prevent the deficiency from occurring again, including utility's responsible person, actions taken, and when it was (or will be) done.

Provide evidence of the implementation of the corrective actions (invoices, photographs, work logs, updated documentation, etc.) Attach to this report.

Response Provided by:_____ Date:_____

Signature:_____

DATA REQUEST #27

In its Order in Case No. 10481, the Commission stated that "[a]djustments for post test-period additions to plant in service should not be requested unless all revenues, expenses, rate, and capital items have been updated to the same period as the plant additions."

a. State whether Water Service's application is in complies with this requirement.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Yes, Water Service's application complies with this requirement. There is no revenue growth adjustment. The expenses, rate base, and capital items have been updated to the same period as the plant additions.

DATA REQUEST #27

In its Order in Case No. 10481, the Commission stated that "[a]djustments for post test-period additions to plant in service should not be requested unless all revenues, expenses, rate, and capital items have been updated to the same period as the plant additions."

b. Identify each adjustment that Water Service proposes to its revenues, expenses, rate base, and capital that follow this post test-period requirement.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Please see the filing in the application foot notes to Tab 4, Schedule B and Tab 10 Schedule C.

DATA REQUEST #28

Administrative Regulation 807 KAR 5:001, Section 10(1), provides that all applications for a general rate adjustment shall be supported by either a "twelve (12) month historical test period which may include adjustments for known and measurable changes" or a "fully forecasted test period." Given that Water Service had the option to file a forecasted test period, explain why adjustments to reflect estimated post test-period plant additions and inflationary expense adjustments should be allowed in a rate case with an historical test-period.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Adjustments to reflect estimated post test-period plant additions and inflationary expense adjustments should be allowed in a rate case with an historical test-period because Administrative Regulation 807 KAR 5:001, Section 10(1), provides that all applications for a general rate adjustment shall be supported by either a "twelve (12) month historical test period which may include adjustments for known and measurable changes" or a "fully forecasted test period."

DATA REQUEST #29

Refer to the Distribution of Expenses Year End 2004. Throughout this document there are numerous references to distribution codes. List and describe each code, explain how it is calculated.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Please refer to the Manual (WSC Distribution of Rate Base and Expenses Handbook) provided at the beginning of the rate case. This Manual provides explanations of all distribution codes and how they are calculated.

DATA REQUEST #30

Refer to the Distribution of Expenses Year End 2004 SE 50, Distribution of Direct Salaries and Benefits Year Ended 12/31/04 at 8. Provide an explanation and description of the services that were provided to support the direct allocation of the $10,036 operator's salary from Northern Carolina to Water Service. Is this a normal occurrence and identify the amount that is included in the pro forma operations.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The services provided to support the direct operator's salary include responsibility for all operating personnel, facilities, maintenance, capital projects, and environmental compliance to ensure that all Kentucky customers receive the best possible service. This is a normal occurrence. The amount included in the pro forma operations is $9,206 which is based on Carl Daniel's salary times the percentage allocated to Water Service. The $10,036 salary allocation in the Distribution of Expenses Year End 2004 SE 50 is incorrect because Carl Daniel's time is allocated 6.22% to Water Service. His allocation was recalculated to correctly capture his salary allocation to Water Service which is not 6.22%.

DATA REQUEST #31

Refer to the Distribution of Expenses Year End 2004 SE 60, Distribution of General Expenses.

a. This document consists of 341 pages, but only pages 34 through 42 were provided. Describe the information that is contained on the missing pages and explain why these pages were not provided.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The document has a page that has the number 341, but that page number is out of the context for the Distribution of Expenses Year End 2004 SE 60 document. The actual pages are 34 through 42. The page with the 341 number on it is a segment from another document that does not further relate to SE 60.

DATA REQUEST #31

Refer to the Distribution of Expenses Year End 2004 SE 60, Distribution of General Expenses.

b. Provide a breakdown of salaries-office $1,594,956 and describe the services that these employees provide Water Service.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The $1,594,956 in office salaries represents the salaries in the Northbrook corporate office only. These office salaries are composed of all kinds of different departments such as computer support, accounting, regulatory accounting, finance, administrative, billing and human resources.

DATA REQUEST #31

Refer to the Distribution of Expenses Year End 2004 SE 60, Distribution of General Expenses.

c. Provide a breakdown of bank service charges of $227,072.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The $227,072 for 2004 is total bank charges allocated from Water Service Corporation to all of Utilities, Inc.'s operating companies. Out of this total, $4,650.63 is allocated to Kentucky. The majority of the $4,650.63 includes bank service charges for maintaining the accounts, check cashing, deposits, processing, etc.

DATA REQUEST #32

Refer to the Distribution of Expenses Year End 2004 WSC Rate Base.

a. State whether Water Service's requested rate base includes the allocation of the Service Company's rate base. If yes, state where this allocation is recorded and the amount.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Yes, it was. The amount was $43,029 and it is shown as an addition to rate base (see Schedule C).

DATA REQUEST #32

Refer to the Distribution of Expenses Year End 2004 WSC Rate Base.

b. Identify the proceedings in which this Commission has allowed a utility to recover the allocation of the Service Company's rate base.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

While the Company is not aware of any Kentucky rate cases where the Commission has allowed recovery of the allocation of the Service Company's rate base, our company operates in 16 other states where the Commission has allowed us to recover the allocation of the Service Company's rate base. For example, in a North Carolina's proceeding, Docket #W-1151-Sub 1, the allocation of the Service Company's rate base was allowed. The corporate office provides all utility subdivisions with the benefit of all the services provided at the corporate level, including, but not limited to regulatory services, accounting services, billing service, and human resources. If each subdivision would have a stand alone company providing all of these services, it would be at a much higher rate than the rate allocated from the Service Company. All customers benefit from this less expensive allocation from the Service Company and therefore this allocation should be allowed in the rate base.

DATA REQUEST #33

Refer to Annual Report of Utilities of Kentucky, Inc. to the Public Service Commission of the Commonwealth of Kentucky for the Calendar Year Ended December 31, 1998 at 23 "Statement of Retained Earnings."

a. Provide a detailed explanation of the acquisition adjustment debit that reduces retained earnings by $1,702,742.
b. State the effect to Water Service's rate base, capital structure, and revenue requirement if this adjustment were reversed.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

This is the prior company's annual report, and their related acquisition adjustment, which would have not been booked by Water Service Corporation of Kentucky.

DATA REQUEST #34

In response to Question 18 of her direct testimony, Ms. Weeks explains that Water Service is proposing that its rates be determined by utilizing the rate of return on rate base methodology. Given that the requested rate base exceeds Water Service's capital structure by $837,426, explain why the stockholders are entitled to earn a return in excess of the amount they actually have invested.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

In calculating the capitalization of Water Service, the Rate Base in the amount of $3,981,283 should have been used instead of the Rate Base in the amount of $5,205,581. The correct $3,981,283 number is comparative to the Total Assets in the amount of $4,368,155 since it is from the same year ended 12/31/04. The $5,205,581 number represents the Rate Base as of 12/31/04 plus pro forma adjustments in the amount of $1,224,299. These adjustments inflate the Rate Base for capitalization purposes. The actual 12/31/04 Rate Base in the amount of $3,981,283 is less than the Total Assets, and therefore stockholders do not earn a return in excess of what they actually have invested.

DATA REQUEST #35

Refer to Water Services response to Commission Staff's First Data Request, Item 20. List each fringe benefit offered to Water Service Corporation employees and state the cost to be allocated to Water Service of each benefit by employee for 2004, 2005, and the expected cost in 2006.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The employee fringe benefits are listed in the employee benefit manual (WSC Distribution of Expenses Year End 2004) which was provided in the beginning of the rate case. Please refer to page 32 for Office employees and please refer to page 40 for operator employees.

DATA REQUEST #36

Refer to Water Services response to Commission Staff's First Data Request, Item 22. Explain how Water Service developed the budget for salaries and wages if there is no budgeted number of employees.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Water Services does not have a budget.

DATA REQUEST #37

Refer to Water Services response to Commission Staff's First Data Request, Item 25. Pro vide a group medical insurance policy for Water Service Corporation.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Please see the enclosed group medical insurance policy.

Utilities, Inc.

PPO I

BENEFITS	In-Network	Out-of-Network
Lifetime Comprehensive Major Medical Coverage:	$3,000,000	
Single Deductible:	$300	
Single+1 Deductible:	$600	
Family Deductible: An Aggregate Deductible.	$700	
Out-of-Pocket Expense Limitation: The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, excluding the deductible. Non-PPO charges apply toward a separate out-of-pocket limit. Elective MSA copayment charges in excess of the Schedule of Maximum Allowances (SMA) and items asterisked (*) below do not apply to any out-of-pocket limit.	**$750 Single $1,500 Single+1 $1,500 Family**	**$1,750 Single $3,500 Single+1 $3,500 Family**
Inpatient Hospital Services: Room allowances based on the hospital's most common semi-private room rate. Pre-admission Testing, Coordinated Home Care, and Skilled Nursing Facility are paid on the same basis. Deductible per Admission:	**90% N/A**	**70% $300***
Outpatient Diagnostic Tests: (Hospital & Physician)	**100%+**	**70%**
Outpatient Surgery: (Hospital & Physician)	**90%**	**70%**
Outpatient Hospital Services: Including Radiation and Chemotherapy	**90%**	**70%**
Emergency Accident/Medical Care: (Hospital & Physician) Emergency Medical & Diagnostic Services of a medical condition displaying itself by symptoms of sufficient severity (including severe pain) such that a prudent person could reasonably expect that the absence of immediate medical attention could place the health of the individual in serious jeopardy. Payments are based on the SMA.	**90%**	**90%**
Inpatient Mental Health:	**90%***	**70%***
Outpatient Mental Health:	**90%***	**70%***
Inpatient Substance Abuse: Limited to $10,000 combined inpatient & outpatient per calendar year. Limited to $25,000 combined inpatient & outpatient per lifetime.	**90%***	**70%***
Outpatient Substance Abuse: Limited to $10,000 combined inpatient & outpatient per calendar year. Limited to $25,000 combined inpatient & outpatient per lifetime.	**90%***	**70%***
Physician Office Visit: Office Visit charge and certain services within the office visit.	**100%+ $15 copay***	**70%**
Well Care: Well Adult Care (over age 18) limited to $300 per calendar year. Calendar year maximum and copay do not apply to routine mammograms, pap smears, and PSA tests. Well Child Care limited to $1,000 per calendar year.	**100%+ $15 copay***	**70%***
Medical/Surgical Care: Payments are based on the SMA. PPO providers have agreed to accept the SMA as payment in full for covered services, excluding your deductible and any coinsurance. Non-PPO providers do not accept SMA as payment in full. You will be liable for differences between the physician's charge and our payment.	**90%**	**70%**
Temporomandibular Joint Dysfunction: $2,500 lifetime maximum	**90%***	**70%***
Chiropractic Services: Limited to 30 visits per calendar year.	**100%+ $15 copay***	**70%***
Speech, Occupational & Physical Therapy: Limited to $10,000 per therapy per calendar year.	**90%***	**70%***
Prescription Drugs: Prescription Drug benefit paid at 100% after copayment at participating pharmacies. Provides up to a 30 day supply. Drugs purchased at a non-participating pharmacy are paid at 75% after copayment. Mail order prescription maintenance drugs paid at 100% after **two times** the copayment. Provides up to a 90 day supply of maintenance drugs used on a continuous basis for treatment of chronic health conditions.	**$7 copay* generic $25 copay* brand**	**75% after copay $7 copay* generic $25 copay* brand**
OTHER SERVICES	**Coverage Level**	
Other Covered Services: Blood and blood components; leg, arm and neck braces; private duty nursing*($3,000/month); ambulance service; oxygen & its administration; surgical dressings, casts and splints; durable medical equipment; prosthetic devices.	**80%**	

BASIC PROVISIONS

Medical Services Advisory: Notification required prior to all elective admissions. Emergency and Obstetric Admission Notification required within 2 business days of admittance. Precertification is also required for Private Duty Nursing, Skilled Nursing Facility care and Coordinated Home Care.
If employee elects not to notify MSA Advisor or follow advice given, hospital benefits reduced by 50%.*

Transplant Coverage: Cornea, kidney, bone marrow, heart valve, muscular-skeletal or parathyroid human organ or tissues. In addition, heart, heart/lung, liver, pancreas, and pancreas/kidney may be covered under certain circumstances when performed in an approved facility and with Medical Director approval.

Pre-existing Conditions Waiting Period: Complies with HIPPA. Waived for new groups if replacing other coverage.

Dependent Eligibility: To age 21, 25 if full-time student.

Coordination of Benefits: This program coordinates benefits with other group plans.

* **Copayments do not apply to any out-of-pocket expense limitation.**
\+ **Deductible does not apply.**
Coinsurance amounts in shaded areas, except as otherwise noted, apply to the PPO Out-of-Pocket Expense Limitation.

Note: This sheet only highlights the general program. Specific program details are contained in the Master Policy issued to the Group.

www.bcbsil.com

Rev. 10/24/05

Utilities, Inc.

PPO II

BENEFITS	In-Network	Out-of-Network
Lifetime Comprehensive Major Medical Coverage:	$3,000,000	
Single Deductible:	$300	
Single+1 Deductible:	$600	
Family Deductible: An Aggregate Deductible.	$900	
Out-of-Pocket Expense Limitation: The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, excluding the deductible. Non-PPO charges apply toward a separate out-of-pocket limit. Elective MSA copayment charges in excess of the Schedule of Maximum Allowances (SMA) and items asterisked (*) below do not apply to any out-of-pocket limit.	$1,500 Single $3,000 Single+1 $4,500 Family	$3,000 Single $6,000 Single+1 $9,000 Family
Inpatient Hospital Services: Room allowances based on the hospital's most common semi-private room rate. Pre-admission Testing, Coordinated Home Care, and Skilled Nursing Facility are paid on the same basis. Deductible per Admission:	90% N/A	70% $300*
Outpatient Diagnostic Tests: (Hospital & Physician)	100%+	70%
Outpatient Surgery: (Hospital & Physician)	90%	70%
Outpatient Hospital Services: Including Radiation and Chemotherapy	90%	70%
Emergency Accident/Medical Care: (Hospital & Physician) Emergency Medical & Diagnostic Services of a medical condition displaying itself by symptoms of sufficient severity (including severe pain) such that a prudent person could reasonably expect that the absence of immediate medical attention could place the health of the individual in serious jeopardy. Payments are based on the SMA.	90%	90%
Inpatient Mental Health:	90%*	70%*
Outpatient Mental Health:	90%*	70%*
Inpatient Substance Abuse: Limited to $10,000 combined inpatient & outpatient per calendar year. Limited to $25,000 combined inpatient & outpatient per lifetime.	90%*	70%*
Outpatient Substance Abuse: Limited to $10,000 combined inpatient & outpatient per calendar year. Limited to $25,000 combined inpatient & outpatient per lifetime.	90%*	70%*
Physician Office Visit: Office Visit charge and certain services within the office visit.	100%+ $25 copay*	70%
Well Care: Well Adult Care (over age 18) limited to $300 per calendar year. Calendar year maximum and copay do not apply to routine mammograms, pap smears, and PSA tests. Well Child Care limited to $1,000 per calendar year.	100%+ $25 copay*	70%*
Medical/Surgical Care: Payments are based on the SMA. PPO providers have agreed to accept the SMA as payment in full for covered services, excluding your deductible and any coinsurance. Non-PPO providers do not accept SMA as payment in full. You will be liable for differences between the physician's charge and our payment.	90%	70%
Temporomandibular Joint Dysfunction: $2,500 lifetime maximum	90%*	70%*
Chiropractic Services: Limited to 30 visits per calendar year.	100%+ $25 copay*	70%*
Speech, Occupational & Physical Therapy: Limited to $10,000 per therapy per calendar year.	90%*	70%*
Prescription Drugs: Prescription Drug benefit paid at 100% after copayment at participating pharmacies. Provides up to a 30 day supply. Drugs purchased at a non-participating pharmacy are paid at 75% after copayment. Mail order prescription maintenance drugs paid at 100% after **two times** the copayment. Provides up to a 90 day supply of maintenance drugs used on a continuous basis for treatment of chronic health conditions.	$7 copay* generic $30 copay* brand	75% after copay $7 copay* generic $30 copay* brand
OTHER SERVICES	**Coverage Level**	
Other Covered Services: Blood and blood components; leg, arm and neck braces; private duty nursing*($3,000/month); ambulance service; oxygen & its administration; surgical dressings, casts and splints; durable medical equipment; prosthetic devices.	80%	

BASIC PROVISIONS

Medical Services Advisory: Notification required prior to all elective admissions. Emergency and Obstetric Admission Notification required within 2 business days of admittance. Precertification is also required for Private Duty Nursing, Skilled Nursing Facility care and Coordinated Home Care.
If employee elects not to notify MSA Advisor or follow advice given, hospital benefits reduced by 50%.*
In addition, heart, heart/lung, liver, pancreas, and pancreas/kidney may be covered under certain circumstances when performed in an approved facility and with Medical Director approval.

