COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

ELECTRONIC APPLICATION OF	**)**	
WOOD CREEK WATER DISTRICT	**)**	**CASE NO. 2022-00145**
FOR ADJUSTMENT OF RATES	**)**	

RESPONSE OF WOOD CREEK WATER DISTRICT
TO COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION

Wood Creek Water District submits its Response to the Commission Staff's First Request for Information.

Dated: August 15, 2022

Respectfully submitted,

Damon R. Talley
Stoll Keenon Ogden PLLC
P.O. Box 150
Hodgenville, KY 42748-0150
Telephone: (270) 358-3187
Fax: (270) 358-9560
damon.talley@skofirm.com

Gerald E. Wuetcher
Stoll Keenon Ogden PLLC
300 West Vine Street, Suite 2100
Lexington, Kentucky 40507-1801
Telephone: (859) 231-3017
Fax: (859) 259-3597
gerald.wuetcher@skofirm.com

Counsel for Wood Creek Water District

CERTIFICATE OF SERVICE

In accordance with 807 KAR 5:001, Section 8, and the Public Service Commission's Order of July 22, 2021 in Case No. 2020-00085, I certify that this document was transmitted to the Public Service Commission on August 15, 2022 and that there are currently no parties that the Public Service Commission has excused from participation by electronic means in this proceeding

Counsel for Wood Creek Water District

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

ELECTRONIC APPLICATION OF	**)**	
WOOD CREEK WATER DISTRICT	**)**	**CASE NO. 2022-00145**
FOR ADJUSTMENT OF RATES	**)**	

RESPONSE OF WOOD CREEK WATER DISTRICT

TO COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION

FILED: August 15, 2022

VERIFICATION

COMMONWEALTH OF KENTUCKY)
) SS:
COUNTY OF LAUREL)

The undersigned, Dewayne Lewis, being duly sworn, deposes and states that he is the Office Manager of Wood Creek Water District; he has personal knowledge of the matters set forth in the responses for which he is identified as the witness; and the answers contained therein are true and correct to the best of his information, knowledge and belief.

Dewayne Lewis

Subscribed and sworn to before me, a Notary Public in and before said County and State, this 15 day of August 2022.

(SEAL)
Notary Public

My Commission Expires: 10-28-2023

Notary ID: 634467

TETON JUH-RAWN NAPIER
NOTARY PUBLIC
ID # 634467
MY COMMISSION EXPIRES OCTOBER 28, 2023
STATE AT LARGE, KENTUCKY

VERIFICATION

COMMONWEALTH OF KENTUCKY)
) SS:
COUNTY OF WARREN)

The undersigned, Alan H. Vilines, being duly sworn, deposes and states that he has personal knowledge of the matters set forth in the responses for which he is identified as the witness; and the answers contained therein are true and correct to the best of his information, knowledge and belief.

Alan H. Vilines

Subscribed and sworn to before me, a Notary Public in and before said County and State, this 15th day of August 2022.

Bobbie S. Shanahan
(SEAL)
Notary Public

My Commission Expires: 7/12/2026

Notary ID: KYNP53770

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 1

Responding Witness: Dewayne Lewis

Q-1. **Provide the following expense account data:**

a. Schedules, in comparative form, showing the operating expense account balance for the test year and each of the three most recent calendar years for each account or subaccount included in the utility's annual report. Show the percentage of increase or decrease of each year over the prior year.

b. A listing, with descriptions, of all activities, initiatives or programs undertaken or continued by the utility since its last general rate case for the purpose of minimizing costs or improving the efficiency of its operations or maintenance activities. Include all quantifiable realized and projected savings.

A-1. It should be noted that Wood Creek District's general rate adjustment Application is based upon the historical Test Year of Calendar Year 2020. At the time its Rate Consultant, Alan Vilines, commenced preparing the Cost-of-Service Study and rate analysis, Wood Creek District's 2021 financial records were not yet available. The Calendar Year 2021 financial records for 2021 are now available. In various places where the Commission Staff is requesting comparative data to the Test Year data, Wood Creek District has provided the 2021 data as well.

a. See Attachment 1a.

b. There have been no realized or projected savings.

WOOD CREEK WATER DISTRICT
COMPARISON OF OPERATING EXPENSES INCLUDED IN ANNUAL REPORT
2019-2020

	12/31/2019	12/31/2020	Increase/ (Decrease)	%
601 Salaries and Wages- Employees				
Supply and Exp-Maint.	49,642	8,353	(41,289)	-83.17%
Water Treatment Exp-Op.	851,425	883,125	31,700	3.72%
Water Treatment Exp-Maint.	6,043	3,767	(2,276)	-37.66%
Trans and Dist. Exp-Op	91,072	176,951	85,879	94.30%
Trans and Dist. Exp - Maint.	749,521	683,713	(65,808)	-8.78%
Customer Accts Exp.	304,608	287,044	(17,564)	-5.77%
Admin and Gen Exp.	174,401	162,714	(11,687)	-6.70%
615 Purchased Power				
Supply and Exp-Op.	231,528	201,386	(30,142)	-13.02%
Water Treatment Exp-Op.	73,113	57,129	(15,984)	-21.86%
Trans and Dist. Exp-Op	41,912	40,651	(1,261)	-3.01%
Admin and Gen Exp.	2,626	3,596	970	36.94%
618 Chemicals				
Water Treatment Exp-Op.	541,529	556,183	14,654	2.71%
620 Materials and Supplies				
Water Treatment Exp-Op.	94,269	88,328	(5,941)	-6.30%
Water Treatment Exp-Maint.	165,535	52,290	(113,245)	-68.41%
Trans and Dist. Exp-Op	249,179	245,156	(4,023)	-1.61%
Trans and Dist. Exp - Maint.	326,296	309,237	(17,059)	-5.23%
Customer Accts Exp.	74,784	78,078	3,294	4.40%
Admin and Gen Exp.	52,513	49,392	(3,121)	-5.94%
631 Contractual Services- Eng.				
Admin and Gen Exp.	2,040	3,757	1,717	84.17%
632 Contractual Services- Acct.				
Admin and Gen Exp.	14,030	12,650	(1,380)	-9.84%
633 Contractual Services - Legal				
Admin and Gen Exp.	4,700	3,260	(1,440)	-30.64%
650 Transportation Expenses				
Water Treatment Exp-Op.	2,775	2,402	(373)	-13.44%
Trans and Dist. Exp-Op	83,621	78,708	(4,913)	-5.88%
Customer Accts Exp.	14,812	9,680	(5,132)	-34.65%
Admin and Gen Exp.	3,061	4,349	1,288	42.08%
656 Insurance Vehicle				
Admin and Gen Exp.	24,308			
657 Insurance - General Liability				
Admin and Gen Exp.	7,331	62,252		
658 Insurance - Worker's Compensation				
Admin and Gen Exp.	88,160	92,534	4,374	4.96%
659 Insurance - Other				
Admin and Gen Exp.	48,910	48,910	0	0.00%
670 Bad Debt				
Customer Accts Exp.	51,629	24,657	(26,972)	-52.24%
675 Miscellaneous Expenses				
Admin and Gen Exp.	93,531	44,410	(49,121)	-52.52%

WOOD CREEK WATER DISTRICT
COMPARISON OF OPERATING EXPENSES INCLUDED IN ANNUAL REPORT
2020-2021

	12/31/2020	12/31/2021	Increase/ (Decrease)	%
601 Salaries and Wages- Employees				
Supply and Exp-Maint.	8,353	66,889	58,536	700.78%
Water Treatment Exp-Op.	883,125	1,008,352	125,227	14.18%
Water Treatment Exp-Maint.	3,767	10,193	6,426	170.59%
Trans and Dist. Exp-Op	176,951	173,758	(3,193)	-1.80%
Trans and Dist. Exp - Maint.	683,713	742,303	58,590	8.57%
Customer Accts Exp.	287,044	336,598	49,554	17.26%
Admin and Gen Exp.	162,714	191,861	29,147	17.91%
615 Purchased Power				
Supply and Exp-Op.	201,386	248,300	46,914	23.30%
Water Treatment Exp-Op.	57,129	65,884	8,755	15.32%
Trans and Dist. Exp-Op	40,651	40,956	305	0.75%
Admin and Gen Exp.	3,596	3,963	367	10.21%
618 Chemicals				
Water Treatment Exp-Op.	556,183	666,999	110,816	19.92%
620 Materials and Supplies				
Water Treatment Exp-Op.	88,328	78,890	(9,438)	-10.69%
Water Treatment Exp-Maint.	52,290	101,218	48,928	93.57%
Trans and Dist. Exp-Op	245,156	238,001	(7,155)	-2.92%
Trans and Dist. Exp - Maint.	309,237	440,333	131,096	42.39%
Customer Accts Exp.	78,078	81,903	3,825	4.90%
Admin and Gen Exp.	49,392	65,448	16,056	32.51%
631 Contractual Services- Eng.				
Admin and Gen Exp.	3,757	0	(3,757)	-100.00%
632 Contractual Services- Acct.				
Admin and Gen Exp.	12,650	17,226	4,576	36.17%
633 Contractual Services - Legal				
Admin and Gen Exp.	3,260	8,534	5,274	161.78%
650 Transportation Expenses				
Water Treatment Exp-Op.	2,402	2,935	533	22.19%
Trans and Dist. Exp-Op	78,708	65,758	(12,950)	-16.45%
Customer Accts Exp.	9,680	12,666	2,986	30.85%
Admin and Gen Exp.	4,349	2,899	(1,450)	-33.34%
657 Insurance - General Liability				
Admin and Gen Exp.	62,252	48,977	(13,275)	-21.32%
658 Insurance - Worker's Compensation				
Admin and Gen Exp.	92,534	74,562	(17,972)	-19.42%
659 Insurance - Other				
Admin and Gen Exp.	48,910	48,910	0	0.00%
670 Bad Debt				
Customer Accts Exp.	24,657	68,270	43,613	176.88%
675 Miscellaneous Expenses				
Admin and Gen Exp.	44,410	161,749	117,339	264.22%

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 2

Responding Witness: Dewayne Lewis

Q-2. Provide, in the format provided in Schedule A, schedules showing a comparison of the balance in the revenue accounts for each month of the test year to the same month of the immediately preceding 12-month period for each revenue account or subaccount included in the utility's chart of accounts. Include appropriate footnotes to show the month each rate change was approved and the month the full impact of the change was recorded in the accounts.

Q-2. See Attachment 2.

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #461.1 Sales to Residential Customers	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	190,108	189,295	174,707	190,378	193,340	201,023	205,718	216,279	199,426	194,598	193,477	192,289	2,340,638
Previous 12 months 2019	183,595	184,143	176,724	178,370	185,202	209,558	198,415	199,854	293,100	191,261	200,367	127,370	2,327,959
Increase	6,513	5,152		12,008	8,138		7,303	16,425		3,337		64,919	12,679
Decrease			-2,017			-8,535			-93,674		-6,890		

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #461.2 Sales to Commercial Customers	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	44,471	46,406	39,170	41,590	47,577	43,955	72,554	61,165	58,265	59,140	47,773	53,227	615,293
Previous 12 months 2019	38,560	40,410	35,275	43,256	44,382	50,739	51,136	60,880	64,114	56,099	59,653	34,148	578,652
Increase	5,911	5,996	3,895		3,195		21,418	285		3,041		19,079	36,641
Decrease				-1,666		-6,784			-5,849		-11,880		

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #466.00 Sales for resale to West Laurel	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	80,272	77,619	93,534	97,116	107,325	109,369	118,139	121,738	116,745	119,557	106,940	106,572	1,254,926
Previous 12 months 2019	85,949	80,037	88,772	87,201	104,086	96,352	110,162	118,763	109,771	100,102	89,253	89,193	1,159,641
Increase			4,762	9,915	3,239	13,017	7,977	2,975	6,974	19,455	17,687	17,379	95,285
Decrease	-5,677	-2,418											

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #466.03 Sales for resale to East Laurel	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	109,628	114,840	131,945	128,359	139,208	138,264	157,113	157,267	146,527	149,056	138,104	145,512	1,655,823
Previous 12 months 2019	126,969	115,953	122,940	119,647	144,657	137,280	145,798	151,671	141,078	132,330	127,018	130,316	1,595,657
Increase			9,005	8,712		984	11,315	5,596	5,449	16,726	11,086	15,196	60,166
Decrease	-17,341	-1,113			-5,449								

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #466.04 Sales for resale to Livingston	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	3,845	3,711	3,469	5,093	3,214	4,265	4,071	4,072	3,942	3,492	3,873	4,212	47,259
Previous 12 months 2019	5,313	5,401	5,624	2,902	3,744	2,636	3,333	2,269	2,785	4,293	4,567	4,686	47,553
Increase				2,191		1,629	738	1,803	1,157				
Decrease	-1,468	-1,690	-2,155		-530					-801	-694	-474	-294

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #471.1 Service charges	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	3,680	4,160	2,200	2,400	1,640	2,280	1,720	1,480	1,840	1,800	1,120	3,750	28,070
Previous 12 months 2019	2,200	4,680	3,800	4,680	3,800	4,960	3,680	4,800	3,800	4,240	5,560	3,960	50,160
Increase	1,480												
Decrease		-520	-1,600	-2,280	-2,160	-2,680	-1,960	-3,320	-1,960	-2,440	-4,440	-210	-22,090

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #471.2 Penalties	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	6,127	5,187	0	0	0	0	0	0	0	0	0	0	11,314
Previous 12 months 2019	6,693	6,458	5,806	6,319	5,650	5,293	7,157	6,591	6,077	6,500	5,752	6,227	74,523
Increase													
Decrease	-566	-1,271	-5,806	-6,319	-5,650	-5,293	-7,157	-6,591	-6,077	-6,500	-5,752	-6,227	-63,209

WOOD CREEK WATER DISTRICT
CASE NO. 2022-00145

Comparison of Revenue Account Balances
With those of the Preceding 12 months

Account #474.2 Tap on fees	1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month	10th month	11th month	12th month	TOTAL
Test Period 2020	2,120	1,060	2,650	2,650	3,710	5,300	2,650	3,710	3,710	2,650	3,320	5,480	39,010
Previous 12 months 2019	4,190	2,750	3,380	1,590	1,590	2,650	3,180	3,410	5,300	4,770	5,300	4,110	42,220
Increase				1,060	2,120	2,650		300				1,370	
Decrease	-2,070	-1,690	-730				-530		-1,590	-2,120	-1,980		-3,210

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 3

Responding Witness: Dewayne Lewis

Q-3. Provide the utility's cash account balances at the beginning of the most recent calendar year and at the end of each month through the date of this request.

A-3. See Attachment 3.

WOOD CREEK WATER DISTRICT
CASH ACCOUNT BALANCES

Balance at beginning of most recent calendar year
and at the end of each month

	Cash - Operations Account	Cash - Meter Deposit Account	Cash -Reserve Account	Cash -Reserve Account
January 1, 2021	897,533.94	17,967.20	169,204.82	16,452.52
January 31, 2021	532,118.03	16,208.47	169,212.00	16,453.22
February 28, 2021	705,102.64	15,906.24	169,218.49	16,453.85
March 31, 2021	682,606.48	14,168.45	169,225.68	16,454.55
April 30, 2021	644,498.71	14,106.66	169,233.10	16,455.27
May 31, 2021	575,735.40	14,215.51	169,239.82	16,455.93
June 30, 2021	381,700.05	14,494.64	169,246.78	16,456.60
July 31, 2021	228,626.31	14,218.18	169,254.20	16,457.32
August 31, 2021	336,997.99	14,477.35	169,261.15	16,458.00
September 30, 2021	280,623.42	14,271.02	169,268.11	16,458.68
October 31, 2021	392,458.04	13,863.99	169,275.29	16,459.38
November 30, 2021	356,179.31	13,097.71	169,282.25	16,460.05
December 31, 2021	530,557.40	12,915.84	169,289.44	16,460.75
January 31, 2022	424,954.08	11,804.80	169,296.63	16,461.45
February 28, 2022	429,906.62	12,423.14	109,505.97	16,462.08
March 31, 2022	149,697.34	12,437.68	109,510.62	16,462.78
April 30, 2022	143,173.20	12,320.00	109,515.27	16,463.48
May 31, 2022	264,033.33	12,309.16	0.00	0.00
June 30, 2022	272,851.90	13,129.69	0.00	0.00

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 4

Responding Witness: Dewayne Lewis

Q-4. Provide the following monthly account balances and a calculation of the average (13-month) account balances for the 12 months preceding the test year:

a. Plant in service (Account No. 101);

b. Plant purchased or sold (Account No. 102);

c. Property held for future use (Account No. 105);

d. Completed construction not classified (Account No. 106);

e. Construction work in progress (Account No. 107);

f. Depreciation reserve (Account No. 108);

g. Materials and supplies (include all accounts and subaccounts);

h. Computation and development of minimum cash requirements;

i. Balance in accounts payable applicable to amounts included in utility plant in service (if actual is indeterminable, provide a reasonable estimate.);

j. Balance in accounts payable applicable to amounts included in plant under construction (if actual is indeterminable, provide a reasonable estimate.); and

k. Balance in accounts payable applicable to prepayments by major category or subaccount.

A-4. See Attachment 4. All accounts not shown in Attachment 4 had no recorded balance.

WOOD CREEK WATER DISTRICT
ACCOUNT BALANCES

Month	Acct 105/107 Construction in Progress	Acct 108 Depreciation Reserve	Acct 151 Materials and Supplies
January 31, 2019	0.00	17,522,503.92	760,707.58
February 28, 2019	0.00	17,522,503.92	760,707.58
March 31, 2019	0.00	17,522,503.92	760,707.58
April 30, 2019	0.00	17,522,503.92	760,707.58
May 31, 2019	0.00	17,522,503.92	760,707.58
June 30, 2019	0.00	17,522,503.92	760,707.58
July 31, 2019	12,000.00	17,522,503.92	760,707.58
August 31, 2019	12,000.00	17,522,503.92	760,707.58
September 30, 2019	12,000.00	17,522,503.92	760,707.58
October 31, 2019	12,000.00	17,522,503.92	760,707.58
November 30, 2019	12,000.00	17,522,503.92	760,707.58
December 31, 2019	12,000.00	18,453,197.06	867,663.71
January 31, 2020	24,000.00	18,453,197.06	867,663.71
February 28, 2020	24,000.00	18,453,197.06	867,663.71
March 31, 2020	24,000.00	18,453,197.06	867,663.71
April 30, 2020	36,000.00	18,453,197.06	867,663.71
May 31, 2020	36,000.00	18,453,197.06	867,663.71
June 30, 2020	36,000.00	18,453,197.06	867,663.71
July 31, 2020	48,000.00	18,453,197.06	867,663.71
August 31, 2020	48,000.00	18,453,197.06	867,663.71
September 30, 2020	48,000.00	18,453,197.06	867,663.71
October 30, 2020	48,000.00	18,453,197.06	867,663.71
November 30, 2020	48,000.00	18,453,197.06	867,663.71
December 31, 2020	812,481.36	19,424,035.06	978,776.16

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 5

Responding Witness: Dewayne Lewis

Q-5. Provide a detailed analysis of expenses for professional services during the test year, as shown in Schedule B, and all workpapers supporting the analysis. At a minimum, the workpapers should show the payee, dollar amount, reference (i.e., voucher no., etc.), account charged, hourly rates and time charged to the company according to each invoice, and a description of the services provided.

A-5. See Attachment 5.

WOOD CREEK WATER DISTRICT
Analysis of expenses for professional services during test year

LEGAL:

Date	Payee	Dollar Amount	Invoice #	Account Charged	Hourly Rate	Time (hours)	Description
01/07/20	Larry G. Bryson, PSC	45.00	11200	633.8	150.00	0.30	correspondence
01/07/20	Larry G. Bryson, PSC	200.00	11200	633.8	150.00	flat rate	prepare deed
02/03/20	Larry G. Bryson, PSC	45.00	11214	633.8	150.00	0.30	correspondence
03/02/20	Larry G. Bryson, PSC	150.00	11231	633.8	150.00	1.00	court motion
03/02/20	Larry G. Bryson, PSC	45.00	11231	633.8	150.00	0.30	order for conference
03/31/20	Larry G. Bryson, PSC	195.00	11251	633.8	150.00	1.30	phone calls
03/31/20	Larry G. Bryson, PSC	60.00	11251	633.8	150.00	0.40	correspondence
03/31/20	Larry G. Bryson, PSC	75.00	11251	633.8	150.00	0.50	draft audit letter
07/02/20	Larry G. Bryson, PSC	285.00	11304	633.8	150.00	1.90	correspondence
07/02/20	Larry G. Bryson, PSC	210.00	11304	633.8	150.00	1.40	phone calls
07/02/20	Larry G. Bryson, PSC	75.00	11304	633.8	150.00	0.50	conference
07/02/20	Larry G. Bryson, PSC	90.00	11304	633.8	150.00	0.60	review order
07/30/20	Larry G. Bryson, PSC	420.00	11325	633.8	150.00	2.80	correspondence
07/30/20	Larry G. Bryson, PSC	90.00	11325	633.8	150.00	0.60	phone calls
08/31/20	Larry G. Bryson, PSC	225.00	11342	633.8	150.00	1.50	correspondence
08/31/20	Larry G. Bryson, PSC	120.00	11342	633.8	150.00	0.80	meeting
08/31/20	Larry G. Bryson, PSC	75.00	11342	633.8	150.00	0.50	phone call
08/31/20	Larry G. Bryson, PSC	75.00	11342	633.8	150.00	0.50	draft appeal
10/05/20	Larry G. Bryson, PSC	30.00	11357	633.8	150.00	0.20	review appeal notice
10/05/20	Larry G. Bryson, PSC	150.00	11357	633.8	150.00	1.00	review response
10/05/20	Larry G. Bryson, PSC	45.00	11357	633.8	150.00	0.30	correspondence
12/17/20	Larry G. Bryson, PSC	60.00	11394	633.8	150.00	0.40	phone call
11/05/20	Larry G. Bryson, PSC	60.00	11377	633.8	150.00	0.40	correspondence
01/04/21	Larry G. Bryson, PSC	75.00	11413	633.8	150.00	0.50	meeting
01/04/21	Larry G. Bryson, PSC	60.00	11413	633.8	150.00	0.40	correspondence
01/04/21	Larry G. Bryson, PSC	300.00	11413	633.8	150.00	2.00	research

ENGINEERING:

Date	Payee	Dollar Amount	Invoice #	Account Charged	Hourly Rate	Time (hours)	Description
04/23/20	Kenvirons, Inc.	12,000.00	20200240	105.0 c.i.p.	n/a	n/a	construction design
07/13/20	Kenvirons, Inc.	12,000.00	20200510	105.0 c.i.p.	n/a	n/a	construction design
10/21/20	Kenvirons, Inc.	5,000.00	20200884	631.0	n/a	n/a	division of water permit for sewer ext.
10/21/20	Kenvirons, Inc.	3,757.00	20200838	631.0	112.15	33.50	waterline relocation

ACCOUNTING;

Date	Payee	Dollar Amount	Invoice #	Account Charged	Hourly Rate	Time (hours)	Description
04/23/20	Cloyd & Associates, PSC	12,650.00	322765	632.8	n/a	n/a	annual audit

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 6

Responding Witness: Dewayne Lewis

Q-6. Provide the following information:

a. A detailed analysis of charges booked for advertising expenditures during the test year. Include a complete breakdown of Account No. 660 – Advertising Expenses, and any other advertising expenditures included in any other expense accounts, as shown in Schedule C1. The analysis should specify the purpose of the expenditure and the expected benefit to be derived.

b. An analysis of Account No. 675 – Miscellaneous General Expenses for the test year. Include a complete breakdown of this account as shown in Schedule C2 and provide detailed workpapers supporting this analysis. At a minimum, the analysis should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule C2.

c. An analysis of Accounts No. 433 and 434 – Extraordinary Income and Extraordinary Deductions for the test year. Include a complete breakdown of this account as shown in Schedule C3, and provide detailed workpapers supporting this analysis. At a minimum, the analysis should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and a brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule C3.

A-6. a. See Attachment 6a.

b. See Attachment 6b.

c. No entries were recorded in Accounts No. 433 and No. 434 for the test period.