Pre-existing Conditions Waiting Period: Complies with HIPPA. Waived for new groups if replacing other coverage.

Dependent Eligibility: To age 21, 25 if full-time student.

Coordination of Benefits: This program coordinates benefits with other group plans.

* Copayments do not apply to any out-of-pocket expense limitation.
\+ Deductible does not apply.
Coinsurance amounts in shaded areas, except as otherwise noted, apply to the PPO Out-of-Pocket Expense Limitation.

Note: This sheet only highlights the general program. Specific program details are contained in the Master Policy issued to the Group.

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Rev. 10/24/05

BlueCare® DENTAL
TRADITIONAL PLAN

BlueCross BlueShield of Illinois

The following is a list of common services available through the BlueCare® Traditional Plan.
This fee-for-service plan allows the member the freedom to choose a provider without network requirements.

HIGHLIGHT SHEET- Utilities, Inc.

Benefits	Benefit Level
Benefit Period Maximum	$1,000
Deductible	$25 per person per benefit period $75 maximum per family (Deductible applies to Primary and Major services only)
Dependent Coverage	Spouse and unmarried dependents up to age 21 or unmarried, full-time students up to age 25.
Preventive Services Dental Exams (2 exams per benefit period) Prophylaxis (2 cleanings per benefit period) Fluoride Treatment (to age 19) Dental X-rays Sealants (to age 19) Space Maintainers (to age 19)	100% of the Usual and Customary
Emergency Services Emergency Exams Treatment for the relief of pain	100% of the Usual and Customary
Primary Services Routine Fillings (amalgams and resins) Endodontics – root canals – apicoectomy – direct pulp caps – hemisection Periodontics – scaling and root planing – gingivectomy – periodontal maintenance – osseous surgery Oral Surgery – extractions, except as excluded under "Special Limitations" – alveoloplasty Recementing of Crowns and Bridges	80% of the Usual and Customary
Major Services Inlays, Onlays and Crowns (other than temporary crowns) Full and Partial Dentures Bridges Crown, Bridge and Denture Repairs Denture Adjustments, Rebasing and Relining	50% of the Usual and Customary
Orthodontics	No Benefit

Please note: *This information only provides highlights of this program. Please see the BlueCare Dental Traditional Certificate for additional benefit information.*

An [illegible] With You in Mind

you really seeing your best? Or are you simply used to the view? With good vision, your experiences are clearer. Sharper. Brighter.

Besides helping you see better, routine eye exams can detect a number of serious health conditions such as glaucoma, cataracts and diabetes. Even cancer. Plus, eye exams for kids can spot problems that can impact learning and development.

Always Accepting New Patients

is important.

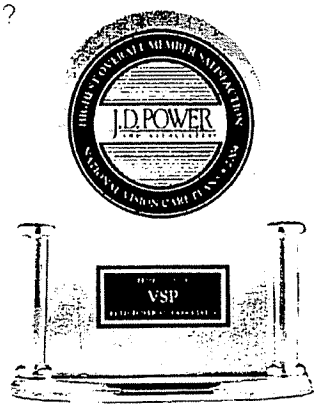
VSP network doctors are located right where you need them — close to work, home and shopping centers. They provide exceptional care and offer a wide selection of frames to choose from — all at one convenient location. Their commitment to care and service grows with you and your family for a lifetime of care.

No ID cards. No claim forms. Easy as 1, 2, 3.

1. Find a VSP network doctor at **vsp.com** or call 800-877-7195.
2. Make an appointment and tell the doctor you are a VSP member.
3. Your doctor and VSP will handle the rest.

Answers Anytime, Anywhere

What's important to you? Do you need an evening appointment? Interested in a doctor who focuses on sports eyewear or children? Searching for information on conditions of the eye? Visit **vsp.com** today. You'll like what you see.



2004 National Vision Plan Member Satisfaction Study. Study is based on [illegible] respondents who are members of large national vision plans. Study conducted for VSP by J.D. Power and Associates.

Your eyecare benefit is brought to you by Utilites Inc. and VSP.

Your Coverage

When visiting a VSP network doctor, you'll receive:
Exam covered in full ..... ***every 12 months***

Prescription Glasses

Lenses covered in full ..... ***every 12 months***
Single vision, lined bifocal and lined trifocal lenses.

Frame ..... ***every 24 months***
Frame of your choice covered up to $ 120.00. Plus, 20% off any out-of-pocket costs.

~OR~

Contacts ..... ***every 12 months***
When you choose contacts instead of glasses, your $120.00 allowance applies to the cost of your contacts and the fitting and evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts. If you choose contacts you will be eligible for a frame 24 months from the date the contacts were obtained.

Current soft contact lens wearers may qualify for VSP's Contact Lens Care Program that includes a contact lens exam (fitting and evaluation) and initial lens supply. Learn more from your doctor or vsp.com.

Extra Discounts and Savings

Laser Vision Correction Discounts

Prescription Glasses

- *Polycarbonate lenses for dependent children covered in full (effective 1/1/05)*
- *Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives*
- *20% off additional prescription glasses and sunglasses**

Contacts*

- *15% off cost of contact lens exam (fitting and evaluation)*

* Available from the same VSP doctor who provided your eye exam within the last 12 months

Your Copays

Exam	**$10.00**
Prescription Glasses	**$25.00**
Contacts	**No copay applies**

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call us first at 800-877-7195.

Out-of-Network Reimbursement Amounts:

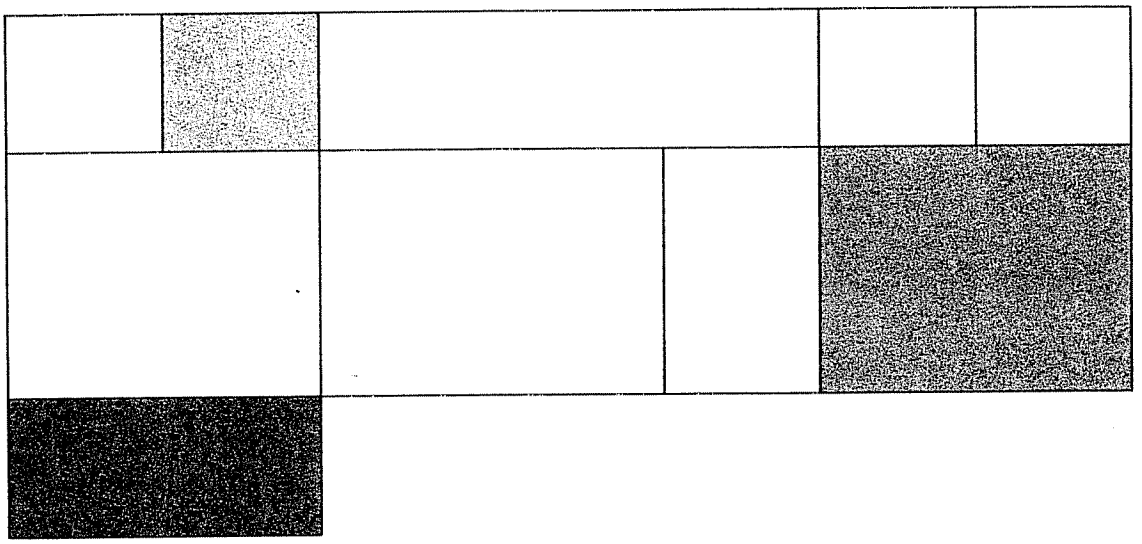
Exam	*Up to $25.00*
Lenses:	
Single Vision	*Up to $30.00*
Lined Bifocal	*Up to $35.00*
Lined Trifocal	*Up to $45.00*
Frame	*Up to $45.00*
Contacts	*Up to $105.00*

VSP guarantees service from VSP network doctors only.

In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

UTILITIES, INC.

#37 (Staff)



Your Health Care Benefit Program
Medical, Dental and
Prescription Drug Benefits

P17023 and 017022

Effective Date: January 1, 2005

A message from

Utilities, Inc.

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

Utilities, Inc.

Utilities, Inc.
2335 Sanders Road
Northbrook, IL 60062
(847) 498-6440

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

LIMITED BENEFITS FOR NON-PARTICIPATING PROVIDERS

You should be aware that when you elect to receive Covered Services from a Non-Participating Professional Provider in non-emergency situations, the amount of the benefit payment to such Non-Participating Professional Provider will be a reduced benefit payment that would have been made if services had been rendered by a Participating Professional Provider. **In certain cases, you can expect to pay in excess of 50% of the Non-Participating Professional Provider's billed charge even after the Claim Administrator has paid the Maximum Allowance under your coverage.** Participating Professional Providers have agreed to accept the Maximum Allowance (please refer to the definition of "Maximum Allowance") with no additional billing after you have paid your Coinsurance and deductible amount.

You may obtain further information about the participating status of Professional Providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE MEDICAL SERVICES ADVISORY PROGRAM	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet
MSA®′ Registered Mark of Health Care Service Corporation a Mutual Legal Reserve Company	
Lifetime Maximum for all Benefits	$3,000,000
Individual Deductible	$300 per benefit period
Individual + 1 Deductible	$600 per benefit period
Family Deductible	$850 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$1,500 per benefit period
— Non-Participating Provider	$3,000 per benefit period
— Non-Administrator Provider	No limit
Individual + 1 Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$3,000 per benefit period
— Non-Participating Provider	$6,000 per benefit period
— Non-Administrator Provider	No limit
Family Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$3,750 per benefit period
— Non-Participating Provider	$6,000 per benefit period
— Non-Administrator Provider	No limit
Private Duty Nursing Service Benefit Maximum	$3,000 per month
Wellness Care (age 18 & over) Benefit Maximum	$300 per benefit period
Muscle Manipulations Benefit Maximum	30 visits per benefit period
Physical Therapy Services Benefit Maximum	$10,000 per benefit period

Occupational Therapy Benefit Maximum	$10,000 per benefit period
Speech Therapy Benefit Maximum	$10,000 per benefit period
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	$2,500
Inpatient and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$10,000
Lifetime Maximum Inpatient and Outpatient Substance Abuse RehabilitationTreatment	$25,000

HOSPITAL BENEFITS

Payment level for Covered Services from a **Participating Provider:**	
— Inpatient Covered Services	90% of the Eligible Charge, after the deductible
— Outpatient Covered Services	90% of the Eligible Charge, after the deductible
— Outpatient Diagnostic Services	100% of the Eligible Charge, no deductible
— Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	90% of the Eligible Charge, after the deductible
Payment level for Covered Services from a **Non-Participating Provider:**	
— Inpatient Deductible	$300 deductible per admission plus $300 admission fee
— Inpatient Covered Services	70% of the Eligible Charge, after the deductible
— Outpatient Covered Services	70% of the Eligible Charge, after the deductible

— Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	70% of the Eligible Charge, after the deductible
Payment level for Covered Services from a **Non-Administrator Provider**	50% of the Eligible Charge
Hospital Emergency Care	
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider	90% of the Eligible Charge, after the deductible
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider	90% of the Eligible Charge, after the deductible
PHYSICIAN BENEFITS	
Payment level for Surgical/ Medical Covered Services	
— Participating Provider	90% of the Maximum Allowance, after the deductible
— Non-Participating Provider	70% of the Maximum Allowance, after the deductible
Physician office Copayment	
— Participating Provider	$25 per visit, then payable at 100%
— Non-Participating Provider	70% of the Maximum Allowance, after the deductible
Payment level for Emergency Accident Care when rendered by a Physician	90% of the Maximum Allowance, after the deductible
Payment level for Emergency Medical Care when rendered by a Physician	90% of the Maximum Allowance, after the deductible
Payment level for Outpatient Diagnostic Service	
— Participating Provider	100% of the Maximum Allowance, no deductible

— Non-Participating Provider	70% of the Maximum Allowance, no deductible
Payment level for Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	
— Participating Provider	90% of the Maximum Allowance
— Non-Participating Provider	70% of the Maximum Allowance
Additional Surgical Opinion	100% of the Claim Charge
OTHER COVERED SERVICES	
Payment level	80% of the Eligible Charge or Maximum Allowance
PRESCRIPTION DRUG PROGRAM BENEFITS	
Copayment	
— generic drugs and diabetic supplies	$5 per prescription
— brand name drugs	$30 per prescription
Home Delivery Prescription Drug Program	
Copayment	
— generic drugs and diabetic supplies	$10 per prescription
— brand name drugs	$60 per prescription
DENTAL BENEFITS	
Individual Deductible	$25 per benefit period
Individual + 1 Deductible	$50 per benefit period
Family Deductible	$75 per benefit period
Preventive Services Benefit Payment Level	100% of the U&C Fee*, no deductible
Emergency Services Benefit Payment Level	100% of the U&C Fee*, no deductible
Primary Services Benefit Payment Level	80% of the U&C Fee*, after the deductible

Major Services Benefit Payment Level	50% of the U&C Fee*, after the deductible
Benefit Period Maximum	$1,000

*Usual and Customary Fee

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a

Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the

Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE..... means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of

another state but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT..... means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE .....means coverage you had under any of the following:

(i) a group health plan;

(ii) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

(iii) Medicare (Parts A, B or C of Title XVIII of the Social Security Act);

(iv) Medicaid (Title XIX of the Social Security Act);

(v) military service-related care;

(vi) the Indian Health Service or a tribal organization;

(vii) a State health benefits risk pool;

(viii) the Federal Employees Health Benefits Program;

(ix) a public health plan maintained by a State, county or other political subdivision of a State;

(x) Section 5(e) of the Peace Corps Act.

CRNA.....means a Certified Registered Nurse Anesthetist, who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A "Participating CRNA" means a CRNA who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating CRNA" means a CRNA who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified in accordance with the guidelines established by Medicare.

ELIGIBLE CHARGE.....means (a) in the case of a Provider other than a Professional Provider which has a written agreement with the Claim Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with the Claim Administrator to provide care to you at the time Covered Services are rendered, ither of the following charges for Covered Services as determined at the discretion of the Claim Administrator:

(i) the charge which the particular Hospital or facility usually charges its patients for Covered Services, or

(ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claim Administrator.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS ADMISSION....means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage or, if your Employer has a waiting period prior to your Coverage Date, the first day of the waiting period (that is, the date employment begins.)

ENROLLMENT PERIOD.....means the period specified in the Benefit Program Application during which you may apply for coverage if you did not apply prior to your Eligibility Date or if you did not apply for Family Coverage when eligible to do so.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the lying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost ome capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating, will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Mental Illness and Substance Abuse.

MENTAL ILLNESS.....means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Abuse

Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PREEXISTING CONDITION.....means any disease, illness, sickness, malady or condition which was diagnosed or treated by a Provider within 6 months prior to your Enrollment Date. For purposes of this definition, pregnancy and genetic information are not preexisting conditions.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Non-Participating Provider" means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state.

A "Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE ABUSE.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

SUBSTANCE ABUSE REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Abuse Treatment Facility" means a Substance Abuse Treatment Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Substance Abuse Treatment Facility" means a Substance Abuse Treatment Facility that does not meet the definition of an Administrator Substance Abuse Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

This benefit booklet contains information about the Health Care Plan for persons who meet the following description of an Eligible Person: An Eligible Person means an employee who is scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.

If you meet this description of an Eligible Person, have applied for this coverage and have received an ID card, then you are entitled to the benefits described in this benefit booklet.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled "Benefits for Medicare Eligible Covered Persons" will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS

AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your Employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your Employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your Employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE

You can change from Individual to Family Coverage, either because of:

- marriage
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under the Health Care Plan and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application for this change within 31 days of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care, your Family Coverage will then be effective from the date of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care.

If you make application for Family Coverage within 31 days of the termination of previous health coverage, your Family Coverage will be effective from the date you make application for coverage.

If you do not make application for Family Coverage within those 31 days, you can make application at any time to make those changes and your dependents will be subject to the 546 days Preexisting Condition waiting period as

described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 21 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. The coverage for unmarried children will end on the birthday.

Any newborn children will be covered from the moment of birth. Please notify your Employee Benefits Department within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are dependent upon you or other care providers for support and maintenance because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

ADDING DEPENDENTS TO FAMILY COVERAGE

You can add additional dependents to your Family Coverage, either because of:

- marriage
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under the Health Care Plan and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application to add additional dependents to your Family Coverage within 31 days of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care or legal guardianship, coverage for your dependents will then be effective from the date of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care. However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Employee Benefits Department so that your membership records can be adjusted.

If you make application to add dependents to your Family Coverage within 31 days of the termination of previous health coverage, your dependents coverage will be effective from the date you make application for coverage.

If you do not make application to add additional dependents (other than a newborn for whom no additional premium is required) to your Family Coverage within those 31 days, you can make application at any time to make those changes and your dependents will be subject to the 546 days Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Employee Benefits Department will provide you with the application and tell you the date that the change will be effective. Premiums will be adjusted accordingly.

PREEXISTING CONDITION WAITING PERIOD

Your benefits (other than for Maternity Services) are subject to a Preexisting Condition waiting period of 365 days. The Preexisting Condition waiting period will begin on the Enrollment Date for you and your eligible dependents (if Family Coverage is effective) and will continue for the number of days specified. This Preexisting Condition waiting period will also apply to each dependent (other than a newborn child, an adopted child under age 18, or a child under age 18 placed for adoption or a child under your legal guardianship if the child is enrolled within 31 days of birth, adoption, placement of adoption or legal guardianship) for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such a dependent will begin on the dependent's Enrollment Date.

However, benefits for those persons who do not apply for coverage when first eligible to do so are subject to a Preexisting Condition waiting period of 546 days.

If you had health coverage prior to getting this coverage without a break in coverage of 63 days or more, your Preexisting Condition waiting period is reduced by the length of time you had Creditable Coverage. You have the right to request a Certificate of Creditable Coverage from any previous health plan or insurer and the Claim Administrator will assist you in obtaining the Certificate of Creditable Coverage, if needed.

This Preexisting Conditions waiting period does not apply to those persons who were Eligible Persons and applied for coverage at the time that the Health Care Plan became effective.

The Preexisting Conditions waiting period does not apply to the following Benefits Section(s) of this benefit booklet: Outpatient Prescription Drug Program and Vision Care Program.

TERMINATION OF COVERAGE

You will no longer be entitled to the health care benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the Health Care Plan of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

Upon termination of your coverage under the Health Care Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Health Care Plan.

MEDICAL SERVICES ADVISORY PROGRAM

The Claim Administrator has established the Medical Services Advisory Program (MSA) to perform a review of Inpatient Hospital Covered Services **prior to** such services being rendered.

The MSA Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our Medical Department are an essential part of the MSA Program.

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

The provisions of the MSA PROGRAM section do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are specified in the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the MSA. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are not Medically Necessary, it will be referred to the Claim Administrator's Physician for review. If the Claim Administrator's Physician concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits described in this benefit booklet, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Maternity Admission Review**

  Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  When you are pregnant, you or someone who calls on your behalf must, in order to receive maximum benefits described in this benefit booklet, notify the MSA before the end of your first trimester of pregnancy. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

CASE MANAGEMENT

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency admission review, the MSA will send you a letter confirming that you or your representative called the MSA. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the MSA. In the event that the extension is determined not to be

Medically Necessary, the length of stay/service will not be extended, and the case will be referred to the Claim Administrator's Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the MSA. Should the Claim Administrator's Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under the Health Care Plan, see the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The MSA does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The MSA's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the MSA and the Claim Administrator's Physician decide they were not Medically Necessary.

MSA PROCEDURE

When you contact the MSA, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;
2. the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the MSA, the MSA:

1. will review the medical information provided and may follow up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the MSA prior to or while receiving services, you may appeal that decision by contacting the MSA or the Claim Administrator's Medical Director.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the MSA, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the MSA will not interfere with your relationship with any Provider. However, the Claim Administrator has established the MSA program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits described in this benefit booklet.

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first 50% of the Hospital or facility charges for an eligible stay in addition to any deductibles, Copayments and/or Coinsurance applicable as described in this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The provisions of this Medical Services Advisory Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit will result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the Mental Health Unit. This call must be made at least one day prior to the Hospital admission.

  If the proposed Hospital admission does not meet the criteria for Medically Necessary care, it will be referred to a Physician in the Mental Health Unit. If the Mental Health Unit Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some days or the entire hospitalization will be denied. Your Physician and the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Mental Illness Admission Review**

  Emergency Mental Illness Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  In the event of an Emergency Mental Illness Admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this benefit booklet, notify the Mental Health Unit no later than 48 hours or as soon as reasonably possible after the admission has occurred.

If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the Mental Health Unit. This call must be made at least one day prior to the admission.

- **Length of Stay Review**

  Length of stay review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Upon completion of the preadmission or emergency admission review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Mental Health Unit. Should the Mental Health Unit Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The Mental Health Unit's determination of Medically Necessary care is limited to merely

whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Provider;
2. the name of the Hospital or facility where the admission and/or service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Physician disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Provider may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Provider will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Provider still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield Mental Health Unit
P. O. Box 805107
Chicago, Illinois 60680-4112

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Provider. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to notify the Mental Health Unit as required in the Preadmission Review provision of this section, you will then be responsible for the first 50% of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a

Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

You are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $300 deductible or a $600 deductible depending on whether you have individual or Individual +1 coverage. In other words, after each member accumulates claims for more than $300 of Covered Services in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

Each time you are admitted to a Non-Participating Hospital or Non-Administrator Hospital, you must satisfy a $300 deductible and a $300 admission fee.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of $850, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in an Administrator Hospital or other Administrator facility.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 60 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 90% of the Hospital's Eligible Charge when you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible and your Inpatient Hospital admission fee. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible and your Inpatient Hospital admission fee.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator to be life threatening and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Administrator Hospital payment level (depending on the type of Provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator as not being life

threatening and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Administrator or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer life threatening.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation therapy treatments
3. Chemotherapy
4. Shock therapy treatments
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Mammograms —Benefits for an annual routine mammogram will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet.
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or pap smear test for females at the benefit payment described in the Wellness Care provision of this benefit booklet.
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment described in the Wellness Care provision of this benefit booklet.
12. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this benefit booklet.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 90% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for Outpatient Diagnostic Service will be provided at 100% of the Eligible Charge from a Participating Provider.

Benefits for Outpatient Diagnostic Service will not be subject to the program deductible.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Administrator Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 90% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 90% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will be subject to the program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic

disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Physician Assistant or registered nurse practitioner under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your program deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

No benefits are available under this Benefit Section for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital or Skilled Nursing Facility. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education nd medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age 18, even though they are not ill. Benefits will be limited to the following services:

1. immunizations;
2. physical examinations;
3. routine diagnostic tests.

Shock therapy treatments

Allergy injections and allergy surveys

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of $10,000 per benefit period.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $10,000 per benefit period.

Muscle Manipulations—Benefits will be provided for muscle manipulations. Your benefits for muscle manipulations will be limited to a maximum of 30 visits per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of $10,000 per benefit period.

Mammograms —Benefits for an annual routine mammogram will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or pap smear test for females at the benefit payment described in the Wellness Care provision of this benefit booklet.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment described in the Wellness Care provision of this benefit booklet.

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedure will be provided at the benefit payment level for Surgery described in this benefit booklet.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

No benefits will be provided for abortions.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

Benefits will be provided at 90% of the Maximum Allowance after you have met your program deductible when you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Health Care Plan and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services other than Surgery, therapy and certain Diagnostic Services in a Participating Provider's office, benefits will be provided at 100% of the Maximum Allowance and are subject to a Copayment of $25 per visit. Such Diagnostic Services include MRI, CT Scan, pulmonary function studies, cardiac catheterization, EKG, EEG, ECG and swan ganz catheterization.

When you receive Covered Services for Well Child Care from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance subject to the office visit Copayment stated above.

Benefits for Well Child Care from a Participating Provider will not be subject to the program deductible, nor will it be subject to the calendar year maximum.

Benefits for muscle manipulations will be provided at 100% of the Maximum Allowance subject to the Physician office visit Copayment when Covered Services are received from a Participating Provider.

Benefits for muscle manipulations from a Participating Provider will be subject to the program deductible.

Benefits for Outpatient Diagnostic Service will be provided at 100% of the Maximum Allowance from a Participating Provider.

Benefits for Outpatient Diagnostic Service will not be subject to the program deductible.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 70% of the Maximum Allowance, after you have met your program deductible, unless specifically mentioned below.

Participating and Non-Participating Provider

Benefits for Emergency Accident Care will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Medical Care will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for

the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Participating Professional Provider or the Claim Administrator.

Regarding the Schedule of Maximum Allowances, you should also understand the following.

If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.

If two or more surgical procedures are related or are performed in the same operative area, and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.

Procedures performed for conditions resulting from the same accident or injury are considered related.

If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.

OTHER COVERED SERVICES

)THER COVERED SERVICES

This section of your benefit booklet describes "Other Covered Services" and the benefits that will be provided for them.

- Blood and blood components
- Leg, back, arm and neck braces
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of $3,000 per month.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by the Claim Administrator. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:
    a. they are required to replace all or part of an organ or tissue of the human body, or
    b. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.
- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of $3,000 per benefit period.
- Orthotic Services

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum

Allowance. Therefore you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Participating Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to persons age 18 and over, even though you are not ill. Benefits will be limited to the following services:

1. immunizations;
2. routine physical examination;
3. routine diagnostic tests.

When you receive Covered Services for wellness care from a Participating Provider, other than in a Physician's office, benefits will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

When you receive Covered Services in a Participating Professional Provider's office, benefits for office visits are subject to a Copayment of $25 per visit.

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefits for wellness care will be limited to a maximum of $300 per benefit period.

The following Covered Services are not subject to the wellness care maximum: routine mammogram, pap smear test, prostate test and digital rectal examination, and colorectal cancer screening.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 90% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 60 days of care in a Skilled Nursing Facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility. Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 90% of the Eligible Charge. Benefits for services by a Non-Administrator Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE ABUSE REHABILITATION TREATMENT

Benefits for all of the Covered Services previously described in this benefit booklet are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit booklet. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level described later in this benefit section.

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by

(1) a Physician; (2) a Psychologist, Clinical Social Worker or Clinical Professional Counselor; or (3) a Marriage and Family Therapist working within the scope of their license.

Benefit Payment for Outpatient Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for Outpatient Mental Illness treatment will be provided at 90% of the Eligible Charge or at 90% of the Maximum Allowance when you receive services from a Participating Provider after you have met your program deductible. When you receive Covered Services from a Non-Participating Provider for Outpatient Mental Illness treatment, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program approved by the Claim Administrator) will be provided at 90% of the Eligible Charge or at 90% of the Maximum Allowance when you receive services from a Participating Provider after you have met your program deductible.

When you receive Covered Services from a Non-Participating Provider for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Benefit Maximum for Inpatient and Outpatient treatment of Substance Abuse Rehabilitation Treatment

Your benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $10,000 per benefit period.

Lifetime Benefit Maximum for treatment of Substance Abuse Rehabilitation Treatment

A lifetime maximum of $25,000 will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.

None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family

Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Infertility

Covered Services related to the diagnosis and/or treatment of infertility when rendered in conjunction with conception through normal intercourse are the same as your benefits for any other condition. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $2,500.

MASTECTOMY - RELATED SERVICES

Benefits for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas, are the same as for any other condition.

PAYMENT PROVISIONS

Lifetime Maximum

The total maximum amount of benefits to which you are entitled under this Participating Provider Option program is $3,000,000. This is an individual maximum. There is no family maximum.

As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $1,000 or the amount you have received in benefits that benefit period, whichever is less.

Cumulative Benefit Maximums

All benefits payable under this Health Care Plan are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, the Claim Administrator will include benefit payments under both this and/or any prior or subsequent health care program administered by the Claim Administrator issued to you as an Eligible Person or a dependent of an Eligible Person under this Heath Care Plan.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $1,500 for Individual coverage (or $3,000 for Individual + 1 coverage), any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is life threatening)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- the program deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider

- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment
- charges for Outpatient Prescription Drugs
- the Copayment for Physician office visits
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Claim Administrator's Mental Health Unit
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

If you have Family Coverage and your expenses as described above equals $3,750 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $3,000 for Individual coverage (or $6,000 for Individual + 1 coverage), any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided.

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- the program deductible(s)
- the Inpatient Hospital admission deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- the Coinsurance resulting from Hospital services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility for Covered Services

- charges for Covered Services which have a separate dollar maximum specifically mentioned in this certificate
- charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment
- charges for Outpatient Prescription Drugs
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Claim Administrator's Mental Health Unit
- any unreimbursed expenses incurred for "comprehensive major medical" Covered Services within your prior contract's benefit period.

If you have Family Coverage and your expense as described above equals $6,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Health Care Plan is terminated, benefits will be provided for, and limited to, the Covered Services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including but not limited, to Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

/hen you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your benefit booklet explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drug, and
- the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/ Tretinoin and Minoxidil/Rogaine);
- drugs which are not self-administered;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Benefit Payment for Prescription Drugs

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider. "Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan to administer its prescription drug program to provide services to you at the time you receive the services.

When you obtain drugs and diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$5 for each prescription** - for generic drugs and diabetic supplies.
- **$30 for each prescription** -for brand name drugs.

When you obtain drugs and diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or the Claim Administrator's office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs and diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and oral contraceptives obtained through the Home Delivery Prescription Drug Program. One mail order prescription means up to a 90 consecutive day supply of a drug. For information about this program, contact your employer or Claim Administrator.

When you obtain drugs and diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$10 for each prescription** - for generic drugs and diabetic supplies.
- **$60 for each prescription** - for brand name drugs.

DENTAL BENEFIT SECTION

The benefits of this section are subject to all of the terms and conditions of this enefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Claim Administrator until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Preventive Dental Services

Your Preventive Dental benefits are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to dependent children under age 19 and are limited to two applications each benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine bitewing X-rays are limited to one set per benefit period. Any additional full mouth X-rays are subject to Medical Necessity.
- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.
- Sealants—Benefits for sealants are only available to persons under age 14.

Primary Dental Services

Your Primary Dental benefits cover a wide range of services that can help you maintain continued good dental health. These services are as follows:

- Fillings
- Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Endodontics
- Pulp Vitality Tests
- Apicoectomies
- Hemisection
- Biopsies of Oral Tissue
- Periodontics/Periodontal Therapy

  Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per benefit period.

  Periodontal maintenance procedures — Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.
- Stainless Steel Crowns
- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.

Major Dental Services

Your Major Dental Benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- Fixed Bridgework
- Repair of Crowns, Bridges and Removable Dentures
- Recementing of Crowns, Inlays, Onlays and Bridges
- Full and Partial Dentures

- Denture Adjustments, Rebasing and Relining—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Full Mouth Rehabilitation—Benefits will be provided for procedures necessary for eliminating oral disease and replacing missing teeth. Benefits are not available for appliances or restorations intended to increase vertical dimension.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

Deductible

Each benefit period, you must satisfy a $25 deductible for Individual coverage (or $50 deductible for Individual + 1 coverage). This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges of more than $25 per member of either Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

Family Deductible

If you have Family Coverage and your family has reached the dental deductible amount of $75, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.

Benefit Payment for Dental Services

Benefit Payment Level

100% of the Usual and Customary Fee will be paid for the Preventive Dental Services described in this Dental Benefits Section.

80% of the Usual and Customary Fee will be paid for the Primary Dental Services described in this Dental Benefits Section.

50% of the Usual and Customary Fee will be paid for the Major Dental Services described in this Dental Benefits Section.

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $1,000. This is an individual maximum. There is no family maximum.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by the Claim Administrator.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Claim Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
   - — surgical services related to a congenital malformation;
   - — surgical removal of complete bony impacted teeth;
   - — excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

— excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this benefit booklet.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.
8. Implants and any related services and supplies (other than crowns) associated with the placement and care of implants.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Health Care Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Health Care Plan.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled "Medicare Eligible Covered Persons" in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you. However, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS—WHAT IS NOT COVERED

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary

and, therefore, not eligible for payment under the terms of your Health Care Plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

You may furnish or submit any additional documentation which you or your Physician believe appropriate.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received. However, this exclusion shall not be applicable to medical assis-

tance benefits under Article V or VI of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the benefit booklet if not provided in connection with an approved clinicial trial program.

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

— Hearing aids or examinations for the prescription or fitting of hearing aids.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses).

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Elective abortions.

— Services and supplies rendered or provided for the diagnosis and treatment of infertility other than in conjunction with conception through normal intercourse; specifically excluded, without limiting this exclusion, are all services and supplies related to artificial insemination and in-vitro fertilization including, but not limited to, gamete intra-fallopian transfer (GIFT).

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.

2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA)

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional 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.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: 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 your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children 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 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or

both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Health Care Plan, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the pharmacy was unable to transmit a claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 853901
Richardson, Texas 75085-3901

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received, will not be eligible for payment.

CLAIMS PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal; and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized presentative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

FILING DENTAL CLAIMS

In order to obtain your dental benefits under this Health Care Plan, it is necessary for a Claim to be filed with the Claim Administrator.