WOOD CREEK WATER DISTRICT
Analysis of advertising expenses

Date	Payee	Dollar Amount	Invoice #	Account Charged	Description
5/29/2020	The Sentinel-Echo	43.58	4012167	620.8	legal ad sealed bids
6/22/2020	The Sentinel-Echo	131.39	5146	620.8	legal ads sealed bids
7/10/2020	The Sentinel-Echo	188.82	7154	620.8	legal ad waterline replacement
12/17/2020	The Sentinel-Echo	24.90	112126	620.8	legal ad sell of surplus property

WOOD CREEK WATER DISTRICT
Analysis of Miscellaneous General Expenses 675-8

Date	Description	Amount
01/31/20	returned checks from jan. bank statement	3,346.18
01/31/20	ach & credit card fees from jan. bank statement	1,786.49
02/28/20	returned checks from feb. bank statement	1,044.34
02/28/20	ach & credit card fees from feb. bank statement	2,216.18
03/31/20	returned checks from mar. bank statement	928.80
03/31/20	ach & credit card fees from mar. bank statement	2,165.83
04/30/20	returned checks from april bank statement	380.25
04/30/20	ach & credit card fees from april bank statement	1,958.31
05/31/20	returned checks from may bank statement	162.76
05/31/20	ach & credit card fees from may bank statement	2,210.40
06/30/20	returned checks from june bank statement	254.13
06/30/20	ach & credit card fees from june bank statement	2,346.94
07/31/20	returned checks from july bank statement	56.90
07/31/20	ach & credit card fees from july bank statement	2,082.97
08/31/20	returned checks from aug. bank statement	203.68
08/31/20	ach & credit card fees from aug. bank statement	2,143.24
09/30/20	returned checks from sept. bank statement	236.61
09/30/20	ach & credit card fees from sept. bank statement	2,070.08
10/31/20	returned checks from oct. bank statement	171.75
10/31/20	ach & credit card fees from oct. bank statement	2,072.27
11/30/20	returned checks from nov. bank statement	78.21
11/30/20	ach & credit card fees from nov. bank statement	2,788.03
12/31/20	returned checks from dec. bank statement	568.57
12/31/20	ach & credit card fees from dec. bank statement	2,156.21
12/31/20	adjusting entry for returned checks added back	-14,393.84
		19,035.29

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 7

Responding Witness: Dewayne Lewis

Q-7. Provide an analysis of the utility's expenses for research and development activities for the test year and the three most recent calendar years. The analysis should include the following:

a. The basis of fees paid to research organizations and the utility's portion of the total revenue of each organization. Where the contribution is monthly, provide the current rate and the effective date.

b. Details of the research activities conducted by each organization.

c. Details of services and other benefits provided to the utility by each organization.

d. Annual expenditures of each organization with a basic description of the nature of costs incurred by the organization.

e. Details of the expected benefits to the utility.

A-7. Wood Creek District had no expenses for research and development activities for the years in question.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 8

Responding Witness: Dewayne Lewis

Q-8. Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 11 (sic):

a. Provide the names of affiliates that provided some form of service to the utility and the type of service the utility received from each affiliate.

b. Provide the names of affiliates to whom the utility provided some form of service and the type of service the utility provided to each affiliate.

c. Identify the service agreement with each affiliate, state whether the service agreement has been previously filed with the Commission, and identify the proceeding in which it was filed. Provide each service agreement that has not been previously filed with the Commission.

A-8. Question 11 of this Request for Information does not address affiliate-related activities.

Wood Creek District has no affiliates.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 9

Responding Witness: Dewayne Lewis

Q-9. Describe the utility's lobbying activities and provide a schedule showing the name, salary, and job title of each individual whose job function involves lobbying on the local, state, or national level.

A-9. Wood Creek District has not engaged in any lobbying activities and has no employee whose job duties include lobbying on the local, state or national level.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 10

Responding Witness: Dewayne Lewis

Q-10 Provide the following information concerning the costs for the preparation of this case:

a. A detailed schedule of expenses incurred to date for the following categories:

(1) Accounting;

(2) Engineering;

(3) Legal;

(4) Consultants; and

(5) Other Expenses (Identify separately).

b. For each category identified in Item 10.a., the schedule should include the date of each transaction, check number or other document reference, the vendor, the hours worked, the rates per hour, amount, a description of the services performed, and the account number in which the expenditure was recorded. Provide copies of contracts or other documentation that support charges incurred in the preparation of this case. Identify any costs incurred for this case that occurred during the test year.

c. An itemized estimate of the total cost to be incurred for this case. Expenses should be broken down into the same categories as identified in Item 10.a., with an estimate of the hours to be worked and the rates per hour. Include a detailed explanation of how the estimate was determined, along with all supporting workpapers and calculations.

d. Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in Items 10.a. and 10.b., and a cumulative total of cost incurred to date for each category. Updates will be due when the utility files its

monthly financial statements with the Commission, through the month of the public hearing.

A-10. a. See Attachment 10a.

b. See Attachment 10b.

c. See Attachment 10c.

d. Wood Creek District will file monthly updates of rate case expenses. Please note that Wood Creek Water District has not applied for a rate adjustment using a forecasted test period and is therefore not required to file monthly financial statements with the Commission.

Wood Creek Water District
Case No. 2022-00145

Analysis of Rate Case Expense

Line No.	Item (a)	Amount (b)
1.	Accounting	
2.	Engineering	
3.	Legal	$ 46,807.50
4.	Consultants	
5.	Other Expenses (Publication of Notice - Sentinel-Echo)	$ 1,322.18
6.	Total	$ 48,129.68
7.	Amount Assigned to Kentucky Jurisdictional	$ 48,129.68

Detail of Expenses to Date

633-6 Contract Services - Legal

Date	Check #	Vendor	Amount
2/2/2022	971456	Stoll, Keenon, Ogden, PLLC	$ 610.50
6/2/2022	979493	Stoll, Keenon, Ogden, PLLC	$ 1,604.00
7/6/2022	981644	Stoll, Keenon, Ogden, PLLC	$ 40,281.00
8/2/2022	983561	Stoll, Keenon, Ogden, PLLC	$ 4,312.00
	Total		$ 46,807.50

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

February 2, 2022
Invoice #: 971456
Account #: 125866/169969

Re: Rate Case 2021

Fees rendered this bill	$ 610.50
Total Current Charges This Matter	**$ 610.50**

Please return this page with payment to:

Stoll Keenon Ogden PLLC
PO Box 11969
Lexington KY 40579-1969

Or pay electronically via ACH to:

Stoll Keenon Ogden PLLC
Fifth Third Bank, Cincinnati OH
ABA/Bank Routing Number: [redacted]
Account Number: [redacted]
Please reference your account and invoice #s
Email remittance to:
payments@skofirm.com

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

February 2, 2022
Invoice #: 971456
Account #: 125866/169969

Re: Rate Case 2021

Fees rendered this bill	$ 610.50
Total Current Charges This Matter	**$ 610.50**

Keep this copy for your records.

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 971456

Professional Services for the period through 01/31/22, including the following:

Re: Rate Case 2021
Our Reference: 125866/169969/DRT/2404

Date	Description	Tkpr	Hours
01/05/22	Conferred with Alan Vilines re division of work for preparing General Rate case; discussed additional Exhibits and documents needed to be prepared by Alan Vilines; discussed feasibility of using Calendar Year 2020 as Test Year	DRT	0.30
01/05/22	Reviewed 807 KAR 5:001, Section 16 and other relevant PSC regulations concerning requirements for filing General Rate case and whether Test Year must be the most recent Calendar Year; prepared lengthy email memo to Alan Vilines confirming that Test Year can be 2020; outlined additional documents and Exhibits to be prepared by Alan Vilines	DRT	0.80
01/05/22	Researched time restrictions on whether Wood Creek can file General Rate case using calendar year 2020 as the Test Year for rate application filed under 807 KAR 5:001	GEW	0.50
01/19/22	Conferred with Dewayne re General Rate Adjustment and need to obtain services of KRWA to prepare Cost of Service Study for General Rate Adjustment	DRT	NO CHARGE
	Total Services		**$610.50**

Summary of Services

Init	Timekeeper	Hours	Rate	Value
GEW	Wuetcher, G E	0.50	385.00	192.50
DRT	Talley, D R	1.10	380.00	418.00
	Total Services	1.60		$610.50

TOTAL FEES & DISBURSEMENTS $610.50

Total Current Charges This Matter **$610.50**

Keep this copy for your records.

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

June 2, 2022
Invoice #: 979493
Account #: 125866/169969

Re: Rate Case 2022

Fees rendered this bill	$ 1,604.00
Total Current Charges This Matter	**$ 1,604.00**

Please return this page with payment to:

Stoll Keenon Ogden PLLC
PO Box 11969
Lexington KY 40579-1969

Or pay electronically via ACH to:

Stoll Keenon Ogden PLLC
Fifth Third Bank, Cincinnati OH
ABA/Bank Routing Number: [redacted]
Account Number: [redacted]
Please reference your account and invoice #s
Email remittance to:
payments@skofirm.com

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

June 2, 2022
Invoice #: 979493
Account #: 125866/169969

Re: Rate Case 2022

Fees rendered this bill	$ 1,604.00
Total Current Charges This Matter	**$ 1,604.00**

Keep this copy for your records.

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 979493

Professional Services for the period through 05/31/22, including the following:

Re: Rate Case 2022
Our Reference: 125866/169969/DRT/2404

Date	Description	Tkpr	Hours
05/18/22	Reviewed email memo from Alan Vilines re whether 2020 can be used as the historical test year; reviewed PSC Order overruling Motion for Deviation and granting extension of time until June 20, 2022 to file Application for a General Rate Adjustment; conferred with Alan Vilines re Test Year and other issues re the Cost of Service Study	DRT	0.50
05/18/22	Researched PSC Regulations, including 807 KAR 5:001 re Historical Test Year requirements and limitations; prepared email memo to Alan Vilines confirming that 2020 Historical Test year can be utilized in preparing Cost of Service Study and Rate Analysis	DRT	0.60
05/18/22	Prepared Notice of Intent to Use Electronic Filing Procedures; prepared Notice of Intent to File an Application for General Rate Adjustment; prepared notice to Attorney General's Office	GEW	1.10
05/19/22	Made final revisions to Notice of Intent; filed Notice of intent with PSC; prepared e-mail memo to Attorney General and attached Notice of intent	GEW	0.50
05/27/22	Exchanged email memos with Jerry Wuetcher re division of work on PSC Application; answered Jerry Wuetcher's questions re PSC Application	DRT	0.50
05/31/22	Prepared email memo to Alan Vilines re June 13 deadline for preparing COSS and rate recommendations; conferred with Dewayne re Board meeting date and Resolution that will need to be adopted; reviewed reply email memo from Alan Vilines; prepared follow-up email memo to Alan Vilines	DRT	0.60
05/31/22	Exchanged email memos with SKO attorney Cameron Myers re preparing Resolution authorizing Board Chairman to file PSC Application	DRT	NO CHARGE
05/31/22	Reviewed prior PSC Orders requiring Wood Creek to file a General Rate Case and denying Wood Creek's Motion for a Deviation; prepared list of information to be included in Resolution; forwarded information to Cameron Myers	DRT	0.40
	Total Services		**$1,604.00**

Keep this copy for your records.

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 979493

Summary of Services

Init	Timekeeper	Hours	Rate	Value
GEW	Wuetcher, G E	1.60	385.00	616.00
DRT	Talley, D R	2.60	380.00	988.00
	Total Services	4.20		$1,604.00

TOTAL FEES & DISBURSEMENTS	$1,604.00
Total Current Charges This Matter	**$1,604.00**

Keep this copy for your records.

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

July 6, 2022
Invoice #: 981644
Account #: 125866/169969

Re: Rate Case 2022

Fees rendered this bill	$ 40,281.00
Total Current Charges This Matter	**$ 40,281.00**
Balance as of June 2, 2022	$1,604.00
Less payments on prior billings	$0.00
Balance due on prior billings	**$1,604.00**
Total Amount Due This Matter	**$41,885.00**

Please return this page with payment to:

Stoll Keenon Ogden PLLC
PO Box 11969
Lexington KY 40579-1969

Or pay electronically via ACH to:

Stoll Keenon Ogden PLLC
Fifth Third Bank, Cincinnati OH
ABA/Bank Routing Number: [redacted]
Account Number: [redacted]
Please reference your account and invoice #s
Email remittance to:
payments@skofirm.com

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

July 6, 2022
Invoice #: 981644
Account #: 125866/169969

Re: Rate Case 2022

Fees rendered this bill	$ 40,281.00
Total Current Charges This Matter	**$ 40,281.00**
Balance as of June 2, 2022	$1,604.00
Less payments on prior billings	$0.00
Balance due on prior billings	**$1,604.00**
Total Amount Due This Matter	**$41,885.00**

Keep this copy for your records.