To file a Claim, obtain a claim form from your Employee Benefits Department before going to your Dentist. This form is also used for pre-estimation of benefits. It is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

You must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

Claims must be filed with the Claim Administrator within 365 days from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

DENTAL CLAIMS PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the

receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal; and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal full amount the Hospital bill for Covered Services is $1,000, how is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service - the amount applied to your deductible, if any, and your coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Blue Cross and Blue Shields' Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to

you. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

In addition, the Claim Administrator entered into agreements with certain entity(ies) to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. This entity(ies) is referred to as a pharmacy benefit manager. The pharmacy benefit manager has agreements with pharmaceutical manufacturers to receive rebates for using their products. The pharmacy benefit manager shares a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator

information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator would be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the right to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PLAN ADMINISTRATION INFORMATION

NAME OF PLAN: Utilities, Inc., ET AL Employee Benefit Plan

PLAN SPONSOR:

Name: Utilities, Inc., ET AL

Address: 2335 Sanders Road
Northbrook, IL 60062
(847) 498-6440

EMPLOYER IDENTIFICATION NUMBER: 36-2588579

PLAN NUMBER: 504

PLAN ADMINISTRATOR:

Name: Utilities, Inc., ET AL

Address: 2335 Sanders Road
Northbrook, IL 60062

Telephone Number: (847) 498-6440

TYPE OF PLAN:
Welfare Benefit Plan

CLAIM ADMINISTRATION: Claims for benefits should be directed to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

AGENT FOR SERVICE OF LEGAL PROCESS:

Winston and Strawn
35 West Wacker Drive
Chicago, IL 60601-9703

ELIGIBILITY: Benefits under this Plan begin 30 days after date of hire

BENEFITS AND ADMINISTRATION:

Minimum Maternity Benefits

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours

following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods.

LOSS OF BENEFITS: The provisions regarding termination of coverage and limitations and exclusions of benefits which may result in reduction or loss of benefits are explained in this booklet.

CONTRIBUTIONS: Utilities, Inc. pays a significant portion of the cost towards a member's health insurance coverage under the terms of the Plan. Members are required to pay a portion of the cost for this Plan. The actual amount paid by the member is subject to change and will be announced by the Company.

PLAN YEAR: The Plan year begins on January 1st and ends on December 31st.

HOW TO GET YOUR BENEFITS:
This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIMS PROCEDURE:
This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIM REVIEW PROCEDURE:
This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

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:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

c. 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:

a. 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 booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

b. 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 exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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 under the plan 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, 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 the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the
U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

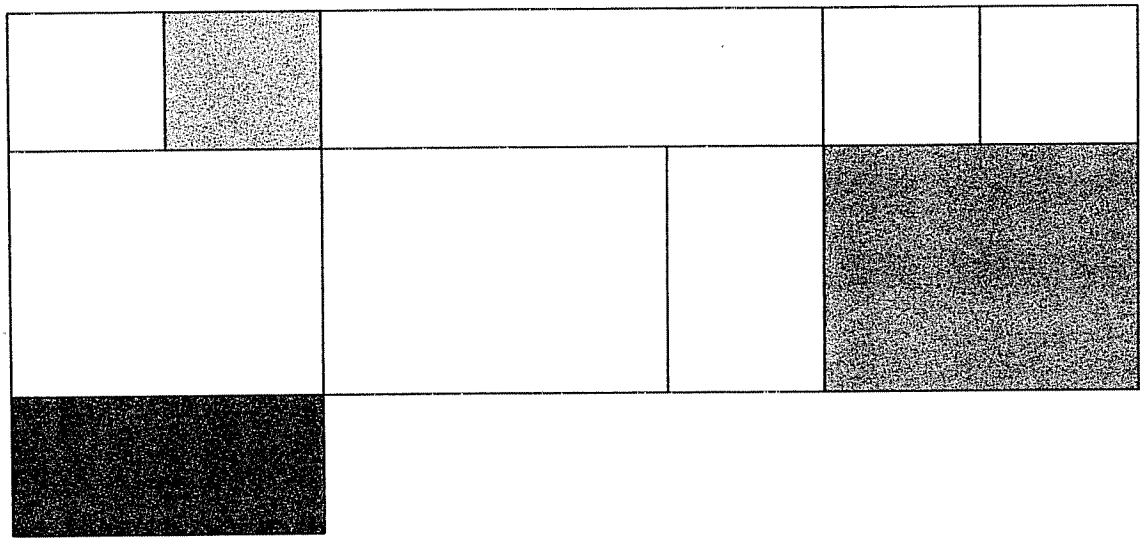
If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance with Your Questions:

If you have any questions about the 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.

UTILITIES, INC.

#37 (Staff)



Your Health Care Benefit Program
Medical, Dental and
Prescription Drug Benefits

P17022 and 017022

Effective Date: January 1, 2005

A message from

Utilities, Inc.

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

Utilities, Inc.

Utilities, Inc.
2335 Sanders Road
Northbrook, IL 60062
(847) 498-6440

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

LIMITED BENEFITS FOR NON-PARTICIPATING PROVIDERS

You should be aware that when you elect to receive Covered Services from a Non-Participating Professional Provider in non-emergency situations, the amount of the benefit payment to such Non-Participating Professional Provider will be a reduced benefit payment that would have been made if services had been rendered by a Participating Professional Provider. **In certain cases, you can expect to pay in excess of 50% of the Non-Participating Professional Provider's billed charge even after the Claim Administrator has paid the Maximum Allowance under your coverage.** Participating Professional Providers have agreed to accept the Maximum Allowance (please refer to the definition of "Maximum Allowance") with no additional billing after you have paid your Coinsurance and deductible amount.

You may obtain further information about the participating status of Professional Providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

TABLE OF CONTENTS

BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE MEDICAL SERVICES ADVISORY PROGRAM	A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet
MSA®′ Registered Mark of Health Care Service Corporation a Mutual Legal Reserve Company	
Lifetime Maximum for all Benefits	$3,000,000
Individual Deductible	$300 per benefit period
Individual + 1 Deductible	$600 per benefit period
Family Deductible	$700 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$750 per benefit period
— Non-Participating Provider	$1,750 per benefit period
— Non-Administrator Provider	No limit
Individual + 1 Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$1,500 per benefit period
— Non-Participating Provider	$3,500 per benefit period
— Non-Administrator Provider	No limit
Family Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$1,500 per benefit period
— Non-Participating Provider	$3,500 per benefit period
— Non-Administrator Provider	No limit
Private Duty Nursing Service Benefit Maximum	$3,000 per month
Wellness Care (age 18 & over) Benefit Maximum	$300 per benefit period
Muscle Manipulations Benefit Maximum	30 visits per benefit period
Physical Therapy Services Benefit Maximum	$10,000 per benefit period

Occupational Therapy Benefit Maximum	$10,000 per benefit period
Speech Therapy Benefit Maximum	$10,000 per benefit period
Temporomandibular Joint Dysfunction and Related Disorders Lifetime Maximum	$2,500
Inpatient and Outpatient Substance Abuse Rehabilitation Treatment Benefit Period Maximum	$10,000
Lifetime Maximum Inpatient and Outpatient Substance Abuse RehabilitationTreatment	$25,000

HOSPITAL BENEFITS

Payment level for Covered Services from a **Participating Provider:**	
— Inpatient Covered Services	90% of the Eligible Charge, after the deductible
— Outpatient Covered Services	90% of the Eligible Charge, after the deductible
— Outpatient Diagnostic Services	100% of the Eligible Charge, no deductible
— Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	90% of the Eligible Charge, after the deductible
Payment level for Covered Services from a **Non-Participating Provider:**	
— Inpatient Deductible	$300 deductible per admission plus $300 admission fee
— Inpatient Covered Services	70% of the Eligible Charge, after the deductible
— Outpatient Covered Services	70% of the Eligible Charge, after the deductible

— Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	70% of the Eligible Charge, after the deductible
Payment level for Covered Services from a **Non-Administrator Provider**	50% of the Eligible Charge
Hospital Emergency Care	
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider	90% of the Eligible Charge, after the deductible
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider	90% of the Eligible Charge, after the deductible

PHYSICIAN BENEFITS

Payment level for Surgical/ Medical Covered Services	
— Participating Provider	90% of the Maximum Allowance, after the deductible
— Non-Participating Provider	70% of the Maximum Allowance, after the deductible
Physician office Copayment	
— Participating Provider	$15 per visit, then payable at 100%
— Non-Participating Provider	70% of the Maximum Allowance, after the deductible
Payment level for Emergency Accident Care when rendered by a Physician	90% of the Maximum Allowance, after the deductible
Payment level for Emergency Medical Care when rendered by a Physician	90% of the Maximum Allowance, after the deductible
Payment level for Outpatient Diagnostic Service	
— Participating Provider	100% of the Maximum Allowance, no deductible

— Non-Participating Provider	70% of the Maximum Allowance, no deductible
Payment level for Outpatient treatment of Mental Illness and Outpatient Substance Abuse Rehabilitation Treatment	
— Participating Provider	90% of the Maximum Allowance
— Non-Participating Provider	70% of the Maximum Allowance
Additional Surgical Opinion	100% of the Claim Charge
OTHER COVERED SERVICES	
Payment level	80% of the Eligible Charge or Maximum Allowance
PRESCRIPTION DRUG PROGRAM BENEFITS	
Copayment	
— generic drugs and diabetic supplies	$5 per prescription
— brand name drugs	$25 per prescription
Home Delivery Prescription Drug Program	
Copayment	
— generic drugs and diabetic supplies	$10 per prescription
— brand name drugs	$50 per prescription
DENTAL BENEFITS	
Individual Deductible	$25 per benefit period
Individual + 1 Deductible	$50 per benefit period
Family Deductible	$75 per benefit period
Preventive Services Benefit Payment Level	100% of the U&C Fee*, no deductible
Emergency Services Benefit Payment Level	100% of the U&C Fee*, no deductible
Primary Services Benefit Payment Level	80% of the U&C Fee*, after the deductible

Major Services	
Benefit Payment Level	50% of the U&C Fee*, after the deductible
Benefit Period	
Maximum	$1,000

*Usual and Customary Fee

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a

Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding "The Claim Administrator's Separate Financial Arrangements with Providers.")

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the

Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE..... means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of

another state but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT..... means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE .....means coverage you had under any of the following:

(i) a group health plan;

(ii) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

(iii) Medicare (Parts A, B or C of Title XVIII of the Social Security Act);

(iv) Medicaid (Title XIX of the Social Security Act);

(v) military service-related care;

(vi) the Indian Health Service or a tribal organization;

(vii) a State health benefits risk pool;

(viii) the Federal Employees Health Benefits Program;

(ix) a public health plan maintained by a State, county or other political subdivision of a State;

(x) Section 5(e) of the Peace Corps Act.

CRNA.....means a Certified Registered Nurse Anesthetist, who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A "Participating CRNA" means a CRNA who has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating CRNA" means a CRNA who does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified in accordance with the guidelines established by Medicare.

ELIGIBLE CHARGE.....means (a) in the case of a Provider other than a Professional Provider which has a written agreement with the Claim Administrator to provide care to you at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with the Claim Administrator to provide care to you at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of the Claim Administrator:

(i) the charge which the particular Hospital or facility usually charges its patients for Covered Services, or

(ii) the charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claim Administrator.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS ADMISSION....means an admission for the treatment of Mental Illness as a result of the sudden and unexpected onset of a mental condition that the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage or, if your Employer has a waiting period prior to your Coverage Date, the first day of the waiting period (that is, the date employment begins.)

ENROLLMENT PERIOD.....means the period specified in the Benefit Program Application during which you may apply for coverage if you did not apply prior to your Eligibility Date or if you did not apply for Family Coverage when eligible to do so.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the ying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan or Blue Cross Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means the amount determined by the Claim Administrator which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Professional Providers, whether Participating or Non-Participating, will be based on the Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claim Administrator.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Mental Illness and Substance Abuse.

MENTAL ILLNESS.....means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Abuse

Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PREEXISTING CONDITION.....means any disease, illness, sickness, malady or condition which was diagnosed or treated by a Provider within 6 months prior to your Enrollment Date. For purposes of this definition, pregnancy and genetic information are not preexisting conditions.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Non-Participating Provider" means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, Clinical Social Worker or any Provider designated by the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state.

A "Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE ABUSE.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

SUBSTANCE ABUSE REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Abuse Treatment Facility" means a Substance Abuse Treatment Facility which has a written agreement with the Claim Administrator or a Blue Cross and Blue Shield Plan or Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

A "Non-Administrator Substance Abuse Treatment Facility" means a Substance Abuse Treatment Facility that does not meet the definition of an Administrator Substance Abuse Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

This benefit booklet contains information about the Health Care Plan for persons who meet the following description of an Eligible Person: An Eligible Person means an employee who is scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.

If you meet this description of an Eligible Person, have applied for this coverage and have received an ID card, then you are entitled to the benefits described in this benefit booklet.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled "Benefits for Medicare Eligible Covered Persons" will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS

AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

~OUR MSP RESPONSIBILITIES

In order to assist your Employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your Employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your Employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own health care expenses are covered, not the health care expenses of other members of your family.

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE

You can change from Individual to Family Coverage, either because of:

- marriage
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under the Health Care Plan and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application for this change within 31 days of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care, your Family Coverage will then be effective from the date of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care.

If you make application for Family Coverage within 31 days of the termination of previous health coverage, your Family Coverage will be effective from the date you make application for coverage.

If you do not make application for Family Coverage within those 31 days, you an make application at any time to make those changes and your dependents will be subject to the 546 days Preexisting Condition waiting period as

described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

FAMILY COVERAGE

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse's) enrolled unmarried children who are under age 21 will be covered. Enrolled unmarried children who are full-time students will be covered up to age 25. The coverage for unmarried children will end on the birthday.

Any newborn children will be covered from the moment of birth. Please notify your Employee Benefits Department within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are dependent upon you or other care providers for support and maintenance because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship) or foster children.

ADDING DEPENDENTS TO FAMILY COVERAGE

You can add additional dependents to your Family Coverage, either because of:

- marriage
- the birth or adoption of a child
- obtaining legal guardianship of a child
- previous health insurance coverage terminating which was in effect when you were first eligible to enroll for coverage under the Health Care Plan and which is not terminating for failure to pay premiums or fraudulent cause, and where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment.

If you make application to add additional dependents to your Family Coverage within 31 days of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care or legal guardianship, coverage for your dependents will then be effective from the date of the marriage, birth, adoption, obtaining legal guardianship or interim court order of adoption or placement of adoption vesting temporary care. However, an application to add a newborn to Family Coverage is not necessary if an additional premium is not required. Please notify your Employee Benefits Department so that your membership records can be adjusted.

If you make application to add dependents to your Family Coverage within 31 days of the termination of previous health coverage, your dependents coverage will be effective from the date you make application for coverage.

If you do not make application to add additional dependents (other than a newborn for whom no additional premium is required) to your Family Coverage within those 31 days, you can make application at any time to make those changes and your dependents will be subject to the 546 days Preexisting Condition waiting period as described in the Preexisting Condition Waiting Period provision of this benefit section. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this at any time. Your Employee Benefits Department will provide you with the application and tell you the date that the change will be effective. Premiums will be adjusted accordingly.

PREEXISTING CONDITION WAITING PERIOD

Your benefits (other than for Maternity Services) are subject to a Preexisting Condition waiting period of 365 days. The Preexisting Condition waiting period will begin on the Enrollment Date for you and your eligible dependents (if Family Coverage is effective) and will continue for the number of days specified. This Preexisting Condition waiting period will also apply to each dependent (other than a newborn child, an adopted child under age 18, or a child under age 18 placed for adoption or a child under your legal guardianship if the child is enrolled within 31 days of birth, adoption, placement of adoption or legal guardianship) for whom coverage is applied for after your Coverage Date. The Preexisting Condition waiting period for such a dependent will begin on the dependent's Enrollment Date.

However, benefits for those persons who do not apply for coverage when first eligible to do so are subject to a Preexisting Condition waiting period of 546 days.

If you had health coverage prior to getting this coverage without a break in coverage of 63 days or more, your Preexisting Condition waiting period is reduced by the length of time you had Creditable Coverage. You have the right to request a Certificate of Creditable Coverage from any previous health plan or insurer and the Claim Administrator will assist you in obtaining the Certificate of Creditable Coverage, if needed.

This Preexisting Conditions waiting period does not apply to those persons who were Eligible Persons and applied for coverage at the time that the Health Care Plan became effective.

The Preexisting Conditions waiting period does not apply to the following Benefits Section(s) of this benefit booklet: Outpatient Prescription Drug Program and Vision Care Program.

TERMINATION OF COVERAGE

You will no longer be entitled to the health care benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the Health Care Plan of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

Upon termination of your coverage under the Health Care Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Health Care Plan.

MEDICAL SERVICES ADVISORY PROGRAM

The Claim Administrator has established the Medical Services Advisory Program (MSA) to perform a review of Inpatient Hospital Covered Services **prior to** such services being rendered.

The MSA Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The Physicians in our Medical Department are an essential part of the MSA Program.

Failure to contact the MSA or to comply with the determinations of the MSA will result in a reduction in benefits. The MSA's toll-free telephone number is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

The provisions of the MSA PROGRAM section do not apply to the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment. The provisions for the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are specified in the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the MSA. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are not Medically Necessary, it will be referred to the Claim Administrator's Physician for review. If the Claim Administrator's Physician concurs that the proposed admission or health care services are not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The MSA will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In the event of an emergency admission, you or someone who calls on your behalf must, in order to receive maximum benefits described in this benefit booklet, notify the MSA no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Maternity Admission Review**

  Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  When you are pregnant, you or someone who calls on your behalf must, in order to receive maximum benefits described in this benefit booklet, notify the MSA before the end of your first trimester of pregnancy. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

CASE MANAGEMENT

After your case has been evaluated, you may be assigned a case manager. In some cases, if your condition would require care in a Hospital or other health care facility, the case manager may recommend an alternative treatment plan.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The case manager will continue to monitor your case for the duration of your condition. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency admission review, the MSA will send you a letter confirming that you or your representative called the MSA. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the MSA. In the event that the extension is determined not to be

Medically Necessary, the length of stay/service will not be extended, and the case will be referred to the Claim Administrator's Physician for review.

1EDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the MSA. Should the Claim Administrator's Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions from coverage under the Health Care Plan, see the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The MSA does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The MSA's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the MSA and the Claim Administrator's Physician decide they were not Medically Necessary.

MSA PROCEDURE

When you contact the MSA, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Physician;
2. the name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the MSA, the MSA:

1. will review the medical information provided and may follow up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the MSA prior to or while receiving services, you may appeal that decision by contacting the MSA or the Claim Administrator's Medical Director.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the MSA, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the MSA will not interfere with your relationship with any Provider. However, the Claim Administrator has established the MSA program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits described in this benefit booklet.

Should you fail to notify the MSA as required in the Preadmission Review provision of this section, you will then be responsible for the first 50% of the Hospital or facility charges for an eligible stay in addition to any deductibles, Copayments and/or Coinsurance applicable as described in this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The provisions of this Medical Services Advisory Program do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, Clinical Social Workers and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit will result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever a nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the Mental Health Unit. This call must be made at least one day prior to the Hospital admission.

  If the proposed Hospital admission does not meet the criteria for Medically Necessary care, it will be referred to a Physician in the Mental Health Unit. If the Mental Health Unit Physician concurs that the proposed admission does not meet the criteria for Medically Necessary care, some days or the entire hospitalization will be denied. Your Physician and the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

- **Emergency Mental Illness Admission Review**

  Emergency Mental Illness Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  In the event of an Emergency Mental Illness Admission, you or someone who calls on your behalf must, in order to receive maximum benefits under this benefit booklet, notify the Mental Health Unit no later than 48 hours or as soon as reasonably possible after the admission has occurred.

If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Whenever an admission to a Partial Hospitalization Treatment Program is recommended by your Physician, you must, in order to receive maximum benefits described in this benefit booklet, call the Mental Health Unit. This call must be made at least one day prior to the admission.

- **Length of Stay Review**

  Length of stay review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

  Upon completion of the preadmission or emergency admission review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Mental Health Unit. Should the Mental Health Unit Physician concur that the Inpatient care or other health care services or supplies are not Medically Necessary, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the section entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The Mental Health Unit's determination of Medically Necessary care is limited to merely

whether a proposed admission, continued hospitalization or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit, you should be prepared to provide the following information:

1. the name of the attending and/or admitting Provider;
2. the name of the Hospital or facility where the admission and/or service has been scheduled;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Provider;
2. may determine that the services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Physician disagree with the determinations of the Mental Health Unit prior to or while receiving services, you or the Provider may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Provider will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Provider still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield Mental Health Unit
P. O. Box 805107
Chicago, Illinois 60680-4112

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any pertinent documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Provider. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to notify the Mental Health Unit as required in the Preadmission Review provision of this section, you will then be responsible for the first 50% of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a

Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider)ption" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

You are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $300 deductible or a $600 deductible depending on whether you have individual or Individual +1 coverage. In other words, after each member accumulates claims for more than $300 of Covered Services in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

Each time you are admitted to a Non-Participating Hospital or Non-Administrator Hospital, you must satisfy a $300 deductible and a $300 admission fee.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of $700, it will not be necessary for anyone else in your family to meet a program deductible in that benefit period. That is, for the remainder of that benefit period, no other family members are required to meet a program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

The level of benefits paid for Hospital Covered Services is generally greater when received in an Administrator Hospital or other Administrator facility.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 60 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 90% of the Hospital's Eligible Charge when you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible and your Inpatient Hospital admission fee. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible and your Inpatient Hospital admission fee.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Provider resulting from Emergency Accident Care or Emergency Medical Care will be provided at the same payment level which you would have received had you been in a Participating Hospital for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator to be life threatening and therefore not permitting your safe transfer to a Participating Hospital or other Participating Provider.

Benefits for an Inpatient Hospital admission to a Non-Administrator or Non-Participating Hospital resulting from Emergency Accident Care or Emergency Medical Care will be provided at the Non-Participating Hospital payment level or the Non-Administrator Hospital payment level (depending on the type of provider) for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator as not being life

threatening and therefore permitting your safe transfer to a Participating Hospital or other Participating Provider.

In order for you to continue to receive benefits at the Participating Provider payment level following an emergency admission to a Non-Administrator or Non-Participating Hospital, you must transfer to a Participating Provider as soon as your condition is no longer life threatening.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation therapy treatments
3. Chemotherapy
4. Shock therapy treatments
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care
9. Mammograms —Benefits for an annual routine mammogram will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet.
10. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or pap smear test for females at the benefit payment described in the Wellness Care provision of this benefit booklet.
11. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment described in the Wellness Care provision of this benefit booklet.
12. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedures will be provided at the benefit payment level for Surgery described in this benefit booklet.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 90% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for Outpatient Diagnostic Service will be provided at 100% of the Eligible Charge from a Participating Provider.

Benefits for Outpatient Diagnostic Service will not be subject to the program deductible.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge, after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at 50% of the Eligible Charge after you have met your program deductible. Covered Services received for Emergency Accident Care and Emergency Medical Care from a Non-Administrator Provider will be paid at the same payment level which would have been paid had such services been received from a Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 90% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 90% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will be subject to the program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Your benefits are also subject to the Preexisting Condition waiting period. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a CRNA. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic

disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Physician Assistant or registered nurse practitioner under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your program deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home.

No benefits are available under this Benefit Section for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness or Outpatient Substance Abuse Rehabilitation Treatment. In addition, the treatment of Mental Illness and Substance Abuse Rehabilitation Treatment are subject to the maximums specified in the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

Consultations

Your coverage includes benefits for consultations when you are an Inpatient in a Hospital or Skilled Nursing Facility. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Well Child Care

Benefits will be provided for Covered Services provided by a Physician to children under age 18, even though they are not ill. Benefits will be limited to the following services:

1. immunizations;
2. physical examinations;
3. routine diagnostic tests.

Shock therapy treatments

Allergy injections and allergy surveys

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of $10,000 per benefit period.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of $10,000 per benefit period.

Muscle Manipulations—Benefits will be provided for muscle manipulations. Your benefits for muscle manipulations will be limited to a maximum of 30 visits per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of $10,000 per benefit period.

Mammograms —Benefits for an annual routine mammogram will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or pap smear test for females at the benefit payment described in the Wellness Care provision of this benefit booklet.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males at the benefit payment described in the Wellness Care provision of this benefit booklet.

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Benefits for colorectal cancer screening will be provided at the benefit payment described in the Wellness Care provision of this benefit booklet. Benefits for surgical procedures, such as colonoscopy and sigmoidoscopy, are not provided at the Wellness Care payment level. Such procedure will be provided at the benefit payment level for Surgery described in this benefit booklet.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

No benefits will be provided for abortions.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

Benefits will be provided at 90% of the Maximum Allowance after you have met your program deductible when you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this Health Care Plan and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services other than Surgery, therapy and certain Diagnostic Services in a Participating Provider's office, benefits will be provided at 100% of the Maximum Allowance and are subject to a Copayment of $15 per visit. Such Diagnostic Services include MRI, CT Scan, pulmonary function studies, cardiac catheterization, EKG, EEG, ECG and swan ganz catheterization.

When you receive Covered Services for Well Child Care from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance subject to the office visit Copayment stated above.

Benefits for Well Child Care from a Participating Provider will not be subject to the program deductible, nor will it be subject to the calendar year maximum.

Benefits for muscle manipulations will be provided at 100% of the Maximum Allowance subject to the Physician office visit Copayment when Covered Services are received from a Participating Provider.

Benefits for muscle manipulations from a Participating Provider will be subject to the program deductible.

Benefits for Outpatient Diagnostic Service will be provided at 100% of the Maximum Allowance from a Participating Provider.

Benefits for Outpatient Diagnostic Service will not be subject to the program deductible.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 70% of the Maximum Allowance, after you have met your program deductible, unless specifically mentioned below.

Participating and Non-Participating Provider

Benefits for Emergency Accident Care will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Medical Care will be provided at 90% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for

the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Participating Professional Provider or the Claim Administrator.

Regarding the Schedule of Maximum Allowances, you should also understand the following.

If two or more surgical procedures are related or performed in the same operative area and are performed by the same or different Physician, Dentist or Podiatrist during the same operation, benefits will be provided only for the procedure which has the larger Maximum Allowance.

If two or more surgical procedures are related or are performed in the same operative area, and are performed on different dates by the same or a different Physician, Dentist or Podiatrist, benefits will be based upon the procedure which has the largest Maximum Allowance and 50% of the Maximum Allowance for the procedure which has the next largest allowance.

Procedures performed for conditions resulting from the same accident or injury are considered related.

If a surgical procedure is repeated during an Inpatient stay, the benefit payment will be based upon 50% of the Maximum Allowance for such repeat procedure and only one such repeat will be considered a Covered Service.

OTHER COVERED SERVICES

THER COVERED SERVICES

This section of your benefit booklet describes "Other Covered Services" and the benefits that will be provided for them.

- Blood and blood components
- Leg, back, arm and neck braces
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of $3,000 per month.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Durable medical equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and any other internal and permanent devices as reasonably approved by the Claim Administrator. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.
- Prosthetic appliances—Benefits will be provided for prosthetic devices, special appliances and surgical implants when:
    a. they are required to replace all or part of an organ or tissue of the human body, or
    b. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

- Optometric services—Benefits will be provided for services which may be legally rendered by an Optometrist, provided that benefits would have been provided had such services been rendered by a Physician.
- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of $3,000 per benefit period.
- Orthotic Services

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

The expenses that are your responsibility for your Other Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum

Allowance. Therefore you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- CRNAs
- Marriage and Family Therapists
- Physical Therapists
- Occupational Therapists
- Speech Therapists
- Other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Participating Professional Provider or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have coverage each will have their benefits paid by their own program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

— **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

— In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to persons age 18 and over, even though you are not ill. Benefits will be limited to the following services:

1. immunizations;
2. routine physical examination;
3. routine diagnostic tests.

When you receive Covered Services for wellness care from a Participating Provider, other than in a Physician's office, benefits will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

When you receive Covered Services in a Participating Professional Provider's office, benefits for office visits are subject to a Copayment of $15 per visit.

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefits for wellness care will be limited to a maximum of $300 per benefit period.

The following Covered Services are not subject to the wellness care maximum: routine mammogram, pap smear test, prostate test and digital rectal examination, and colorectal cancer screening.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 90% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 50% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 60 days of care in a Skilled Nursing Facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility. Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 90% of the Eligible Charge. Benefits for services by a Non-Administrator Ambulatory Surgical Facility will be provided at 50% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE ABUSE REHABILITATION TREATMENT

Benefits for all of the Covered Services previously described in this benefit booklet are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these services are rendered by a Substance Abuse Treatment Facility. Benefits will be provided at the payment levels described later in this benefit booklet. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level described later in this benefit section.

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness. Medical Care for the treatment of a Mental Illness is eligible when rendered by

(1) a Physician; (2) a Psychologist, Clinical Social Worker or Clinical Professional Counselor; or (3) a Marriage and Family Therapist working within the scope of their license.

Benefit Payment for Outpatient Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for Outpatient Mental Illness treatment will be provided at 90% of the Eligible Charge or at 90% of the Maximum Allowance when you receive services from a Participating Provider after you have met your program deductible. When you receive Covered Services from a Non-Participating Provider for Outpatient Mental Illness treatment, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefits for Outpatient Substance Abuse Rehabilitation Treatment (in a program approved by the Claim Administrator) will be provided at 90% of the Eligible Charge or at 90% of the Maximum Allowance when you receive services from a Participating Provider after you have met your program deductible.

When you receive Covered Services from a Non-Participating Provider for Outpatient Substance Abuse Rehabilitation Treatment, benefits will be provided at 70% of the Eligible Charge or 70% of the Maximum Allowance after you have met your program deductible.

Benefit Payment for Inpatient treatment of Mental Illness and Substance Abuse Rehabilitation Treatment

Benefits for the Inpatient treatment of Mental Illness and Inpatient Substance Abuse Rehabilitation Treatment will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Benefit Maximum for Inpatient and Outpatient treatment of Substance Abuse Rehabilitation Treatment

Your benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment are limited to a maximum of $10,000 per benefit period.

Lifetime Benefit Maximum for treatment of Substance Abuse Rehabilitation Treatment

A lifetime maximum of $25,000 will apply to benefits for Inpatient and Outpatient Substance Abuse Rehabilitation Treatment.

None of the charges for the Inpatient and/or Outpatient treatment of Mental Illness or Substance Abuse Rehabilitation Treatment will be included in the calculation of your out-of-pocket expenses.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family

Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Infertility

Covered Services related to the diagnosis and/or treatment of infertility when rendered in conjunction with conception through normal intercourse are the same as your benefits for any other condition. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

Your benefits for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders are limited to a lifetime maximum of $2,500.

MASTECTOMY - RELATED SERVICES

Benefits for Covered Services related to mastectomies, including, but not limited to, 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas, are the same as for any other condition.

PAYMENT PROVISIONS

Lifetime Maximum

The total maximum amount of benefits to which you are entitled under this Participating Provider Option program is $3,000,000. This is an individual maximum. There is no family maximum.

As you use your benefits, a certain amount will automatically be restored to your lifetime maximum each year. This amount will be $1,000 or the amount you have received in benefits that benefit period, whichever is less.

Cumulative Benefit Maximums

All benefits payable under this Health Care Plan are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, the Claim Administrator will include benefit payments under both this and/or any prior or subsequent health care program administered by the Claim Administrator issued to you as an Eligible Person or a dependent of an Eligible Person under this Heath Care Plan.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $750 for Individual coverage (or $1,500 for Individual + 1 coverage), any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is life threatening)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- the program deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider

- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment
- charges for Outpatient Prescription Drugs
- the Copayment for Physician office visits
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Claim Administrator's Mental Health Unit
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

If you have Family Coverage and your expenses as described above equals $1,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $1,750 for Individual coverage (or $3,500 for Individual + 1 coverage), any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided.

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- the program deductible(s)
- the Inpatient Hospital admission deductible(s)
- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- the Coinsurance resulting from Hospital services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility for Covered Services

- charges for Covered Services which have a separate dollar maximum specifically mentioned in this certificate
- charges for Covered Services received for the treatment of Mental Illness for those illnesses not classified as Serious Mental Illness and/or Substance Abuse Rehabilitation Treatment
- charges for Outpatient Prescription Drugs
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the Medical Services Advisory Program and/or the Claim Administrator's Mental Health Unit
- any unreimbursed expenses incurred for "comprehensive major medical" Covered Services within your prior contract's benefit period.

If you have Family Coverage and your expense as described above equals $3,500 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this Health Care Plan is terminated, benefits will be provided for, and limited to, the Covered Services which are provided by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including but not limited, to Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your benefit booklet explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drug, and
- the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/ Tretinoin and Minoxidil/Rogaine);
- drugs which are not self-administered;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Benefit Payment for Prescription Drugs

The benefits you receive and the Copayment amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider. "Participating Prescription Drug Provider" means a Pharmacy that has a written agreement with the Claim Administrator or another Blue Cross and Blue Shield Plan to administer its prescription drug program to provide services to you at the time you receive the services.

When you obtain drugs and diabetic supplies from a Participating Prescription Drug Provider, you must pay a Copayment amount of:

- **$5 for each prescription** - for generic drugs and diabetic supplies.
- **$25 for each prescription** -for brand name drugs.