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 981644

Professional Services for the period through 06/30/22, including the following:

Re: Rate Case 2022
Our Reference: 125866/169969/DRT/2404

Date	Description	Tkpr	Hours
06/01/22	Exchanged e-mails with Damon Talley re drafting WCWD Resolution authorizing the District Chairman to file a PSC Application for a General Rate Adjustment; prepared first draft of Resolution; reviewed first draft of Resolution; made numerous revisions to first draft of Resolution; reviewed and revised Resolution multiple times	CFM	2.90
06/01/22	Conferred with Jerry Wuetcher re PSC Application and assigning various tasks; commenced preparing a list of Exhibits for Application	DRT	0.50
06/01/22	Reviewed email memo from SKO attorney Cameron Myers re draft Resolution authorizing Chairman to file PSC Application for General Rate Adjustment; reviewed draft Resolution; prepared reply email memo to Cameron with suggested edits to Resolution	DRT	0.60
06/01/22	Prepared portions of first draft of PSC Application for General Rate Adjustment	GEW	2.10
06/03/22	Conferred with Dewayne re publication date for Customer Notice; also discussed his Resume and obtaining information needed to prepare his Written Testimony; prepared email memo to Alan Vilines re need to Customer Notice and other matters	DRT	0.70
06/03/22	Reviewed email memo from Alan Vilines re preliminary schedules and Customer Notice; reviewed three (3) documents prepared by Alan Vilines; prepared reply email memo to Alan Vilines	DRT	0.60
06/03/22	Prepared lengthy email memo to Jerry Wuetcher re Customer Notice, publication deadline, and assigning tasks re rate Application and Exhibits; reviewed follow-up emails from Jerry Wuetcher; prepared reply email memo to Jerry Wuetcher	DRT	0.80
06/03/22	Conferred with Jerry Wuetcher re division of work on Application and Exhibits; reviewed Filing Requirements Checklist with Jerry Wuetcher; assigned responsibility for each Exhibit required by PSC; reviewed email memo from PSC Staff Attorney; prepared reply email memo to Staff Attorney; reviewed documents prepared by Jerry Wuetcher for rate case	DRT	1.10
06/03/22	Prepared remainder of first draft of PSC Application for General Rate Adjustment; conferred with D. Talley re Application; prepared Notice of Intent to file PSC Application for General Rate Adjustment	GEW	1.80
06/06/22	Conferred with Damon Talley re preparation of Customer Notice for Wood Creek Water District's General Rate Adjustment; reviewed Rate Study prepared by Alan Vilines to obtain necessary data; calculated impact of proposed rates on customer bills; prepared first draft of Customer Notice	CFM	2.30
06/06/22	Reviewed portions of Cost of Service Study and Rate Report to	DRT	0.60

Date	Description	Tkpr	Hours
	obtain information needed to prepare Customer Notice		
06/06/22	Prepared email memo to Cameron Myers re Customer Notice; forwarded template for Customer Notice to him; provided Table L from Rate Study to Cameron Myers; provided guidance to Cameron Myers; answered his questions re Customer Notice	DRT	0.30
06/06/22	Made calculations to be inserted into Columns five and six of first Table contained in Customer Notice; analyzed existing Tariff with five declining block rate tiers; compared it to proposed four (4) declining block rate tiers with different usages; experimented with different means of creating Table or chart to effectively do a side-by-side comparison of present rates and proposed rates as required by PSC; finally created Table which effectively presents the current rates and the proposed rates in a side-by-side comparison; forwarded template for this Table to Cameron Myers	DRT	1.20
06/06/22	Made calculations to be inserted into the fourth and fifth columns of the second Table in the Customer Notice; conferred with Alan Vilines to obtain additional information needed for Customer Notice; exchanged email memos with Alan Vilines re Billing Analysis and average usage by each customer class	DRT	0.80
06/06/22	Reviewed Billing Analysis using current rates prepared by Alan Vilines; reviewed Billing Analysis using proposed rates prepared by Alan Vilines; prepared email memo to Alan Vilines re Billing Analysis	DRT	0.80
06/06/22	Made calculations for third Table contained in Customer Notice; exchanged email memos with Alan Vilines re Customer Charges and reason that each size meter has a different Customer Charge imbedded in the minimum bill for each size meter; made additional calculations for columns four, five, and six of third Table	DRT	1.20
06/06/22	Reviewed all calculations contained in the Customer Notice for accuracy	DRT	NO CHARGE
06/07/22	Conferred with Damon Talley and made numerous revisions to draft Customer Notice for Wood Creek Water District's General Rate Adjustment; prepared Exhibit A to Resolution	CFM	1.40
06/07/22	Reviewed email memo from Cameron Myers re rationale for making some of the changes to the previous version of the Customer Notice; reviewed 6-6-22 version of Customer Notice; prepared email memo to Cameron Myers with suggested minor changes to Customer Notice	DRT	0.50
06/07/22	Conferred with Cameron Myers re cosmetic changes to Customer Notice to make it more "user friendly" and to improve the appearance of the Customer Notice	DRT	NO CHARGE
06/07/22	Prepared email memo to client re Resolution authorizing Chairman to file General Rate case as ordered by PSC; attached Resolution to email memo; reviewed reply email memo from client approving Resolution	DRT	0.30
06/07/22	Conferred with Dewayne re Monthly Managerial Reports, his Written Testimony, Capital Budget, and other matters; prepared follow-up	DRT	0.60

Date	Description	Tkpr	Hours
	email memos to Dewayne; prepared email memo to Dewayne, engineer and Randy Jones		
06/07/22	Reviewed, proofread, and approved final version of Customer Notice	DRT	NO CHARGE
06/07/22	Prepared email memo to Cameron Myers to provide guidance to Cameron Myers re preparing Exhibit A to Resolution; reviewed, proofread, and approved Exhibit A; prepared follow-up email memo to Cameron Myers re Exhibit A	DRT	0.50
06/08/22	Prepared email memo to Dewayne and attached Resolution to be adopted by Board authorizing Chairman to file General Rate case Application	DRT	0.20
06/08/22	Proofread final version of Customer Notice for accuracy	DRT	NO CHARGE
06/08/22	Prepared lengthy and detailed email memo to Dewayne re publishing the Customer Notice and obtaining Affidavit of Publication; forwarded Customer Notice to Dewayne	DRT	0.30
06/08/22	Provided information needed to prepare Wholesale Customer Notice to Cameron Myers; performed calculations needed for Wholesale Customer Notice; provided guidance to Cameron Myers re preparation of Wholesale Customer Notice	DRT	0.60
06/09/22	Prepared Wholesale Consumer Notice	CFM	0.60
06/09/22	Reviewed email memo from Jerry Wuetcher re additional items of information needed for PSC Application and need for Billing Analysis; prepared email memo to Jerry Wuetcher and provided some of the missing information to him; forwarded Billing Analysis to Jerry Wuetcher	DRT	0.70
06/09/22	Conferred with Dewayne re Monthly Financial Report to Board; reviewed copy of Monthly Financial Report; forwarded Financial Report to Jerry Wuetcher; prepared email memo to Dewayne and requested all Financial Reports for all 12 months in calendar year 2020; reviewed PSC regulations re filing requirements for Capital Budget and other matters; started preparing list of Exhibits which have not been prepared; composed another email memo to Dewayne re customer count and PSC Annual report for 2021	DRT	1.20
06/09/22	Conferred with Jerry Wuetcher to make some strategy decisions re PSC Application; discussed division of work and made assignments to avoid duplication of efforts; prepared email memo to Alan Vilines re his Written Testimony and additional information needed from him; exchanged several other email memos with Jerry Wuetcher re PSC Application and Wholesale Customer Notice	DRT	1.30
06/09/22	Reviewed email memo from Cameron Myers re Wholesale Customer Notice; reviewed and approved Wholesale Customer Notice; prepared reply email memo to Cameron Myers	DRT	NO CHARGE
06/09/22	Reviewed previous version of PSC Application for General Rate Adjustment; made revisions to it; prepared additional paragraphs to include in PSC Application for General Rate Adjustment; conferred	GEW	4.70

Date	Description	Tkpr	Hours
	with D. Talley re PSC Application for General Rate Adjustment		
06/10/22	Reviewed email memo from Alan Vilines re his Resume; reviewed Alan's Resume and Written Testimony submitted by Alan in a prior PSC case; conferred with Alan Vilines re allocation factors and other similar topics	DRT	0.50
06/10/22	Prepared additional paragraphs to include in PSC Application for General Rate Adjustment; reviewed and revised latest version of PSC Application for General Rate Adjustment; prepared email memo to D. Talley and attached latest version of PSC Application for General Rate Adjustment	GEW	2.80
06/13/22	Prepared template for letter to each wholesale customer; conferred with Livingston City official to verify Mayor's name and City's email address; revised template for letter; finalized all three letters to wholesale customers	DRT	0.60
06/13/22	Prepared lengthy email memo to Dewayne and attached letter to each wholesale customer; attached Wholesale Customer Notice to email; outlined necessary steps for Dewayne to provide proper notice to the wholesale customers	DRT	0.30
06/13/22	Prepared email memo to Jerry Wuetcher re notice to wholesale customers; forwarded Wholesale Customer Notice to Jerry Wuetcher to be used as an Exhibit to PSC Application; exchanged several email memos with Jerry Wuetcher re numerous other Exhibits to PSC Application	DRT	0.80
06/13/22	Reviewed two (2) Exhibits prepared by Jerry Wuetcher (new Tariff Sheet and side-by-side comparison of present rates and proposed rates); made list of proposed revisions; prepared email memo to Jerry Wuetcher and explained rationale for revisions; reviewed reply email memo from Jerry Wuetcher; approved revised Exhibits	DRT	0.70
06/13/22	Prepared email memo to Jerry Wuetcher and Alan Vilines re WCWD Board approving proposed rates and adopting Resolution; reviewed reply email memo from Alan Vilines; exchanged other email memos with Alan Vilines re different Exhibits and to obtain additional information for PSC Application	DRT	0.50
06/13/22	Prepared outline of Written Testimony to be provided by Dewayne; reviewed and revised outline and added more questions	DRT	1.10
06/13/22	Provided numerous email memos to SKO attorney Duncan Crosby and provided outline of Dewayne's Written Testimony; provided additional guidance to Duncan Crosby so he can prepare Written Testimony	DRT	NO CHARGE
06/13/22	Made revisions to PSC Application for General Rate Adjustment; reviewed PSC regulations re contents of PSC Application for General Rate Adjustment; prepared three (3) new paragraphs to include in PSC Application for General Rate Adjustment to comply with PSC regulations	GEW	3.10
06/14/22	Reviewed separate email memos from client with signed copies of letters to Wholesale Customers, signed Resolution, 2021 PSC	DRT	0.40

Date	Description	Tkpr	Hours
	Annual Report, and 2021 Audit Report; prepared reply email memos to client		
06/14/22	Conferred with Dewayne to obtain information needed for his Written Testimony and PSC Application; conferred with City Clerk for City of Livingston re Wholesale Customer Notice and proposed rate increase; prepared memo to file	DRT	0.50
06/14/22	Reviewed draft version of Written Testimony of Dawayne Lewis; made suggested edits to his Resume and to Written Testimony; added additional questions and answers to the first draft of Dewayne Lewis' Written Testimony; prepared email memo to Duncan Crosby explaining rationale for my suggested edits and additional questions and answers	DRT	1.10
06/14/22	Prepared detailed email memo to client re posting Customer Notice as required by PSC Regulations	DRT	0.20
06/14/22	Reviewed PSC Annual Report for 2021; noticed possible error in some of the statistical information contained in the PSC Annual Report; reviewed several prior PSC Annual Reports and noticed same discrepancy or error; prepared detailed email memo to client concerning this error and requested him to notify CPA who prepared Annual Report and file an amended page to the 2021 PSC Annual Report	DRT	1.20
06/14/22	Conferred with Jerry Wuetcher re status of draft Application, missing Exhibits, additional information needed from client, etc.; assigned tasks that still need to be performed; exchanged numerous email memos with Jerry Wuetcher throughout the day concerning the Application, Exhibits, and Written Testimony	DRT	1.30
06/14/22	Proofread Cost of Service Study (COSS) prepared by Alan Vilines; reviewed Rate Study Report prepared by Alan Vilines; prepared lengthy email memo to Alan Vilines and listed technical edits that need to be made to COSS and Rate Study Report	DRT	1.50
06/14/22	Prepared several Exhibits to be included in PSC Application for General Rate Adjustment; reviewed and revised multiple versions of PSC Application for General Rate Adjustment; prepared email memo to D. Talley and forwarded latest version of PSC Application for General Rate Adjustment	GEW	5.10
06/14/22	Prepared portions of Written Testimony of Dewayne Lewis; prepared Resume of Dewayne Lewis based upon information provided by D. Talley; prepared remainder of Written Testimony of Dewayne Lewis; reviewed and revised first draft of Written Testimony of Dewayne Lewis	WDC	4.40
06/15/22	Reviewed revised version of Written Testimony for Dewayne Lewis	DRT	NO CHARGE
06/15/22	Prepared email memo to client and forwarded revised draft of Written Testimony for Dewayne Lewis	DRT	0.20
06/15/22	Reviewed copy of Customer Notice published in the London newspaper; conferred with client to obtain additional information needed for PSC Application and Exhibits; compared customer count	DRT	0.80

Date	Description	Tkpr	Hours
	as of 5-31-22 with number of customers in PSC Annual Report and in COSS & Billing Analysis		
06/15/22	Prepared lengthy email memo to Jerry Wuetcher re customer count, software, Written Testimony, and other topics; reviewed reply email memo from Jerry Wuetcher	DRT	0.50
06/15/22	Exchanged numerous email memos with Jerry Wuetcher re missing information and legal strategy concerning some of the PSC Exhibits	DRT	0.60
06/15/22	Reviewed first draft of PSC Application prepared by Jerry Wuetcher; prepared email memo to Jerry Wuetcher re adding an additional Exhibit to PSC Application; prepared list of suggested edits and an additional provision to be added to the PSC Application	DRT	1.70
06/15/22	Reviewed email memo from Alan Vilines re COSS; reviewed revised COSS and paid close attention to technical corrections made by Alan Vilines; prepared email memo to Alan and approved technical corrections that he made to COSS	DRT	0.60
06/15/22	Prepared first draft of Written Testimony of A. Vilines; reviewed first draft of Written Testimony of A. Vilines; prepared additional Questions and Answers to be included in Written Testimony of A. Vilines	GEW	3.10
06/15/22	Made revisions to draft testimony of Dewayne Lewis as requested by Dewayne Lewis and D. Talley	WDC	0.20
06/16/22	Added executed signature page of Resolution to Word version of Resolution adopted by the Board on 6-13-22 to be used as an Exhibit to PSC Application; added Exhibit A (Proposed Rates) to Resolution; compiled documents into a pdf version of Resolution; formatted Resolution for filing with the PSC	CFM	0.50
06/16/22	Reviewed numerous email memos from client; reviewed various documents and Exhibits prepared by client and forwarded by him, including RD Budget for 2021, RD Budget for 2022, Monthly Financial Reports for 2021; prepared numerous reply email memos to client; reviewed information re number of customers and categories of customers as of 12-31-21; compared these numbers to those contained in the Billing Analysis	DRT	1.10
06/16/22	Exchanged numerous email memos with Jerry Wuetcher re PSC Application and Exhibits; provided missing information and Exhibits needed by Jerry Wuetcher	DRT	0.80
06/16/22	Conferred with client re his Written Testimony, status of PSC Application and Exhibits, additional information needed from client; reviewed revisions to Written Testimony made by Dewayne	DRT	0.40
06/16/22	Prepared email memo to Duncan Crosby and forwarded revisions to Written Testimony of Dewayne Lewis	DRT	NO CHARGE
06/16/22	Conferred with Jerry Wuetcher re status report, missing Exhibits, and status of Vilines' Written Testimony; made assignments of remaining tasks; prepared lengthy follow-up email memo to Jerry Wuetcher	DRT	0.70

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 981644

Date	Description	Tkpr	Hours
06/16/22	Reviewed email memo from Duncan Crosby re revisions to Written Testimony of Dewayne Lewis; reviewed revisions to Written Testimony; prepared email memo to Duncan Crosby approving final version of Written Testimony; proofread final version of Written Testimony for Quality Control	DRT	NO CHARGE
06/16/22	Prepared numerous additional Questions and Answers to be included in Written Testimony of A. Vilines; reviewed Rate Study prepared by A. Vilines; prepared more Questions and Answers to be included in Written Testimony of A. Vilines based upon the Rate Study; prepared email memo to A. Vilines and D. Talley and attached latest version of Written Testimony of A. Vilines	GEW	8.10
06/16/22	Made additional revisions to draft testimony of Dewayne Lewis	WDC	0.30
06/17/22	Reviewed the first draft of the Written Testimony for Alan Vilines; made suggested revisions to Written Testimony; communicated those suggested revisions to Alan Vilines and to Jerry Wuetcher via email memo	DRT	1.10
06/17/22	Reviewed email memo from Alan Vilines; reviewed significant changes made by Alan Vilines to his Written Testimony to make it more easily understood; prepared email memo approving these proposed changes	DRT	0.50
06/17/22	Reviewed email memo from Alan Vilines re incorrect amounts for Average Customer's bill for both current rates and proposed rates for a customer who uses a 5/8 by 3/4-inch meter; confirmed the accuracy of Alan Vilines' newly calculated rates; revised the third chart in the Customer Notice and inserted the correct numbers	DRT	0.70
06/17/22	Exchanged numerous email memos with Jerry Wuetcher re missing information needed by Jerry Wuetcher to finish revising and completing the PSC Application; provided this information to Jerry Wuetcher	DRT	0.80
06/17/22	Prepared numerous Exhibits to include in PSC Application for General Rate Adjustment; made revisions to Written Testimony of A. Vilines; reviewed and revised Exhibits to PSC Application for General Rate Adjustment; made extensive revisions to PSC Application for General Rate Adjustment to fulfil requirements in PSC regulations for General Rate Adjustment; conferred with D. Talley re additional Exhibits and revisions to PSC Application for General Rate Adjustment; made additional revisions to PSC Application for General Rate Adjustment requested by D. Talley	GEW	12.10
06/18/22	Reviewed and made corrections to Customer Notice based upon information provided by Alan Vilines	DRT	0.30
06/18/22	Reviewed "near" final version of the PSC Application and the 22 Exhibits; made list of minor edits, corrections, or tweaks to be made to the Application and Exhibits; reviewed second revised version of Written Testimony of Alan Vilines; prepared email memo to Jerry Wuetcher re list of revisions; exchanged other email memos with Jerry Wuetcher re the Application and Exhibits; reviewed and approved the final version of the PSC Application and Exhibits	DRT	2.20

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 981644

Date	Description	Tkpr	Hours
06/18/22	Prepared numerous Exhibits to PSC Application for General Rate Adjustment, including Exhibit 8, Exhibit 11, Exhibit 12, Exhibit 14, Exhibit 16, Exhibit 17, Exhibit 20, and Exhibit 22; made additional revisions to PSC Application for General Rate Adjustment; prepared Filing Requirements Checklist (Exhibit 1); assembled PSC Application for General Rate Adjustment and Exhibits for filing with the PSC	GEW	8.10
06/19/22	Exchanged numerous email memos with Jerry Wuetcher re a few more revisions that needed to be made to the Application, Exhibits, and Filing Requirements Checklist	DRT	0.80
06/19/22	Proofread certain portions of Application and Exhibits once more; suggested a few more changes to Jerry Wuetcher to make the Application flow better in certain parts; re-read portions of Alan Vilines Written Testimony once again after Jerry Wuetcher made some minor edits to it	DRT	0.50
06/19/22	Revised PSC Application for General Rate Adjustment and Exhibits as suggested by D. Talley	GEW	0.50
06/20/22	Prepared PSC Transmittal Letter and filed PSC Application for General Rate Adjustment with PSC	GEW	0.20
06/21/22	Conferred with Shari at Sentinel-Echo re need to make revisions to Customer Notice; prepared detailed email memo to Shari showing the four (4) corrections to be made; reviewed reply email memo from Shari; reviewed proof of revised Customer Notice sent by Shari; prepared follow-up email memo to Shari	DRT	1.10
06/22/22	Reviewed email memo from PSC filings; reviewed "No Deficiency" letter from PSC; prepared email memo to Dewayne re the significance of the "No Deficiency" letter	DRT	0.40
06/23/22	Prepared email memo to Dewayne re need to post the Customer Notice; reviewed reply email memo from Dewayne	DRT	0.30
06/29/22	Reviewed email memo from Shari at newspaper re Tear Sheets and Affidavit of Publication; reviewed Tear Sheet for each publication date; reviewed Affidavit of Publication; prepared reply email memo to Shari	DRT	0.60
	Total Services		**$40,281.00**

Summary of Services

Init	Timekeeper	Hours	Rate	Value
GEW	Wuetcher, G E	51.70	385.00	19,904.50
DRT	Talley, D R	42.80	380.00	16,264.00

Keep this copy for your records.

WDC	Crosby, W D	4.90	415.00	2,033.50
CFM	Myers, C F	7.70	270.00	2,079.00
	Total Services	107.10		$40,281.00

TOTAL FEES & DISBURSEMENTS	$40,281.00
Total Current Charges This Matter	**$40,281.00**

Outstanding Invoices

Date	Invoice No.	Billed Amount	Payment/Credits	Balance Due
06/02/22	979493	$ 1,604.00	$ 0.00	$ 1,604.00

Total Outstanding Invoices This Matter	**$1,604.00**
Total Amount Due This Matter	**$41,885.00**

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

August 2, 2022
Invoice #: 983561
Account #: 125866/169969

Re: Rate Case 2022

Fees rendered this bill	$ 4,312.00
Total Current Charges This Matter	**$ 4,312.00**
Balance as of July 6, 2022	$41,885.00
Less payments on prior billings	$-14,104.00
Balance due on prior billings	**$27,781.00**
Total Amount Due This Matter	**$32,093.00**

Please return this page with payment to:

Stoll Keenon Ogden PLLC
PO Box 11969
Lexington KY 40579-1969

Or pay electronically via ACH to:

Stoll Keenon Ogden PLLC
Fifth Third Bank, Cincinnati OH
ABA/Bank Routing Number: [redacted]
Account Number: [redacted]
Please reference your account and invoice #s
Email remittance to:
payments@skofirm.com

Stoll Keenon Ogden PLLC
P.O. Box 150
112 North Lincoln Boulevard
Hodgenville, Kentucky 42748
(270) 358-3187
Tax ID # 61-0421389

Wood Creek Water District
e-mail bill to client: dewaynelewis@woodcreekwater.org

August 2, 2022
Invoice #: 983561
Account #: 125866/169969

Re: Rate Case 2022

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Less payments on prior billings	$-14,104.00
Balance due on prior billings	**$27,781.00**
Total Amount Due This Matter	**$32,093.00**

Keep this copy for your records.

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 983561

Professional Services for the period through 07/31/22, including the following:

Re: Rate Case 2022
Our Reference: 125866/169969/DRT/2404

Date	Description	Tkpr	Hours
07/01/22	Prepared email memo to PSC Staff re names of Team Leader and staff attorney assigned to case; reviewed reply email memo from PSC Staff with requested information; prepared follow-up email memo to PSC Staff	DRT	0.30
07/08/22	Reviewed PSC Order suspending the proposed rates and establishing the Procedural Schedule	DRT	0.20
07/08/22	Prepared email memo to Dewayne and Alan Vilines explaining significance of the rates being suspended and highlighting certain things in the Procedural Schedule	DRT	0.20
07/08/22	Reviewed the PSC Staff's First Request for Information; noted the breadth of the areas of inquiry and the comprehensive nature of the questions	DRT	0.30
07/11/22	Reviewed email memo from Alan Vilines re PSC Staff's First Request for Information; prepared lengthy reply email memo to Alan Vilines re deadline for filing Response to PSC Staff's First Request for Information; assigned certain questions to Alan Vilines; reviewed follow-up email memo from Alan Vilines	DRT	0.50
07/11/22	Exchanged multiple email memos with Jerry Wuetcher to assign responsibilities for answering certain questions contained in PSC Staff's First Request for Information	DRT	0.40
07/12/22	Conferred with Dewayne Lewis re need to start reviewing and compiling documents and other information needed to prepare draft Response to PSC Staff's First Request for Information	DRT	NO CHARGE
07/12/22	Reviewed PSC Staff's First Request for Information; prepared template for Response to PSC Staff's First Request for Information; identified inapplicable questions	GEW	1.80
07/20/22	Reviewed some of the questions contained in the PSC Staff's First Request for Information; prepared for phone call with Dewayne; conferred with Dewayne re answers to some of the questions contained in the PSC Staff's First Request for Information	DRT	0.40
07/21/22	Prepared and filed Proof of Publication of Notice of General Rate Adjustment with PSC	GEW	0.60
07/25/22	Reviewed email memo from Alan Vilines and the information provided by him that will be incorporated into the Response to the PSC Staff's First Request for Information; prepared reply email memo to Alan Vilines	DRT	0.50
07/26/22	Conferred with Dewayne and reviewed all 43 questions contained in the PSC Staff's First Request for Information with him; reviewed all Schedules with him; discussed possible need for filing a Motion for	DRT	1.10