When you obtain drugs and diabetic supplies from a Participating Prescription Drug Provider, you must pay the Copayment amount described above for each prescription. Benefits will be provided for the remaining Eligible Charge. One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or the Claim Administrator's office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

When you obtain drugs and diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), 75% of the Eligible Charge will be paid minus the Copayment amount.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs and oral contraceptives obtained through the Home Delivery Prescription Drug Program. One mail order prescription means up to a 90 consecutive day supply of a drug. For information about this program, contact your employer or Claim Administrator.

When you obtain drugs and diabetic supplies through the Home Delivery Prescription Drug Program, you must pay a Copayment amount of:

- **$10 for each prescription** - for generic drugs and diabetic supplies.
- **$50 for each prescription** - for brand name drugs.

DENTAL BENEFIT SECTION

The benefits of this section are subject to all of the terms and conditions of this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available, dental services must be Medically Necessary and rendered and billed for by a Dentist or Physician, unless otherwise specified. No payment will be made by the Claim Administrator until after receipt of an Attending Dentist's Statement. In addition, benefits will be provided only if services are rendered on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Benefit Section, it will mean Dentist or Physician.

Preventive Dental Services

Your Preventive Dental benefits are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive Dental Services are as follows:

- Oral Examinations—The initial oral examination and periodic routine oral examinations. However, your benefits are limited to two examinations every benefit period.
- Prophylaxis—The routine scaling and polishing of your teeth. However, your benefits are limited to two cleanings each benefit period.
- Topical Fluoride Application—Benefits for this application are only available to dependent children under age 19 and are limited to two applications each benefit period.
- Dental X-rays—Benefits for panoramic and routine full mouth X-rays are limited to one full mouth series every thirty-six (36) months. Routine bitewing X-rays are limited to one set per benefit period. Any additional full mouth X-rays are subject to Medical Necessity.
- Space Maintainers—Benefits for space maintainers are only available to persons under age 19 and not when part of orthodontic treatment.
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain.
- Sealants—Benefits for sealants are only available to persons under age 14.

Primary Dental Services

Your Primary Dental benefits cover a wide range of services that can help you maintain continued good dental health. These services are as follows:

- Fillings
- Extractions, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Oral Surgery, except as specifically excluded under "Special Limitations" of this Benefit Section.
- Endodontics
- Pulp Vitality Tests
- Apicoectomies
- Hemisection
- Biopsies of Oral Tissue
- Periodontics/Periodontal Therapy

  Gingivectomy and gingivoplasty; gingival curettage; periodontal scaling and root planing; osseous Surgery; and mucogingival Surgery. Your benefits are limited to one full mouth treatment per benefit period.

  Periodontal maintenance procedures — Benefits for periodontal maintenance procedures are limited to two per benefit period. In addition, you must have received active periodontal therapy before benefits for these procedures will be provided.
- Stainless Steel Crowns
- General Anesthesia/Intravenous Sedation—If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.
- Home Visits—Visits by a Dentist to your home when medically required to render a covered dental service.

Major Dental Services

Your Major Dental Benefits are designed to help you pay for certain types of more extensive dental services. These services are as follows:

- Inlays, Onlays and Crowns (other than temporary crowns and stainless steel crowns)
- Fixed Bridgework
- Repair of Crowns, Bridges and Removable Dentures
- Recementing of Crowns, Inlays, Onlays and Bridges
- Full and Partial Dentures

- Denture Adjustments, Rebasing and Relining—During the first six months after obtaining dentures or having them relined, adjustments are covered only if they are done by someone other than the Dentist or his in-office associates who provided or relined the dentures.
- Full Mouth Rehabilitation—Benefits will be provided for procedures necessary for eliminating oral disease and replacing missing teeth. Benefits are not available for appliances or restorations intended to increase vertical dimension.

Once you receive benefits for a crown, inlay, onlay, bridge or denture, replacements are not covered until 5 years have elapsed. Also, benefits are not available for the replacement of a bridge or denture which could have been made serviceable.

BENEFIT PAYMENT FOR DENTAL COVERED SERVICES

Your Dental benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date and ends on the first December 31st following that date.

Deductible

Each benefit period, you must satisfy a $25 deductible for Individual coverage (or $50 deductible for Individual + 1 coverage). This deductible applies to Primary Dental Services and Major Dental Services. In other words, after you incur eligible charges of more than $25 per member of either Primary Dental Services or Major Dental Services in a benefit period, your benefits will begin for those services. Your other dental services are not subject to a deductible.

Family Deductible

If you have Family Coverage and your family has reached the dental deductible amount of $75, it will not be necessary for anyone else in your family to meet a deductible in that benefit period. That is, for the remainder of that benefit period, no other family member(s) is required to meet a dental deductible before receiving dental benefits. A family member may not apply more than the individual dental deductible amount toward the family dental deductible.

Benefit Payment for Dental Services

Benefit Payment Level

100% of the Usual and Customary Fee will be paid for the Preventive Dental Services described in this Dental Benefits Section.

80% of the Usual and Customary Fee will be paid for the Primary Dental Services described in this Dental Benefits Section.

50% of the Usual and Customary Fee will be paid for the Major Dental Services escribed in this Dental Benefits Section.

Benefit Maximum

The maximum amount available for you in dental benefits each benefit period is $1,000. This is an individual maximum. There is no family maximum.

Any expenses incurred beyond the benefit maximum are your responsibility.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

Care By More Than One Dentist

If you should change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefit Program

In all cases in which there is more than one Course of Treatment possible, the benefit payment will be based upon the Course of Treatment bearing the lesser cost.

If you and your Dentist decide on personalized restorations or to employ specialized techniques for dental services rather than standard procedures, the benefits provided will be limited to the benefit for the standard procedures for dental services, as reasonably determined by the Claim Administrator.

Pre-Estimation of Benefits

If your Dentist recommends a Course of Treatment that will cost more than $300, your Dentist should prepare a Claim form describing the planned treatment, copies of necessary X-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Claim Administrator will review the report and materials, taking into consideration alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated benefits which will be provided under this Benefit Section. This is not a guarantee of payment, but an estimate of the benefits available for the proposed services to be rendered.

Special Limitations

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
   - — surgical services related to a congenital malformation;
   - — surgical removal of complete bony impacted teeth;
   - — excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

— excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

4. Dental services which are performed due to an accidental injury when caused by an external force. External force means any outside strength producing damage to the dentition and/or oral structures.
5. Hospital and ancillary charges.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this benefit booklet.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.
8. Implants and any related services and supplies (other than crowns) associated with the placement and care of implants.

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If your coverage under this Health Care Plan should terminate, benefits will continue for any dental Covered Services, except for periodontal treatment, described in this Benefit Section as long as the Covered Service was begun prior to the date your coverage terminated and is completed within 30 days of your termination date. No benefits will be provided for periodontal treatment after the termination of your Health Care Plan.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled "Medicare Eligible Covered Persons" in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you. However, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS—WHAT IS NOT COVERED

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary

and, therefore, not eligible for payment under the terms of your Health Care Plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so within 180 days after you have been notified that your Claim has been denied by writing to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

You may furnish or submit any additional documentation which you or your Physician believe appropriate.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received. However, this exclusion shall not be applicable to medical assis-

tance benefits under Article V or VI of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 § 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, other than the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under the benefit booklet if not provided in connection with an approved clinicial trial program.

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.

— Hearing aids or examinations for the prescription or fitting of hearing aids.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses).

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Elective abortions.

— Services and supplies rendered or provided for the diagnosis and treatment of infertility other than in conjunction with conception through normal intercourse; specifically excluded, without limiting this exclusion, are all services and supplies related to artificial insemination and in-vitro fertilization including, but not limited to, gamete intra-fallopian transfer (GIFT).

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to

notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA)

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional 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.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: 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 your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children 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 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or

both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

HOW TO FILE A CLAIM

In order to obtain your benefits under this Health Care Plan, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

FILING OUTPATIENT PRESCRIPTION DRUG PROGRAM CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the pharmacy was unable to transmit a claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 853901
Richardson, Texas 75085-3901

In any case, Claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received, will not be eligible for payment.

CLAIMS PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal; and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

FILING DENTAL CLAIMS

In order to obtain your dental benefits under this Health Care Plan, it is necessary for a Claim to be filed with the Claim Administrator.

To file a Claim, obtain a claim form from your Employee Benefits Department before going to your Dentist. This form is also used for pre-estimation of benefits. It is your responsibility to insure that the necessary Claim information has been provided to the Claim Administrator.

You must complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

Claims must be filed with the Claim Administrator within 365 days from the date your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

DENTAL CLAIMS PROCEDURES

The Claim Administrator will pay all Claims within 30 days of receipt of all information required to process a Claim. In the event that the Claim Administrator does not process a Claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the

receipt of all Claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If the Claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the health care plan provisions on which the denial is based; (3) a description of additional information which may be necessary to perfect the appeal; and (4) an explanation of how you may have the Claim reviewed by the Claim Administrator if you do not agree with the denial.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Illinois
P.O. Box 23059
Belleville, Illinois 62223-0059

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

While the Claim Administrator will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal full amount the Hospital bill for Covered Services is $1,000, how is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue passes on to the Claim Administrator.

a. Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service - the amount applied to your deductible, if any, and your coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Blue Cross and Blue Shields' Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers ("Participating Prescription Drug Providers") to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to

you. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances.

In addition, the Claim Administrator entered into agreements with certain entity(ies) to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. This entity(ies) is referred to as a pharmacy benefit manager. The pharmacy benefit manager has agreements with pharmaceutical manufacturers to receive rebates for using their products. The pharmacy benefit manager shares a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator

information regarding you or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator would be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the right to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PLAN ADMINISTRATION INFORMATION

NAME OF PLAN: Utilities, Inc., ET AL Employee Benefit Plan

PLAN SPONSOR:

Name: Utilities, Inc., ET AL

Address: 2335 Sanders Road
Northbrook, IL 60062
(847) 498-6440

EMPLOYER IDENTIFICATION NUMBER: 36-2588579

PLAN NUMBER: 504

PLAN ADMINISTRATOR:

Name: Utilities, Inc., ET AL

Address: 2335 Sanders Road
Northbrook, IL 60062

Telephone Number: (847) 498-6440

TYPE OF PLAN:
Welfare Benefit Plan

CLAIM ADMINISTRATION: Claims for benefits should be directed to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

AGENT FOR SERVICE OF LEGAL PROCESS:

Winston and Strawn
35 West Wacker Drive
Chicago, IL 60601-9703

ELIGIBILITY: Benefits under this Plan begin 30 days after date of hire

BENEFITS AND ADMINISTRATION:

Minimum Maternity Benefits

Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours

following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods.

LOSS OF BENEFITS: The provisions regarding termination of coverage and limitations and exclusions of benefits which may result in reduction or loss of benefits are explained in this booklet.

CONTRIBUTIONS: Utilities, Inc. pays a significant portion of the cost towards a member's health insurance coverage under the terms of the Plan. Members are required to pay a portion of the cost for this Plan. The actual amount paid by the member is subject to change and will be announced by the Company.

PLAN YEAR: The Plan year begins on January 1st and ends on December 31st.

HOW TO GET YOUR BENEFITS:
This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIMS PROCEDURE:
This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

CLAIM REVIEW PROCEDURE:
This information is explained in the section of this booklet entitled "HOW TO FILE A CLAIM."

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:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

c. 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:

a. 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 booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

b. 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 exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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 under the plan 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, 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 the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the
U. S. Department of Labor, or you may file suit in 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 if, for example, it finds your Claim is frivolous.

Assistance with Your Questions:

If you have any questions about the 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.

DATA REQUEST #38

Refer to Water Services response to Commission Staff's First Data Request, Item 29. Explain why the contract is not currently available. Provide copies of the contract when it is available.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

As previously mentioned in this proceeding, the contract is currently being located. As soon as it is located, it will be provided to the Commission.

DATA REQUEST #39

Explain how the proposed rates were calculated. Show all calculations and state all assumptions used to develop the rates.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

The proposed metered rates were calculated on a uniform rate structure for the Middlesboro and Clinton systems combined. Using a 5/8" or ¾" inch meter as a base, the following industry standards were used:

2.5 times the base is 1" meter
5 times the base in 1 ½" meter
8 times the base is 2" meter
15 times the base is 3" meter
25 times the base is 4" meter
50 times the base is 6" meter

In addition, based on the average consumption for 5/8" meters, 40% of the average bill comes from the base charge, while the remaining 60% comes from the usage charge.

Finally, flat charges, were increased across the board by 25% above the current charge that was last ordered by the Commission.

DATA REQUEST #40

If a cost of service study was completed, provide a paper copy as well as a electronic copy in Excel or Lotus 1-2-3 format. If these formats are unavailable, provide data in rich text format (RTF).

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

No cost of service study was completed.

DATA REQUEST #41

Refer to the prepared testimony of Kirsten Weeks at question 9.

a. State whether any expenses are specific to a geographical area.
b. State whether the company has maintained separate financial records for each location so that a separate rate structure could be developed for each location.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Expenses are not specific to a geographical area. The company has maintained separate financial records for each location. These separate financial records are based on each subdivision of the company.

DATA REQUEST #41

Refer to the prepared testimony of Kirsten Weeks at question 9.

c. If the response to 41(b) is yes, provide all detailed records related to each location and show all calculations, state all assumptions and provide work papers associated with these records.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

See enclosed trial balances for each subdivision.

Lost Center KY — Sub # 0161

41(c) (Staff)

PERIOD ENDING: 12/31/04 09:15:12 31 JAN 2006 (NV.1CO.TB2LY) PAGE 1
COMPANY: C-160 WATER SERVICE CORPORATION OF KENTUCKY

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
3466094	TOOLS SHOP & MISC EQPT	3,500.00	0.00	3,500.00
101.1	WTR UTILITY PLANT IN SERVICE	3,500.00	0.00	3,500.00
1083094	ACCUM DEPR.-3466094	139.92-	0.00	139.92-
108.3	ACCUM DEPR WATER PLANT	139.92-	0.00	139.92-
	TOTAL BALANCE SHEET	3,360.08	0.00	3,360.08

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
6205003	OPERATORS EXPENSES	413.12	0.00	413.12
401.1ZZ	OPERATORS EXPENSES	413.12	0.00	413.12
4032094	DEPRECIATION-10194	69.96	0.00	69.96
403.2	DEPRECIATION EXP-WATER	69.96	0.00	69.96
	TOTAL INCOME STATEMENT	483.08	0.00	483.08
	TOTAL BALANCE SHEET	3,360.08	0.00	3,360.08
	TOTAL INCOME STATEMENT	483.08	0.00	483.08

NV.1CO.TB2LY

TIMINGS FOR EACH PHASE OF THIS REPORT

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TOTAL	00:00:00	100%

Clinton, Sub # 0162

PERIOD ENDING: 12/31/04 09:03:04 31 JAN 2006 (NV.1CO.TB2LY) PAGE 1
COMPANY: C-160 WATER SERVICE CORPORATION OF KENTUCKY

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
3036010	LAND & LAND RIGHTS	14,115.27	0.00	14,115.27
3042011	STRUCT & IMPRV (SOURCE SUP)	1,000.00	0.00	1,000.00
3043021	STRUCT & IMPRV (PUMP PLT)	5,767.78	0.00	5,767.78
3044031	STRUCT & IMPRV (WATER T P)	26,393.02	0.00	26,393.02
3072014	WELLS & SPRINGS	33,112.03	0.00	33,112.03
3113025	ELECTRIC PUMP EQUIP	82,009.79	0.00	82,009.79
3204032	WATER TREATMENT EQPT	16,817.91	0.00	16,817.91
3305042	DIST RESV & STNDPIPES	134,357.64	0.00	134,357.64
3315043	TRANS & DISTR MAINS	291,451.01	0.00	291,451.01
3335045	SERVICE LINES	90,390.38	0.00	90,390.38
3345046	METERS	72,215.18	0.00	72,215.18
3345047	METER INSTALLATIONS	26,545.82	0.00	26,545.82
3355048	HYDRANTS	22,370.34	0.00	22,370.34
3406090	OFF STRUCT & IMPRV	42,319.97	0.00	42,319.97
3406091	OFF FURN & EQPT	8,374.95	0.00	8,374.95
3446095	LABORATORY EQPT	884.16	0.00	884.16
3466094	TOOLS SHOP & MISC EQPT	29,667.89	0.00	29,667.89
3466097	COMMUNICATION EQPT	6,843.71	0.00	6,843.71
101.1	WTR UTILITY PLANT IN SERVICE	904,636.85	0.00	904,636.85
1083010	ACCUM DEPR-WATER PLANT	1,515.18	0.00	1,515.18
1083014	ACCUM DEPR.-3072014	25,450.09-	0.00	25,450.09-
1083021	ACCUM DEPR.-3043021	2,308.78-	0.00	2,308.78-
1083025	ACCUM DEPR.-3113025	1,980.31-	0.00	1,980.31-
1083031	ACCUM DEPR.-3044031	6,309.54-	0.00	6,309.54-
1083032	ACCUM DEPR.-3204032	5,942.44-	0.00	5,942.44-
1083042	ACCUM DEPR.-3305042	49,131.64-	0.00	49,131.64-
1083043	ACCUM DEPR.-3315043	110,774.45-	0.00	110,774.45-
1083045	ACCUM DEPR.-3335045	65,207.17-	0.00	65,207.17-
1083046	ACCUM DEPR.-3345046	59,244.70-	0.00	59,244.70-
1083047	ACCUM DEPR.-3345047	16,208.79-	0.00	16,208.79-
1083048	ACCUM DEPR.-3355048	8,537.72-	0.00	8,537.72-
1083090	ACCUM DEPR.-3406090	6,074.84-	0.00	6,074.84-
1083091	ACCUM DEPR.-3406091	6,527.43-	0.00	6,527.43-
1083094	ACCUM DEPR.-3466094	15,580.85-	0.00	15,580.85-
1083095	ACCUM DEPR.-3446095	35.28-	0.00	35.28-
1083097	ACCUM DEPR.-3466097	5,334.04-	0.00	5,334.04-
108.3	ACCUM DEPR WATER PLANT	383,132.89-	0.00	383,132.89-
1312076	CASH-CLINTON 1ST NATL BANK CLINTON	80,925.74	0.00	80,925.74
131.2	CASH	80,925.74	0.00	80,925.74
1411000	A/R-CUSTOMER	42,101.80	0.00	42,101.80
1411002	A/R-CUSTOMER ACCRUAL	24,375.00	0.00	24,375.00

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
141.1	ACCOUNTS RECEIVABLE CUSTOMER	66,476.80	0.00	66,476.80
1862024	DEF CHGS-TANK MAINT&REP(WTR)-4	12,605.00	0.00	12,605.00
1865024	AMORT - TANK MAINT&REP (WTR)-4	420.00-	0.00	420.00-
186.2	OTHER DEFERRED CHARGES	12,185.00	0.00	12,185.00
2311000	A/P TRADE	2,700.51	0.00	2,700.51
2311020	A/P CITY OF CLINTON	67,147.41-	0.00	67,147.41-
231.1	ACCOUNTS PAYABLE TRADE	64,446.90-	0.00	64,446.90-
2351000	CUSTOMER DEPOSITS	11,020.00-	0.00	11,020.00-
235.1	CUSTOMER DEPOSITS	11,020.00-	0.00	11,020.00-
2361170	ACCRUED SALES TAX	5,558.40-	0.00	5,558.40-
2361171	ACCRUED SALES TAX 2	5,275.46-	0.00	5,275.46-
236.1	ACCRUED TAXES	10,833.86-	0.00	10,833.86-
2372030	ACCRUED CUST DEP INTEREST	355.03-	0.00	355.03-
237.1	ACCRUED INTEREST	355.03-	0.00	355.03-
	TOTAL BALANCE SHEET	594,435.71	0.00	594,435.71

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
4611020	WATER REVENUE-METERED	153,805.74-	0.00	153,805.74-
4611099	WATER REVENUE ACCRUALS	779.00-	0.00	779.00-
4612030	WATER REVENUE-COMMERCIAL	35,466.35-	0.00	35,466.35-
400.1	WATER REVENUE	190,051.09-	0.00	190,051.09-
4701000	FORFEITED DISCOUNTS	5,949.82-	0.00	5,949.82-
400.3	FORFEITED DISCOUNTS	5,949.82-	0.00	5,949.82-
4711000	MISC SERVICE REVENUES	385.18-	0.00	385.18-
4741009	CUT-OFF CHARGE	440.00-	0.00	440.00-
400.4	MISC. SERVICE REVENUES	825.18-	0.00	825.18-
6151010	ELEC PWR - WATER SYSTEM	5,935.92	0.00	5,935.92
6151040	ELEC PWR - GAS F/MAINT OP	1,033.36	0.00	1,033.36
401.1E	ELECTRIC POWER	6,969.28	0.00	6,969.28
6181010	CHLORINE	1,809.23	0.00	1,809.23
6181090	OTHER CHEMICALS (TREATMENT)	716.13	0.00	716.13
401.1F	CHEMICALS	2,525.36	0.00	2,525.36
6708000	UNCOLLECTIBLE ACCOUNTS	4,378.07	0.00	4,378.07
6708001	AGENCY EXPENSE	45.69	0.00	45.69
401.1K	UNCOLLECTIBLE ACCOUNTS	4,423.76	0.00	4,423.76
6369003	TEMP EMPLOY - CLERICAL	2,030.00	0.00	2,030.00
401.1L	OUTSIDE SERVICES-DIRECT	2,030.00	0.00	2,030.00
6759006	UPS & AIR FREIGHT	26.95	0.00	26.95
6759009	OFFICE SUPPLY STORES	214.34	0.00	214.34
6759013	CLEANING SUPPLIES	3.18	0.00	3.18
6759090	OTHER OFFICE EXPENSES	604.12	0.00	604.12
401.1R	OFFICE SUPPLIES	848.59	0.00	848.59
6759005	POSTAGE & POSTAGE METER-OFFICE	136.00	0.00	136.00
6759007	PRINTING CUSTOMER SERVICE	92.27	0.00	92.27
401.1RR	BILLING & CUSTOMER SERVICE	228.27	0.00	228.27
6759110	OFFICE TELEPHONE	4,550.76	0.00	4,550.76
6759120	OFFICE ELECTRIC	1,620.48	0.00	1,620.48
6759125	OFFICE WATER	393.56	0.00	393.56

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
6759140	ALARM SYS PHONE EXPENSE	670.50	0.00	670.50
401.1S	OFFICE UTILITIES	7,235.30	0.00	7,235.30
6759210	OFFICE CLEANING SERV	2,430.00	0.00	2,430.00
6759230	OFFICE GARBAGE REMOVAL	206.97	0.00	206.97
6759290	OTHER OFFICE MAINT	103.00	0.00	103.00
401.1U	OFFICE MAINTENANCE	2,739.97	0.00	2,739.97
7758370	MEALS & RELATED EXP	334.15	0.00	334.15
401.1V	MISCELLANEOUS EXPENSE	334.15	0.00	334.15
6755090	WATER-OTHER MAINT EXP	3,194.22	0.00	3,194.22
6759503	WATER-MAINT SUPPLIES	718.94	0.00	718.94
6759506	WATER-MAINT REPAIRS	5,758.31	0.00	5,758.31
6759507	WATER-MAIN BREAKS	171.18	0.00	171.18
6759509	WATER-ELEC EQUIPT REPAIR	112.00	0.00	112.00
401.1X	MAINTENANCE-WATER PLANT	9,954.65	0.00	9,954.65
6759080	MAINT-DEFERRED CHARGES	420.00	0.00	420.00
6759402	PART-TIME OPERATORS	4,048.80	0.00	4,048.80
6759412	UNIFORMS	693.65	0.00	693.65
6759415	MOWING/SNOWPLOWING	40.00	0.00	40.00
401.1Z	MAINTENANCE-WTR&SWR PLANT	5,202.45	0.00	5,202.45
6205003	OPERATORS EXPENSES	701.36	0.00	701.36
6759017	OPERATORS-CLEANING SUPPLIES	78.26	0.00	78.26
6759018	OPERATORS-OTHER OFFICE EXPENSE	3,997.04	0.00	3,997.04
6759019	OPERATORS-PUBLICATIONS/SUSCRIPTIONS	24.00	0.00	24.00
6759410	OPERATORS ED EXPENSES	93.21	0.00	93.21
6759413	OPERATORS-POSTAGE	932.90	0.00	932.90
6759414	OPERATORS-OFFICE SUPPLY STORES	423.06	0.00	423.06
6759416	OPERATORS-MEMBERSHIPS	1,140.00	0.00	1,140.00
401.1ZZ	OPERATORS EXPENSES	7,389.83	0.00	7,389.83
6355010	WATER TESTS	1,328.70	0.00	1,328.70
6355030	TESTING EQUIP & CHEM	399.21	0.00	399.21
401.2B	MAINTENANCE-TESTING	1,727.91	0.00	1,727.91
6501020	GASOLINE	30.00	0.00	30.00
6501030	AUTO REPAIR & TIRES	114.87	0.00	114.87
401.2D	TRANSPORTATION EXPENSE	144.87	0.00	144.87

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
4032014	DEPRECIATION-10114	618.96	0.00	618.96
4032021	DEPRECIATION-10121	115.32	0.00	115.32
4032025	DEPRECIATION-10125	541.68	0.00	541.68
4032031	DEPRECIATION-10131	527.88	0.00	527.88
4032032	DEPRECIATION-10132	283.32	0.00	283.32
4032042	DEPRECIATION-10142	2,667.96	0.00	2,667.96
4032043	DEPRECIATION-10143	5,797.08	0.00	5,797.08
4032045	DEPRECIATION-10145	1,761.30	0.00	1,761.30
4032046	DEPRECIATION-10146	1,403.88	0.00	1,403.88
4032047	DEPRECIATION-10147	397.56	0.00	397.56
4032048	DEPRECIATION-10148	441.72	0.00	441.72
4032090	DEPRECIATION-10190	846.36	0.00	846.36
4032091	DEPRECIATION-10191	167.52	0.00	167.52
4032094	DEPRECIATION-10194	536.94	0.00	536.94
4032095	DEPRECIATION-10195	17.64	0.00	17.64
4032097	DEPRECIATION-10197	136.92	0.00	136.92
403.2	DEPRECIATION EXP-WATER	16,262.04	0.00	16,262.04
4081122	PERS PROP & ICT TAX	521.58	0.00	521.58
408.3	OTHER TAXES	521.58	0.00	521.58
4152000	INCOME FROM MGMT. SERVICES	102,670.26-	0.00	102,670.26-
415.1	INCOME FROM MGMT SERVICES	102,670.26-	0.00	102,670.26-
4272050	S/T INT EXP CUSTOMERS DEP	638.40	0.00	638.40
427.2	SHORT TERM INTEREST EXP	638.40	0.00	638.40
	TOTAL INCOME STATEMENT	230,319.94-	0.00	230,319.94-
	TOTAL BALANCE SHEET	594,435.71	0.00	594,435.71
	TOTAL INCOME STATEMENT	230,319.94-	0.00	230,319.94-

NV.1CO.TB2LY

TIMINGS FOR EACH PHASE OF THIS REPORT

ODE/VALIDATE	00:00:00	14.7953%
RETRIEVE	00:00:00	05.4513%
CALCULATE	00:00:00	00.3105%
FORMAT	00:00:03	79.4429%
TOTAL	00:00:04	100%

Middlesborough - Sub # 0170

COMPANY: C-160 WATER SERVICE CORPORATION OF KENTUCKY

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
3011001	ORGANIZATION	1,178.09	0.00	1,178.09
3036010	LAND & LAND RIGHTS	5,928.78	0.00	5,928.78
3043021	STRUCT & IMPRV (PUMP PLT)	24,611.76	0.00	24,611.76
3044031	STRUCT & IMPRV (WATER T P)	315,302.86	0.00	315,302.86
3072014	WELLS & SPRINGS	7,413.16	0.00	7,413.16
3113025	ELECTRIC PUMP EQUIP	298,583.59	0.00	298,583.59
3204032	WATER TREATMENT EQPT	480,472.98	0.00	480,472.98
3305042	DIST RESV & STNDPIPES	331,637.44	0.00	331,637.44
3315043	TRANS & DISTR MAINS	2,377,954.93	0.00	2,377,954.93
3335045	SERVICE LINES	551,444.82	0.00	551,444.82
3345046	METERS	391,685.65	0.00	391,685.65
3345047	METER INSTALLATIONS	167,291.51	0.00	167,291.51
3355048	HYDRANTS	235,698.99	0.00	235,698.99
3406090	OFF STRUCT & IMPRV	17,930.20	0.00	17,930.20
3406091	OFF FURN & EQPT	52,068.98	0.00	52,068.98
3446095	LABORATORY EQPT	29,151.79	0.00	29,151.79
3466094	TOOLS SHOP & MISC EQPT	113,219.25	0.00	113,219.25
3466097	COMMUNICATION EQPT	36,401.68	0.00	36,401.68
3486096	UNDISTR WATER PLANT	69,976.00	0.00	69,976.00
101.1	WTR UTILITY PLANT IN SERVICE	5,507,952.46	0.00	5,507,952.46
1052091	WATER PLANT IN PROCESS	48,077.25	0.00	48,077.25
105.1	WORK IN PROGRESS	48,077.25	0.00	48,077.25
1083001	ACCUM DEPR.-3011001	34.14-	0.00	34.14-
1083010	ACCUM DEPR-WATER PLANT	14,618.71-	0.00	14,618.71-
1083014	ACCUM DEPR.-3072014	186.24-	0.00	186.24-
1083021	ACCUM DEPR.-3043021	11,590.26-	0.00	11,590.26-
1083025	ACCUM DEPR.-3113025	45,040.42-	0.00	45,040.42-
1083031	ACCUM DEPR.-3044031	98,661.89-	0.00	98,661.89-
1083032	ACCUM DEPR.-3204032	139,788.26-	0.00	139,788.26-
1083042	ACCUM DEPR.-3305042	122,150.01-	0.00	122,150.01-
1083043	ACCUM DEPR.-3315043	899,370.84-	0.00	899,370.84-
1083045	ACCUM DEPR.-3335045	427,021.30-	0.00	427,021.30-
1083046	ACCUM DEPR.-3345046	313,250.43-	0.00	313,250.43-
1083047	ACCUM DEPR.-3345047	123,410.43-	0.00	123,410.43-
1083048	ACCUM DEPR.-3355048	50,554.32-	0.00	50,554.32-
1083090	ACCUM DEPR.-3406090	649.82-	0.00	649.82-
1083091	ACCUM DEPR.-3406091	38,309.90-	0.00	38,309.90-
1083094	ACCUM DEPR.-3466094	72,921.31-	0.00	72,921.31-
1083095	ACCUM DEPR.-3446095	22,720.83-	0.00	22,720.83-
1083096	ACCUM DEPR.-10196	1,856.69-	0.00	1,856.69-
1083097	ACCUM DEPR.-3466097	25,862.30-	0.00	25,862.30-
108.3	ACCUM DEPR WATER PLANT	2,407,998.10-	0.00	2,407,998.10-

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
1411000	A/R-CUSTOMER	21,383.77	0.00	21,383.77
1411002	A/R-CUSTOMER ACCRUAL	24,261.00	0.00	24,261.00
141.1	ACCOUNTS RECEIVABLE CUSTOMER	45,644.77	0.00	45,644.77
1862024	DEF CHGS-TANK MAINT&REP(WTR)-4	5,000.00	0.00	5,000.00
1865024	AMORT - TANK MAINT&REP (WTR)-4	581.00-	0.00	581.00-
186.2	OTHER DEFERRED CHARGES	4,419.00	0.00	4,419.00
2334002	A/P WATER SERVICE CORP	275.00	0.00	275.00
233.4	ACCTS PAYABLE ASSOC COS	275.00	0.00	275.00
2351000	CUSTOMER DEPOSITS	25,284.00-	0.00	25,284.00-
235.1	CUSTOMER DEPOSITS	25,284.00-	0.00	25,284.00-
2361170	ACCRUED SALES TAX	74,294.56	0.00	74,294.56
2361292	ACCRUED ST INCOME TAX	500.00	0.00	500.00
236.1	ACCRUED TAXES	74,794.56	0.00	74,794.56
2372030	ACCRUED CUST DEP INTEREST	1,236.70-	0.00	1,236.70-
237.1	ACCRUED INTEREST	1,236.70-	0.00	1,236.70-
2525000	ADV-IN-AID OF CONST-WATER	113,080.53-	0.00	113,080.53-
252.1	ADVANCES IN AID WATER	113,080.53-	0.00	113,080.53-
2711000	CIAC-WATER-UNDISTR.	81,023.99-	0.00	81,023.99-
2711010	CIAC-WATER-TAX	221.00-	0.00	221.00-
271.1	CONTRIBUTIONS IN AID WATER	81,244.99-	0.00	81,244.99-
2722000	ACC AMORT-CIA-WATER	3,365.40	0.00	3,365.40
272.1	ACCUM AMORT OF CIA WATER	3,365.40	0.00	3,365.40
	TOTAL BALANCE SHEET	3,055,684.12	0.00	3,055,684.12