Date	Description	Tkpr	Hours
	an Extension of Time with PSC; made notes to file re narrative answers to be included in the Response to the PSC Staff's First Request for Information		
07/27/22	Reviewed eight (8) email memos and numerous Excel Spreadsheets prepared by Dewayne which provide information needed to answer Questions 1-6, 11, and 14 to PSC Staff's First Request for Information	DRT	1.50
07/27/22	Prepared lengthy email memo to Dewayne re Long Term Debt owed by District	DRT	0.20
07/27/22	Prepared email memo to Jerry Wuetcher re possible need to Prepare Motion for Extension of Time to file Response to PSC Staff's First Request for Information; conferred with Jerry to assign tasks and questions to answer to avoid duplicating efforts	DRT	0.40
07/28/22	Conferred with Dewayne re status of compiling information needed for filing Response to PSC Staff's First Request for Information; discussed need for obtaining additional time; agreed with Dewayne to request an extension of time and ask for 14 days; prepared email memo to Jerry Wuetcher re need to request him to file a Motion for Extension of Time	DRT	0.60
07/28/22	Reviewed email memo from Jerry Wuetcher re Motion for Extension of Time; reviewed first draft of Motion for Extension of Time to file Response; made suggested edits to first draft of Motion for Extension of Time; prepared a new paragraph to add to the Motion for Extension of Time; exchanged additional email memos with Jerry Wuetcher re Motion for Extension of Time	DRT	0.90
07/28/22	Reviewed final version of Motion for Extension of Time for Quality Control	DRT	NO CHARGE
07/28/22	Prepared Motion for Extension of Time; conferred with D. Talley re Motion; revised Motion for Extension of Time; prepared PSC Transmittal Letter; filed Motion for Extension of Time with PSC	GEW	1.20
07/29/22	Prepared email memo to Alan Vilines re filing Motion for Extension of Time and new deadline for preparing Response to PSC Staff's First Request for Information	DRT	0.20
	Total Services		**$4,312.00**

Wood Creek Water District

Stoll Keenon Ogden PLLC
Invoice No. 983561

Summary of Services

Init	Timekeeper	Hours	Rate	Value
GEW	Wuetcher, G E	3.60	385.00	1,386.00
DRT	Talley, D R	7.70	380.00	2,926.00
	Total Services	11.30		$4,312.00

TOTAL FEES & DISBURSEMENTS	$4,312.00
Total Current Charges This Matter	**$4,312.00**

Outstanding Invoices

Date	Invoice No.	Billed Amount	Payment/Credits	Balance Due
07/06/22	981644	$ 40,281.00	$ 12,500.00	$ 27,781.00
Total Outstanding Invoices This Matter				**$27,781.00**
Total Amount Due This Matter				**$32,093.00**

Keep this copy for your records.

M 1

The Sentinel-Echo
P.O.Box 830
London, KY 40743
(606) 878-7400

1| Billing Period	2| Advertiser/Client Name
JUNE 2022	WOOD CREEK WATER DISTRICT

23| Total Amount Due	*Unapplied Amount	3| Terms of Payment
1,322.18		NET 30 DAYS

21| Current Net Amount Due	22| 30 Days	60 Days	Over 90 Days
1,295.20	26.98	0.00	0.00

4| Page Number	5| Billing Date	6| Billed Account Number	7| Advertiser/Client Number
1	06/30/22	10350	10350

Advertising Invoice and Statement

8| Billed Account Name and Address	9| Remittance Address
WOOD CREEK WATER DISTRICT ATTN: DONTA EVANS P. O. BOX 726 LONDON, KY 40741	THE SENTINEL ECHO 123 WEST FIFTH STREET PO BOX 830 LONDON KY 40743

10| Date	11| Newspaper Reference	12|13|14| Description-Other Comments/Charges	15| SAU Size 16| Billed Units	17| Times Run 18| Rate	19| Gross Amount	20| Net Amount
		PREVIOUS BALANCE				26.98
06/15	LEG SE	ADJUST MONTHLY RATES	4x13.00 52.00	1 8.300	431.60	431.60
06/22	LEG SE	ADJUST MONTHLY RATES	4x13.00 52.00	1 8.300	431.60	431.60
06/29	LEG SE	ADJUST MONTHLY RATES	4x13.00 52.00	1 8.300	431.60	431.60
06/30		SERV. CHG AT 1.500%			0.40	0.40

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Statement of Account - Aging of Past Due Amounts

21| Current Net Amount Due	22| 30 Days	60 Days	Over 90 Days	*Unapplied Amount	23| Total Amount Due
1,295.20	26.98	0.00	0.00		1,322.18

The Sentinel-Echo
P.O. Box 830
London, KY 40743
(606) 878-7400

Accounts 30 days old - charged 1 1/2% per month service charge. ANNUAL RATE 18%.

* Unapplied amounts are included in Total Amount Due

24| Invoice Number	25| Advertiser Information 1| Billing Period	6| Billed Account Number	7| Advertiser/Client Number	2| Advertiser/Client Name
2206010350	JUNE 2022	10350	10350	WOOD CREEK WATER DISTRIC

Wood Creek Water District
Case No. 2022-00145

Estimated Rate Case Expense

Line No.	Item (a)	Amount (b)
1.	Accounting	
2.	Engineering	
3.	Legal	$ 86,807.50
4.	Consultants	$ 20,000.00
5.	Other Expenses (Publication of Notice - Sentinel-Echo)	$ 1,322.18
6.	Total	$ 108,129.68
7.	Amount Assigned to Kentucky Jurisdictional	$ 108,129.68

Detail of Expenses to Date Plus Additional Expenses Not Yet Paid

Incurred Expenses

Date	Check #	Vendor	Amount
2/2/2022	971456	Stoll, Keenon, Ogden, PLLC	$ 610.50
6/2/2022	979493	Stoll, Keenon, Ogden, PLLC	$ 1,604.00
7/6/2022	981644	Stoll, Keenon, Ogden, PLLC	$ 40,281.00
8/2/2022	983561	Stoll, Keenon, Ogden, PLLC	$ 4,312.00

Expenses Not Yet Paid

Stoll, Keenon, Ogden, PLLC (Additional work to finalize case)	$ 40,000.00
Kentucky Rural Water Association (Cost of Service Study)	$ 5,000.00
Kentucky Rural Water Association (Additional work regarding data request)	$ 15,000.00
Sentinel-Echo (Customer Notice)	$ 1,322.81
Total	$ 108,130.31

Proposed Rate Study - Amended

Wood Creek Water District

Prepared by: **Kentucky Rural Water Association**

The Kentucky Rural Water Association (KRWA) will perform a general rate study for the Wood Creek Water District (WCWD) upon approval of this proposal. WCWD provides water service to approximately 5,300 residential and commercial customers. The district produces all its drinking water at its 12 MGD water treatment plant on Wood Creek Lake. WCWD sells wholesale water to East Laurel Water District, West Laurel Water Association, and the City of Livingston for $3.42 per 1,000 gallons.

Current monthly residential rates are: First 2,000 gallons - $24.22 (minimum); Next 1,500 gallons - $7.70 per 1,000 gallons; Next 1,500 gallons - $6.87 per 1,000 gallons; Next 2,500 gallons - $5.78 per 1,000 gallons; Over 7,500 gallons - $4.57 per 1,000 gallons. A residential customer using 4,000 gallons per month pays $39.21.

Scope of Work

FIXED COST

This section includes all work already performed for the ARF application, plus completing: Retail and Wholesale Cost of Service Studies; Current and Proposed Rates; and Proposed Billing Analysis. KRWA will also provide a written summary, presentation to the Board of Commissioners (if requested), and a proposed board resolution. Revenue requirements and Schedule of Adjusted Operations will be based on Calendar Year 2020 as in the ARF study.

HOURLY RATE

Assistance required in preparing the PSC application, Customer Notices and pre-filed testimony required by the PSC will be charged at the hourly rate and will be in addition to the Fixed Cost. All other PSC work which could include assisting with the preparation of responses to PSC Requests for Information, attending PSC Informal Conferences, preparing for and attending the formal hearing, and assisting with preparing responses to Post-hearing Requests for Information will also be charged at the hourly rate.

Qualifications

The rate analysis will be performed by Alan Vilines, PE. Gary Larimore, KRWA Executive Director will coordinate the work.

Proposed Costs:

FIXED COST

Wholesale and Retail Cost of Service Study:

Previous work completed on ARF:	$6,200
Additional analysis for cost of service study and meetings:	$3,300

Travel:

Two round trips from Bowling Green to Wood Creek WD:	$500
Total:	**$10,000**
ARC (50%):	**-5,000**
WCWD:	**$5,000**

HOURLY RATE

PSC Application, Testimony, & Information Requests:

Research and compilation:	$100 per hour

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 11

Responding Witness: Dewayne Lewis

Q-11. Provide the following information with regard to uncollectible accounts for the three most recent calendar years:

a. Reserve account balance at the beginning of the year;

b. Charges to the reserve account (accounts charged off);

c. Credits to reserve account;

d. Current year provision;

e. Reserve account balance at the end of the year; and

f. Percent of provision to total revenue.

A-11. Uncollectible accounts charged off 2019:	$56,519.40
Percent to total revenue:	1.94%
Uncollectible accounts charged off 2020:	$29,996.67
Percent to total revenue	1.01%
Uncollectible accounts charged off 2021:	$74,685.80
Percent to total revenue	2.47%

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 12

Responding Witness: Dewayne Lewis

Q-12. **Provide a schedule of franchise fees paid to cities, towns, or municipalities, including the basis of these fees**.

A-12. Wood Creek District is not required to pay any franchise fees to any city, town or municipality.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 13

Responding Witness: Dewayne Lewis

Q-13. Provide the journal entries relating to the purchase of utility plant acquired as an operating unit or system by purchase, merger, consolidation, liquidation, or otherwise currently included in rate base. Also, provide a schedule showing the calculation of the acquisition adjustment at the date of purchase for each item of utility plant, the amortization period, and the unamortized balance at the beginning of the test year.

A-13. No such purchases have been made.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 14

Responding Witness: Dewayne Lewis

Q-14. **Provide the following:**

a. A list of all outstanding issues of long-term debt as of the end of the latest calendar year together with the related information as shown in Schedule D1.

b. An analysis of short-term debt as shown in Schedule D2 as of the end of the latest calendar year.

A-14. a. See Attachment 14a.

b. Wood Creek District obtained a short-term Line of Credit Loan from Cumberland Valley National Bank on July 21, 2021 at an interest rate of 1.50%. It matures on July 20, 2023. Thus far, Wood Creek District has drawn down $192,500 on this Line of Credit.

WOOD CREEK WATER DISTRICT
Schedule of Outstanding Long-Term Debt
For the year ended December 31, 2021

Type of Debt	Date of Issue	Date of Maturity	Interest Rates	Amount Outstanding	Interest Rate	Cost Rate at Issue	Cost Rate at Maturity	Bond Rating	Type	Annualized Cost
Bond payable- USDA Rural Development, Series 2005 B	08/22/07	01/01/45	4.25%	$ 5,793,000	4.25%	4.25%	4.25%	Unrated	Bond Payable	$ 246,203
Bond payable- USDA Rural Development, Series 2005 B	08/22/07	01/01/45	4.25%	$ 5,793,000	4.25%	4.25%	4.25%	Unrated	Bond Payable	$ 24,523
Bond payable- USDA Rural Development, Series 2020	11/04/21	01/01/61	1.75%	$ 5,793,000	1.75%	1.75%	1.75%	Unrated	Bond Payable	$ 51,485
Bond payable- Kentucky Rural Water Finance Corporation, Series 2005B	10/19/05	07/01/31	4.09% - 4.59%	$ 5,793,000	4.09%	4.09%	4.59%	Unrated	Bond Payable	$ 86,705
Bond payable- Kentucky Rural Water Finance Corporation, Series 2007A	01/30/07	07/01/36	4.05% - 4.425%	$ 5,793,000	4.05%	4.05%	4.43%	Unrated	Bond Payable	$ 61,045
Bond payable- Kentucky Rural Water Finance Corporation, Series 2015B	02/19/15	07/01/36	2.25% - 3.50%	$ 5,793,000	2.25%	2.25%	3.50%	Unrated	Bond Payable	$ 58,450

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 15

Responding Witness: Dewayne Lewis

Q-15. Provide the information shown in Schedule E for each construction project in progress, or planned to be in progress, during the 12 months preceding the test year, the test year, and the forecasted test period.

A-15. Wood Creek District's application uses a historical test period. There is no forecasted test period. In its application, Wood Creek District proposes to use the Commission's debt service methodology to determine its revenue requirements. Under this methodology, the level of construction work in progress has no effect on a water district's revenue requirement.

As of December 31, 2020, approximately $812,481.36 was in "Construction Work in Progress Account." This amount is related to the KY 490 US 25 Waterline Replacement Project. The Public Service Commission issued a certificate of public convenience and necessity for this project in Case No. 2020-00352. Total project cost is $3,678,000. Wood Creek District financed the project through the issuance of $2,942,000 in revenue bonds to Rural Development and a Rural Development grant of $736,000. This project was completed in the second quarter of Calendar Year 2022.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 16

Responding Witness: Dewayne Lewis

Q-16. Provide, in the format provided in Schedule F, an analysis of the utility's Construction Work in Progress (CWIP) as defined in the Uniform System of Accounts for each project identified in Schedule E.