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
4611020	WATER REVENUE-METERED	305,286.70-	0.00	305,286.70-
4611099	WATER REVENUE ACCRUALS	481.00-	0.00	481.00-
400.1	WATER REVENUE	305,767.70-	0.00	305,767.70-
4701000	FORFEITED DISCOUNTS	7,718.35-	0.00	7,718.35-
400.3	FORFEITED DISCOUNTS	7,718.35-	0.00	7,718.35-
4711000	MISC SERVICE REVENUES	854.81	0.00	854.81
4741009	CUT-OFF CHARGE	1,720.00-	0.00	1,720.00-
400.4	MISC. SERVICE REVENUES	865.19-	0.00	865.19-
6101010	PURCHASED WATER-WATER SYS	85,614.24	0.00	85,614.24
401.1B	PURCHASED WATER	85,614.24	0.00	85,614.24
6151010	ELEC PWR - WATER SYSTEM	35,547.22	0.00	35,547.22
401.1E	ELECTRIC POWER	35,547.22	0.00	35,547.22
6181010	CHLORINE	39,026.96	0.00	39,026.96
6181090	OTHER CHEMICALS (TREATMENT)	37,762.24	0.00	37,762.24
401.1F	CHEMICALS	76,789.20	0.00	76,789.20
6708000	UNCOLLECTIBLE ACCOUNTS	3,837.62	0.00	3,837.62
6708001	AGENCY EXPENSE	81.74	0.00	81.74
401.1K	UNCOLLECTIBLE ACCOUNTS	3,919.36	0.00	3,919.36
6419090	RENT-OTHERS	1,149.00	0.00	1,149.00
401.1Q	RENT	1,149.00	0.00	1,149.00
6759006	UPS & AIR FREIGHT	73.53	0.00	73.53
6759009	OFFICE SUPPLY STORES	3.75	0.00	3.75
6759014	MEMBERSHIPS - OFFICE EMPLOYEE	250.00	0.00	250.00
401.1R	OFFICE SUPPLIES	327.28	0.00	327.28
6759005	POSTAGE & POSTAGE METER-OFFICE	278.65	0.00	278.65
6759007	PRINTING CUSTOMER SERVICE	1,141.36	0.00	1,141.36
401.1RR	BILLING & CUSTOMER SERVICE	1,420.01	0.00	1,420.01
6759120	OFFICE ELECTRIC	1,220.65	0.00	1,220.65
6759125	OFFICE WATER	167.78	0.00	167.78

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
6759130	OFFICE GAS	1,786.77	0.00	1,786.77
6759135	OPERATIONS TELEPHONES	8,091.77	0.00	8,091.77
6759140	ALARM SYS PHONE EXPENSE	541.07	0.00	541.07
6759190	OTHER OFFICE UTILITIES	48.34	0.00	48.34
401.1S	OFFICE UTILITIES	11,856.38	0.00	11,856.38
6759210	OFFICE CLEANING SERV	1,845.00	0.00	1,845.00
6759290	OTHER OFFICE MAINT	350.00	0.00	350.00
401.1U	OFFICE MAINTENANCE	2,195.00	0.00	2,195.00
7758370	MEALS & RELATED EXP	165.52	0.00	165.52
7758390	OTHER MISC GENERAL	4,795.03-	0.00	4,795.03-
401.1V	MISCELLANEOUS EXPENSE	4,629.51-	0.00	4,629.51-
6755090	WATER-OTHER MAINT EXP	15,901.96	0.00	15,901.96
6759503	WATER-MAINT SUPPLIES	2,760.07	0.00	2,760.07
6759506	WATER-MAINT REPAIRS	21,059.77	0.00	21,059.77
6759507	WATER-MAIN BREAKS	1,631.55	0.00	1,631.55
6759509	WATER-ELEC EQUIPT REPAIR	129.63	0.00	129.63
401.1X	MAINTENANCE-WATER PLANT	41,482.98	0.00	41,482.98
6759080	MAINT-DEFERRED CHARGES	581.00	0.00	581.00
6759405	COMMUNICATION EXPENSES	1,420.00	0.00	1,420.00
6759412	UNIFORMS	4,225.58	0.00	4,225.58
6759490	GARBAGE REMOVAL WTR/SWR	82.44	0.00	82.44
401.1Z	MAINTENANCE-WTR&SWR PLANT	6,309.02	0.00	6,309.02
6205003	OPERATORS EXPENSES	1,463.52	0.00	1,463.52
6759017	OPERATORS-CLEANING SUPPLIES	887.78	0.00	887.78
6759018	OPERATORS-OTHER OFFICE EXPENSE	4,790.19	0.00	4,790.19
6759410	OPERATORS ED EXPENSES	964.28	0.00	964.28
6759413	OPERATORS-POSTAGE	2,307.84	0.00	2,307.84
6759414	OPERATORS-OFFICE SUPPLY STORES	3,655.51	0.00	3,655.51
6759416	OPERATORS-MEMBERSHIPS	1,493.00	0.00	1,493.00
401.1ZZ	OPERATORS EXPENSES	15,562.12	0.00	15,562.12
6355010	WATER TESTS	9,683.00	0.00	9,683.00
6355030	TESTING EQUIP & CHEM	3,395.35	0.00	3,395.35
401.2B	MAINTENANCE-TESTING	13,078.35	0.00	13,078.35
6501030	AUTO REPAIR & TIRES	211.89	0.00	211.89
6509110	OPERATORS TRANS REIM	198.75	0.00	198.75

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
401.2D	TRANSPORTATION EXPENSE	410.64	0.00	410.64
4032001	DEPRECIATION-10101	11.46	0.00	11.46
4032014	DEPRECIATION-10114	144.24	0.00	144.24
4032021	DEPRECIATION-10121	484.26	0.00	484.26
4032025	DEPRECIATION-10125	4,679.70	0.00	4,679.70
4032031	DEPRECIATION-10131	6,306.00	0.00	6,306.00
4032032	DEPRECIATION-10132	7,784.40	0.00	7,784.40
4032042	DEPRECIATION-10142	6,457.44	0.00	6,457.44
4032043	DEPRECIATION-10143	46,857.54	0.00	46,857.54
4032045	DEPRECIATION-10145	10,811.04	0.00	10,811.04
4032046	DEPRECIATION-10146	7,679.52	0.00	7,679.52
4032047	DEPRECIATION-10147	3,113.88	0.00	3,113.88
4032048	DEPRECIATION-10148	2,706.84	0.00	2,706.84
4032090	DEPRECIATION-10190	358.56	0.00	358.56
4032091	DEPRECIATION-10191	1,041.36	0.00	1,041.36
4032094	DEPRECIATION-10194	2,231.94	0.00	2,231.94
4032095	DEPRECIATION-10195	583.08	0.00	583.08
4032097	DEPRECIATION-10197	728.04	0.00	728.04
403.2	DEPRECIATION EXP-WATER	101,979.30	0.00	101,979.30
4071000	AMORT EXP-CIA-WATER	1,628.16-	0.00	1,628.16-
407.6	AMORT EXP-CIA-WATER	1,628.16-	0.00	1,628.16-
4081121	REAL ESTATE TAX	21,448.67	0.00	21,448.67
408.3	OTHER TAXES	21,448.67	0.00	21,448.67
4272050	S/T INT EXP CUSTOMERS DEP	1,452.42	0.00	1,452.42
427.2	SHORT TERM INTEREST EXP	1,452.42	0.00	1,452.42
	TOTAL INCOME STATEMENT	99,932.28	0.00	99,932.28
	TOTAL BALANCE SHEET	3,055,684.12	0.00	3,055,684.12
	TOTAL INCOME STATEMENT	99,932.28	0.00	99,932.28

NV.1CO.TB2LY

TIMINGS FOR EACH PHASE OF THIS REPORT

ı ,ODE/VALIDATE	00:00:00	31.1305%
RETRIEVE	00:00:00	23.6271%
CALCULATE	00:00:00	01.2992%
FORMAT	00:00:00	43.9431%
TOTAL	00:00:01	100%

Middlesborough - Billing Only
Sub # 0171

COMPANY: C-160 WATER SERVICE CORPORATION OF KENTUCKY

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
1411000	A/R-CUSTOMER	36,089.35	0.00	36,089.35
1411002	A/R-CUSTOMER ACCRUAL	32,069.00	0.00	32,069.00
141.1	ACCOUNTS RECEIVABLE CUSTOMER	68,158.35	0.00	68,158.35
2351000	CUSTOMER DEPOSITS	22,485.00-	0.00	22,485.00-
235.1	CUSTOMER DEPOSITS	22,485.00-	0.00	22,485.00-
2361170	ACCRUED SALES TAX	35,176.20-	0.00	35,176.20-
236.1	ACCRUED TAXES	35,176.20-	0.00	35,176.20-
2372030	ACCRUED CUST DEP INTEREST	1,012.09-	0.00	1,012.09-
237.1	ACCRUED INTEREST	1,012.09-	0.00	1,012.09-
	TOTAL BALANCE SHEET	9,485.06	0.00	9,485.06

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
4611020	WATER REVENUE-METERED	328,070.80-	0.00	328,070.80-
4611099	WATER REVENUE ACCRUALS	5,630.00-	0.00	5,630.00-
400.1	WATER REVENUE	333,700.80-	0.00	333,700.80-
4701000	FORFEITED DISCOUNTS	6,333.31-	0.00	6,333.31-
400.3	FORFEITED DISCOUNTS	6,333.31-	0.00	6,333.31-
4711000	MISC SERVICE REVENUES	675.41	0.00	675.41
4741009	CUT-OFF CHARGE	1,560.00-	0.00	1,560.00-
400.4	MISC. SERVICE REVENUES	884.59-	0.00	884.59-
6708000	UNCOLLECTIBLE ACCOUNTS	3,568.64	0.00	3,568.64
6708001	AGENCY EXPENSE	23.37	0.00	23.37
401.1K	UNCOLLECTIBLE ACCOUNTS	3,592.01	0.00	3,592.01
4272050	S/T INT EXP CUSTOMERS DEP	1,259.88	0.00	1,259.88
427.2	SHORT TERM INTEREST EXP	1,259.88	0.00	1,259.88
	TOTAL INCOME STATEMENT	336,066.81-	0.00	336,066.81-
	TOTAL BALANCE SHEET	9,485.06	0.00	9,485.06
	TOTAL INCOME STATEMENT	336,066.81-	0.00	336,066.81-

NV.1CO.TB2LY

TIMINGS FOR EACH PHASE OF THIS REPORT

⌞ODE/VALIDATE	00:00:00	72.6726%
RETRIEVE	00:00:00	09.2563%
CALCULATE	00:00:00	02.4059%
FORMAT	00:00:00	15.6652%
TOTAL	00:00:00	100%

Middlesborough- Billing Only
Sub # 0172

COMPANY: C-160 WATER SERVICE CORPORATION OF KENTUCKY

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
1411000	A/R-CUSTOMER	30,711.68	0.00	30,711.68
1411002	A/R-CUSTOMER ACCRUAL	24,480.00	0.00	24,480.00
141.1	ACCOUNTS RECEIVABLE CUSTOMER	55,191.68	0.00	55,191.68
2351000	CUSTOMER DEPOSITS	26,450.10-	0.00	26,450.10-
235.1	CUSTOMER DEPOSITS	26,450.10-	0.00	26,450.10-
2361170	ACCRUED SALES TAX	30,516.55-	0.00	30,516.55-
236.1	ACCRUED TAXES	30,516.55-	0.00	30,516.55-
2372030	ACCRUED CUST DEP INTEREST	1,359.65-	0.00	1,359.65-
237.1	ACCRUED INTEREST	1,359.65-	0.00	1,359.65-
	TOTAL BALANCE SHEET	3,134.62-	0.00	3,134.62-

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
4611020	WATER REVENUE-METERED	312,889.62-	0.00	312,889.62-
4611099	WATER REVENUE ACCRUALS	1,085.00-	0.00	1,085.00-
400.1	WATER REVENUE	313,974.62-	0.00	313,974.62-
4701000	FORFEITED DISCOUNTS	6,176.19-	0.00	6,176.19-
400.3	FORFEITED DISCOUNTS	6,176.19-	0.00	6,176.19-
4711000	MISC SERVICE REVENUES	843.61	0.00	843.61
4741009	CUT-OFF CHARGE	1,720.00-	0.00	1,720.00-
400.4	MISC. SERVICE REVENUES	876.39-	0.00	876.39-
6708000	UNCOLLECTIBLE ACCOUNTS	2,036.46	0.00	2,036.46
6708001	AGENCY EXPENSE	30.40	0.00	30.40
401.1K	UNCOLLECTIBLE ACCOUNTS	2,066.86	0.00	2,066.86
4272050	S/T INT EXP CUSTOMERS DEP	1,527.78	0.00	1,527.78
427.2	SHORT TERM INTEREST EXP	1,527.78	0.00	1,527.78
	TOTAL INCOME STATEMENT	317,432.56-	0.00	317,432.56-
	TOTAL BALANCE SHEET	3,134.62-	0.00	3,134.62-
	TOTAL INCOME STATEMENT	317,432.56-	0.00	317,432.56-

NV.1CO.TB2LY

TIMINGS FOR EACH PHASE OF THIS REPORT

.ODE/VALIDATE	00:00:00	78.2122%
RETRIEVE	00:00:00	11.5216%
CALCULATE	00:00:00	02.578%
FORMAT	00:00:00	07.6882%
TOTAL	00:00:00	100%

Middlesborough – Billing Only SUB #0173

COMPANY: C-160 WATER SERVICE CORPORATION OF KENTUCKY

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
1411000	A/R-CUSTOMER	27,840.88	0.00	27,840.88
1411002	A/R-CUSTOMER ACCRUAL	19,739.00	0.00	19,739.00
141.1	ACCOUNTS RECEIVABLE CUSTOMER	47,579.88	0.00	47,579.88
2351000	CUSTOMER DEPOSITS	29,350.00-	0.00	29,350.00-
235.1	CUSTOMER DEPOSITS	29,350.00-	0.00	29,350.00-
2361170	ACCRUED SALES TAX	19,625.84-	0.00	19,625.84-
236.1	ACCRUED TAXES	19,625.84-	0.00	19,625.84-
2372030	ACCRUED CUST DEP INTEREST	1,380.46-	0.00	1,380.46-
237.1	ACCRUED INTEREST	1,380.46-	0.00	1,380.46-
	TOTAL BALANCE SHEET	2,776.42-	0.00	2,776.42-

DETAIL TB BY SUB

U T I L I T I E S , I N C O R P O R A T E D

DETAIL TRIAL BALANCE

ACCOUNT	DESCRIPTION	BEG-BALANCE	CURRENT	END-BALANCE
4611020	WATER REVENUE-METERED	234,166.46-	0.00	234,166.46-
4611099	WATER REVENUE ACCRUALS	1,286.00-	0.00	1,286.00-
400.1	WATER REVENUE	235,452.46-	0.00	235,452.46-
4701000	FORFEITED DISCOUNTS	6,741.01-	0.00	6,741.01-
400.3	FORFEITED DISCOUNTS	6,741.01-	0.00	6,741.01-
4711000	MISC SERVICE REVENUES	1,592.01	0.00	1,592.01
4741009	CUT-OFF CHARGE	1,960.00-	0.00	1,960.00-
400.4	MISC. SERVICE REVENUES	367.99-	0.00	367.99-
6708000	UNCOLLECTIBLE ACCOUNTS	2,582.34	0.00	2,582.34
6708001	AGENCY EXPENSE	13.90	0.00	13.90
401.1K	UNCOLLECTIBLE ACCOUNTS	2,596.24	0.00	2,596.24
4272050	S/T INT EXP CUSTOMERS DEP	1,685.46	0.00	1,685.46
427.2	SHORT TERM INTEREST EXP	1,685.46	0.00	1,685.46
	TOTAL INCOME STATEMENT	238,279.76-	0.00	238,279.76-
	TOTAL BALANCE SHEET	2,776.42-	0.00	2,776.42-
	TOTAL INCOME STATEMENT	238,279.76-	0.00	238,279.76-

NV.1CO.TB2LY

TIMINGS FOR EACH PHASE OF THIS REPORT

⌊ODE/VALIDATE	00:00:00	80.9981%
RETRIEVE	00:00:00	08.4828%
CALCULATE	00:00:00	02.759%
FORMAT	00:00:00	07.7601%
TOTAL	00:00:00	100%

DATA REQUEST #42

Refer to Water Services response to Commission Staff's First Data Request, Item 1. Identify the electronic format in which usage information is provides. State the electronic formats to which this information be converted to.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

We are currently working on a way to convert the consumption reports to an electronic format. This report will be provided to the Commission once it is established.

DATA REQUEST #43

At paragraph 5 of its Application, Water Service states that the proposed rates are to recover, among other things, debt service, but latter indicates in its Application there is no debt related to its operations in Kentucky. Reconcile these statements.

Witness responsible for responding to questions relating to the information provided is Kirsten Weeks.

RESPONSE:

Water Service's capital structure is based on its parent company's (Utilities, Inc.) capital structure. None of the wholly owned subsidiaries of WSCK carry debt, since all debt is carried at the parent level. This allows for economies of scale for all of Utilities, Inc. companies. A cost of debt is calculated from the parent company's capital structure, which allows for a return on this debt through the return on rate base.