A-16. Wood Creek Water District's application uses a historical test period. There is no forecasted test period. In its application, Wood Creek Water District proposes to use the Commission's debt service methodology to determine its revenue requirements. Under this methodology, the level of construction work in progress has no effect on a water district's revenue requirement.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 17

Responding Witness: Dewayne Lewis

Q-17. Concerning the utility's construction projects:

a. For each project started during the last five calendar years, provide the information requested in the format contained in Schedule G1. For each project, include the amount of any cost variance and delay encountered, and explain in detail the reasons for such variances and delays.

b. Using the data included in Schedule G1, calculate the annual "Slippage Factor" associated with those construction projects. The Slippage Factor should be calculated as shown in Schedule G2

c. In determining the capital additions reflected in the test year and forecasted test period, explain whether the utility recognized a Slippage Factor.

A-17. The use of a slippage factor is not applicable to Wood Creek District's application. The Public Service Commission has offered the following reason for the use of a "slippage factor" in a rate case proceeding:

> As part of the capital budgeting process, utilities will estimate the level of capital construction that will be undertaken during the year. Because of delays, weather conditions, or other events, the actual level of construction will often vary from the level budgeted. The difference between the actual and budgeted levels is reflected in the calculation of a "slippage factor," which serves as an indicator of the utility's accuracy in predicting the cost of its utility plant additions and when new plant will be placed into service. The Commission has routinely applied a slippage factor in the forward-looking test period rate cases . . . .[1]

The current case involves an application for rate adjustment based upon **a historical test period** and **historical costs**. Neither a forward-looking test

[1] *An Adjustment of the Gas Rates of the Union Light Heat and Power Company*, Case No. 2005-00042 (Ky. PSC Dec. 22, 2005) at 8-9.

period nor budget projections were used to determine Wood Creek District's revenue requirement. No need exists to compare the applicant's construction budget to actual results.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 18

Responding Witness: Dewayne Lewis

Q-18. Describe in detail how the test year capitalization rate was determined. If different rates were used for specific expenses (i.e., payroll, clearing accounts, depreciation, etc.), indicate the rate and how it was determined. Indicate all proposed changes to the capitalization rate and how the changes were determined.

A-18. Wood Creek District's application for rate adjustment is based upon debt service coverage methodology. No capitalization rate was determined. The proposed rates are not based on a rate of return methodology.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 19

Responding Witness: Dewayne Lewis

Q-19. Provide a calculation of the rate or rates used to capitalize interest during construction for the three most recent calendar years. Explain each component entering into the calculation of the rate(s).

A-19. Wood Creek District did not capitalize interest during construction for the three most recent calendar years.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 20

Responding Witness: Dewayne Lewis

Q-20. State whether any changes have been made to the utility's internal accounting manuals, directives, and policies and procedures since the utility's most recent rate case. If so, provide each item that was changed and identify the changes.

A-20. There have been no changes to Wood Creek District's internal accounting manuals, directives, and policies and procedures since its most recent rate case.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 21

Responding Witness: Dewayne Lewis

Q-21. Provide the utility's long-term construction planning program.

A-21. Wood Creek District does not have a long-term construction planning program.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 22

Responding Witness: Dewayne Lewis

Q-22. **Provide a copy of the utility's most recent depreciation schedule. The schedule should include a list of all facilities by account number, service life and accrual rate for each plant item, the methodology that supports the schedule, and the date the schedule was last updated.**

A-22. See Attachment 22.

120060A WOOD CREEK WATER DISTRICT 08/01/2022 12:05 PM

Tax Asset Detail 1/01/21 - 12/31/21

FYE: 12/31/2021

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
Group: 301 Organization											
Location: 301-10 ORGANIZATION											
224	ORGANIZATION	1/01/71	21,836.00	0.00	0.00	21,836.00	0.00	21,836.00	0.00	S/L	40.00
301-10 ORGANIZATION			21,836.00	0.00 c	0.00	21,836.00	0.00	21,836.00	0.00		
		301 Organization	21,836.00	0.00 c	0.00	21,836.00	0.00	21,836.00	0.00		
Group: 303 Land											
Location:											
456	LAND & LAND RIGHTS	2/28/07	11,345.50	0.00	0.00	0.00	0.00	0.00	11,345.50	Land	0.00
457	LAND & LAND RIGHT ROBINS	9/30/07	450,000.00	0.00	0.00	0.00	0.00	0.00	450,000.00	Land	0.00
458	LAND & LAND RIGHTS MOORE	11/30/07	30,000.00	0.00	0.00	0.00	0.00	0.00	30,000.00	Land	0.00
459	LAND & LAND RIGHTS BINDER	2/28/07	531,639.50	0.00	0.00	0.00	0.00	0.00	531,639.50	Land	0.00
460	LAND & LAND RIGHTS CLIFFS	2/28/07	115,440.00	0.00	0.00	0.00	0.00	0.00	115,440.00	Land	0.00
461	LAND & LAND RIGHTS BLEDSOE	2/28/07	443,280.00	0.00	0.00	0.00	0.00	0.00	443,280.00	Land	0.00
462	LAND & LAND RIGHTS BLEDSOE	12/31/07	146,460.00	0.00	0.00	0.00	0.00	0.00	146,460.00	Land	0.00
471	LAND WATERSHED PROJECT	12/31/08	297,876.25	0.00	0.00	0.00	0.00	0.00	297,876.25	Land	0.00
499	LAND AND LAND RIGHTS	6/30/09	504,875.00	0.00	0.00	0.00	0.00	0.00	504,875.00	Land	0.00
509	LAND AQUISITION COSTS	12/31/10	860,822.50	0.00	0.00	0.00	0.00	0.00	860,822.50	Land	0.00
No Location			3,391,738.75	0.00 c	0.00	0.00	0.00	0.00	3,391,738.75		
Location: 303-20 LAND & LAND RIGHTS											
225	LAND AND LAND RIGHTS	3/21/75	15,800.00	0.00	0.00	0.00	0.00	0.00	15,800.00	Land	0.00
226	LAND AND LAND RIGHTS	1/01/77	1,000.00	0.00	0.00	0.00	0.00	0.00	1,000.00	Land	0.00
227	LAND AND LAND RIGHTS	1/01/77	1,675.00	0.00	0.00	0.00	0.00	0.00	1,675.00	Land	0.00
228	LAND AND LAND RIGHTS	1/01/71	49,936.00	0.00	0.00	0.00	0.00	0.00	49,936.00	Land	0.00
229	LAND AND LAND RIGHTS	1/01/80	9,700.00	0.00	0.00	0.00	0.00	0.00	9,700.00	Land	0.00
230	LAND AND LAND RIGHTS	7/01/88	1,924.00	0.00	0.00	0.00	0.00	0.00	1,924.00	Land	0.00
231	LAND AND LAND RIGHTS	7/01/89	8,392.00	0.00	0.00	0.00	0.00	0.00	8,392.00	Land	0.00
232	LAND & LAND RIGHTS	8/31/95	10,000.00	0.00	0.00	0.00	0.00	0.00	10,000.00	Land	0.00
303-20 LAND & LAND RIGHTS			98,427.00	0.00 c	0.00	0.00	0.00	0.00	98,427.00		
Location: 303-21 LAND & LAND CLEAR											
233	LAND AND LAND CLEARING	1/01/71	138,876.00	0.00	0.00	0.00	0.00	0.00	138,876.00	Land	0.00
303-21 LAND & LAND CLEAR			138,876.00	0.00 c	0.00	0.00	0.00	0.00	138,876.00		
Location: 303-30 LAND & LAND RIGHTS											
234	LAND AND LAND RIGHTS	3/01/99	30,000.00	0.00	0.00	0.00	0.00	0.00	30,000.00	Land	0.00
303-30 LAND & LAND RIGHTS			30,000.00	0.00 c	0.00	0.00	0.00	0.00	30,000.00		
Location: 303-40 LAND & LAND RIGHTS											
235	LAND AND LAND RIGHTS	1/01/79	878.00	0.00	0.00	0.00	0.00	0.00	878.00	Land	0.00
236	LAND AND LAND RIGHTS	1/01/83	20,000.00	0.00	0.00	0.00	0.00	0.00	20,000.00	Land	0.00
237	LAND AND LAND RIGHTS	7/01/86	52,000.00	0.00	0.00	0.00	0.00	0.00	52,000.00	Land	0.00
238	LAND AND LAND RIGHTS	7/01/87	1,303.00	0.00	0.00	0.00	0.00	0.00	1,303.00	Land	0.00
239	LAND AND LAND RIGHTS	7/01/88	15,459.00	0.00	0.00	0.00	0.00	0.00	15,459.00	Land	0.00
303-40 LAND & LAND RIGHTS			89,640.00	0.00 c	0.00	0.00	0.00	0.00	89,640.00		
Location: 303-50 LAND & LAND RIGHTS											
240	LAND AND LAND RIGHTS	7/01/87	125,950.00	0.00	0.00	0.00	0.00	0.00	125,950.00	Land	0.00
241	LAND AND LAND RIGHTS	7/01/05	146,587.50	0.00	0.00	0.00	0.00	0.00	146,587.50	Land	0.00
242	LAND AND LAND RIGHTS	7/01/06	26,762.50	0.00	0.00	0.00	0.00	0.00	26,762.50	Land	0.00
601	LAND & LAND RIGHTS	6/30/13	1,020.00	0.00	0.00	101.99	0.00	101.99	918.01	Land	35.00
606	LAND AND LAND RIGHTS	6/30/14	47,333.50	0.00	0.00	0.00	0.00	0.00	47,333.50	Land	0.00
630	LAND RIGHTS - ROBINSON	12/29/16	5,000.00	0.00	0.00	0.00	0.00	0.00	5,000.00	Land	0.00
649	LAND & LAND RIGHTS - WITT - WTP	9/28/17	18,905.84	0.00	0.00	0.00	0.00	0.00	18,905.84	Land	0.00
666	LAND	6/30/18	124,000.00	0.00	0.00	0.00	0.00	0.00	124,000.00	Land	0.00
679	LAND	2/07/19	16,800.00	0.00	0.00	0.00	0.00	0.00	16,800.00	Land	0.00
680	LAND	10/22/19	50,000.00	0.00	0.00	0.00	0.00	0.00	50,000.00	Land	0.00
681	LAND	12/18/19	30,000.00	0.00	0.00	0.00	0.00	0.00	30,000.00	Land	0.00
720	Donnie Mcqueen Land	9/23/21	24,950.00	0.00 c	0.00	0.00	0.00	0.00	24,950.00	Land	0.00
303-50 LAND & LAND RIGHTS			617,309.34	0.00 c	0.00	101.99	0.00	101.99	617,207.35		
Location: 303-90 LAND AND LAND RIGH											
517	LAND - LAUREL CO SCH BD	1/01/01	9,000.00	0.00	0.00	0.00	0.00	0.00	9,000.00	Land	0.00
518	LAND	7/01/09	39,007.50	0.00	0.00	0.00	0.00	0.00	39,007.50	Land	0.00
573	Land and Land Rights	7/01/11	3,500.00	0.00	0.00	0.00	0.00	0.00	3,500.00	Land	0.00
721	Land	6/30/21	5,000.00	0.00 c	0.00	0.00	0.00	0.00	5,000.00	Land	0.00
303-90 LAND AND LAND RIGH			56,507.50	0.00 c	0.00	0.00	0.00	0.00	56,507.50		
		303 Land	4,422,498.59	0.00 c	0.00	101.99	0.00	101.99	4,422,396.60		

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
Group: 304 Structures & Improvem											
Location: 304-20 STRUCT & IMPROVEMT											
243	STRUCTURES & IMPROVEMENTS	7/01/99	795,118.00	0.00	0.00	769,723.90	22,717.66	792,441.56	2,676.44	S/L	35.00
244	BOAT DOCK	7/01/06	10,362.23	0.00	0.00	7,512.60	518.11	8,030.71	2,331.52	S/L	20.00
434	PLANT GATE & SIGN	9/30/07	4,661.50	0.00	0.00	2,699.81	155.38	2,855.19	1,806.31	S/L	30.00
472	SIGN AT PLANT	3/31/08	4,661.50	0.00	0.00	2,472.32	133.19	2,605.51	2,055.99	S/L	35.00
473	GATE AT PLANT	4/30/08	1,392.00	0.00	0.00	732.45	39.77	772.22	619.78	S/L	35.00
722	Structures and improvements	6/30/21	206,651.43	0.00 c	0.00	0.00	5,166.29	5,166.29	201,485.14	S/L	20.00
304-20 STRUCT & IMPROVEMT			1,022,846.66	0.00 c	0.00	783,141.08	28,730.40	811,871.48	210,975.18		
Location: 304-30 STRUCT & IMPROVEMT											
402	STRUCTURES AND IMPROVEMENTS	1/01/71	234,229.00	0.00	0.00	234,229.00	0.00	234,229.00	0.00	S/L	40.00
403	STRUCTURES AND IMPROVEMENTS	1/01/78	559,813.00	0.00	0.00	489,831.29	13,995.33	503,826.62	55,986.38	S/L	40.00
404	STRUCTURES AND IMPROVEMENT	7/01/86	735,684.00	0.00	0.00	526,019.02	18,392.10	544,411.12	191,272.88	S/L	40.00
405	STRUCTURES & IMPROVEMENTS	7/01/91	1,870,601.00	0.00	0.00	1,150,419.43	46,765.03	1,197,184.46	673,416.54	S/L	40.00
406	ROOF-PLANT	3/11/91	16,000.00	0.00	0.00	9,947.00	400.00	10,347.00	5,653.00	S/L	40.00
407	ROOF-CHEMICAL BUILDING	2/15/95	6,575.00	0.00	0.00	3,575.90	164.38	3,740.28	2,834.72	S/L	40.00
408	STORAGE BUILDING	1/16/96	1,700.00	0.00	0.00	892.50	42.50	935.00	765.00	S/L	40.00
410	FENCE	10/24/96	448.00	0.00	0.00	228.44	11.20	239.64	208.36	S/L	40.00
497	NEW WATER PLANT	6/30/08	6,145,881.90	0.00	0.00	1,690,117.55	153,647.05	1,843,764.60	4,302,117.30	S/L	40.00
500	STRUCTURE & IMPROVEMENTS	6/30/09	179,869.41	0.00	0.00	45,866.73	4,496.74	50,363.47	129,505.94	S/L	40.00
304-30 STRUCT & IMPROVEMT			9,750,801.31	0.00 c	0.00	4,151,126.86	237,914.33	4,389,041.19	5,361,760.12		
Location: 304-40 STRUCT & IMPROVEMT											
257	STRUCTURES AND IMPROVEMENTS	1/01/76	1,738.00	0.00	0.00	1,738.00	0.00	1,738.00	0.00	S/L	20.00
258	STRUCTURES AND IMPROVEMENTS	1/01/78	20,504.00	0.00	0.00	20,504.00	0.00	20,504.00	0.00	S/L	20.00
259	STRUCTURES AND IMPROVEMENTS	1/01/79	17,159.00	0.00	0.00	17,159.00	0.00	17,159.00	0.00	S/L	20.00
260	STRUCTURES AND IMPROVEMENTS	1/01/82	214.00	0.00	0.00	214.00	0.00	214.00	0.00	S/L	20.00
261	STRUCTURES AND IMPROVEMENT	7/01/86	2,111.00	0.00	0.00	2,111.00	0.00	2,111.00	0.00	S/L	20.00
262	STORAGE BUILDING	7/01/87	109,960.00	0.00	0.00	109,960.00	0.00	109,960.00	0.00	S/L	20.00
263	FENCE	6/08/92	506.00	0.00	0.00	506.00	0.00	506.00	0.00	S/L	20.00
264	STRUCTURES AND IMPROVEMENTS	7/01/99	795,118.00	0.00	0.00	769,723.90	22,717.66	792,441.56	2,676.44	S/L	35.00
304-40 STRUCT & IMPROVEMT			947,310.00	0.00 c	0.00	921,915.90	22,717.66	944,633.56	2,676.44		
Location: 304-50 STRUCT & IMPROVEMT											
1	STORAGE BUILDING	7/01/88	1,769.00	0.00	0.00	1,189.47	44.23	1,233.70	535.30	S/L	40.00
2	NEW OFFICE	5/01/89	172,919.00	0.00	0.00	113,834.22	4,322.98	118,157.20	54,761.80	S/L	40.00
3	PAVING	7/01/90	14,865.00	0.00	0.00	14,865.00	0.00	14,865.00	0.00	S/L	20.00
4	PLANT FURNACE	7/01/90	1,172.00	0.00	0.00	739.66	29.30	768.96	403.04	S/L	40.00
5	BATHROOM FIXTURES	7/01/90	165.00	0.00	0.00	100.85	4.13	104.98	60.02	S/L	40.00
6	LAKE-BUILDING	7/01/91	2,318.00	0.00	0.00	1,363.84	46.36	1,410.20	907.80	S/L	50.00
7	FENCE	10/24/96	3,843.00	0.00	0.00	1,960.44	96.08	2,056.52	1,786.48	S/L	40.00
8	STRUCTURES & IMPROVEMENTS	7/01/04	33,843.00	0.00	0.00	24,294.43	966.94	25,261.37	8,581.63	S/L	35.00
9	STRUCTURES & IMPROVMENTS	7/01/06	6,855.28	0.00	0.00	4,235.57	195.87	4,431.44	2,423.84	S/L	35.00
438	FENCE AT WAREHOUSE	2/26/07	8,735.00	0.00	0.00	5,105.81	249.57	5,355.38	3,379.62	S/L	35.00
439	BLACKTOP OFFICE PARKING LOT	4/27/07	13,428.00	0.00	0.00	7,737.10	383.66	8,120.76	5,307.24	S/L	35.00
440	SIDEWALKS AT OFFICE	3/27/07	1,594.00	0.00	0.00	925.08	45.54	970.62	623.38	S/L	35.00
441	METAL CARPORT	5/08/07	1,620.00	0.00	0.00	933.45	46.29	979.74	640.26	S/L	35.00
443	BUILDING	11/30/07	29,042.00	0.00	0.00	8,325.37	726.05	9,051.42	19,990.58	S/L	40.00
474	CABINETS AT PLANT	2/29/08	8,900.00	0.00	0.00	2,855.42	222.50	3,077.92	5,822.08	S/L	40.00
475	3 TON HP/DUCT PTS/LAB	2/29/08	4,480.00	0.00	0.00	1,437.33	112.00	1,549.33	2,930.67	S/L	40.00
476	PLANT AND OFFICE SHELVING	2/29/08	1,400.00	0.00	0.00	449.17	35.00	484.17	915.83	S/L	40.00
477	WAREHOUSE HEAT PUMP	3/31/08	2,000.00	0.00	0.00	637.50	50.00	687.50	1,312.50	S/L	40.00
478	ROOF-STORAGE BUILDING	4/30/08	2,800.00	0.00	0.00	886.67	70.00	956.67	1,843.33	S/L	40.00
479	ROAD TO SLUDG DUMP	12/31/08	7,036.44	0.00	0.00	3,467.94	201.04	3,668.98	3,367.46	S/L	35.00
480	TOP SOIL BIN	12/31/08	23,279.70	0.00	0.00	6,983.88	581.99	7,565.87	15,713.83	S/L	40.00
501	STRUCTURE & IMPROVEMENTS	6/30/09	17,230.23	0.00	0.00	8,061.27	492.29	8,553.56	8,676.67	S/L	35.00
568	Structures and Improvements	7/01/11	1,107.00	0.00	0.00	407.23	31.63	438.86	668.14	S/L	35.00
619	STRUCTURES AND IMPROVEMENTS	6/30/15	5,121.48	0.00	0.00	1,408.39	256.07	1,664.46	3,457.02	S/L	20.00
682	DOCKS (AMERICAN MUSCLE)	10/15/19	40,799.00	0.00	0.00	2,549.94	2,039.95	4,589.89	36,209.11	S/L	20.00
701	C A MILLS	6/30/20	5,680.00	0.00	0.00	142.00	284.00	426.00	5,254.00	S/L	20.00
304-50 STRUCT & IMPROVEMT			412,002.13	0.00 c	0.00	214,897.03	11,533.47	226,430.50	185,571.63		
Location: 304-90 STRUCTURE & IMPRO											
519	STRUCTURE & IMPROVEMENTS	7/01/09	7,290.01	0.00	0.00	4,191.75	364.50	4,556.25	2,733.76	S/L	20.00
521	STRUCTURE & IMPROVEMENTS	7/01/05	8,375.00	0.00	0.00	6,490.63	418.75	6,909.38	1,465.62	S/L	20.00
578	Structure & Improvements	7/01/11	20,220.25	0.00	0.00	9,604.60	1,011.01	10,615.61	9,604.64	S/L	20.00
589	Stuctures and Improvements	7/01/12	1,143.47	0.00	0.00	485.95	57.17	543.12	600.35	S/L	20.00
304-90 STRUCTURE & IMPRO			37,028.73	0.00 c	0.00	20,772.93	1,851.43	22,624.36	14,404.37		
	304 Structures & Improvem		12,169,988.83	0.00 c	0.00	6,091,853.80	302,747.29	6,394,601.09	5,775,387.74		
Group: 305 Coll. & Impounding											
Location: 305-20 COLLECT & IMPOUND											
245	COLLECTING & IMPOUNDING RES.	1/01/71	30,880.00	0.00	0.00	30,880.00	0.00	30,880.00	0.00	S/L	50.00
305-20 COLLECT & IMPOUND			30,880.00	0.00 c	0.00	30,880.00	0.00	30,880.00	0.00		

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
Location: 352-19 COLLECTION FORCE M											
520	COLLECTION SEWERA	7/01/01	1,401,954.00	0.00	0.00	683,452.15	35,048.85	718,501.00	683,453.00	S/L	40.00
522	COLLECTION SEWERS	7/01/02	120,364.00	0.00	0.00	55,668.35	3,009.10	58,677.45	61,686.55	S/L	40.00
523	COLLECTION SEWERS	7/01/03	8,625.52	0.00	0.00	3,773.70	215.64	3,989.34	4,636.18	S/L	40.00
524	COLLECTION SEWERS	7/01/04	762,695.33	0.00	0.00	314,611.77	19,067.38	333,679.15	429,016.18	S/L	40.00
525	COLLECTION SEWERS	7/01/05	28,218.31	0.00	0.00	10,934.63	705.46	11,640.09	16,578.22	S/L	40.00
526	COLLECTION SEWERS	7/01/06	119,022.33	0.00	0.00	43,145.62	2,975.56	46,121.18	72,901.15	S/L	40.00
527	COLLECTION SEWERS	7/01/08	3,623.94	0.00	0.00	1,132.50	90.60	1,223.10	2,400.84	S/L	40.00
528	COLLECTION SEWERS	7/01/09	1,079,887.51	0.00	0.00	310,467.68	26,997.19	337,464.87	742,422.64	S/L	40.00
529	COLLECTION SEWERS	7/10/10	18,182.12	0.00	0.00	4,772.78	454.55	5,227.33	12,954.79	S/L	40.00
574	Collections Force Main	7/01/11	772,400.41	0.00	0.00	183,445.10	19,310.01	202,755.11	569,645.30	S/L	40.00
590	Collections Force Main	7/01/12	2,771.96	0.00	0.00	589.05	69.30	658.35	2,113.61	S/L	40.00
602	COLLECTION FORCE MAIN	6/30/13	11,060.78	0.00	0.00	1,382.62	184.35	1,566.97	9,493.81	S/L	60.00
698	COLLECTIONS FORCE MAIN	6/30/19	619,317.93	0.00	0.00	23,224.42	15,482.95	38,707.37	580,610.56	S/L	40.00
352-19 COLLECTION FORCE M			4,948,124.14	0.00 c	0.00	1,636,600.37	123,610.94	1,760,211.31	3,187,912.83		
	305 Coll. & Impounding		4,979,004.14	0.00 c	0.00	1,667,480.37	123,610.94	1,791,091.31	3,187,912.83		
Group: 309 Supply Mains											
Location: 309-20 SUPPLY MAINS											
246	SUPPLY MAINS	1/01/78	4,484.00	0.00	0.00	3,817.92	89.68	3,907.60	576.40	S/L	50.00
309-20 SUPPLY MAINS			4,484.00	0.00 c	0.00	3,817.92	89.68	3,907.60	576.40		
	309 Supply Mains		4,484.00	0.00 c	0.00	3,817.92	89.68	3,907.60	576.40		
Group: 310 Power Generation Equi											
Location: 393-00 POWER OPERATED EQU											
530	JD 4501 DOZER	7/01/06	89,500.00	0.00	0.00	89,500.00	0.00	89,500.00	0.00	S/L	10.00
531	KOMATSU PC78MR-6	7/01/06	72,000.00	0.00	0.00	72,000.00	0.00	72,000.00	0.00	S/L	10.00
533	JD 310D BACKHOE	7/16/96	48,250.00	0.00	0.00	48,250.00	0.00	48,250.00	0.00	S/L	10.00
534	IR AIR COMPRESSOR	3/29/01	12,959.00	0.00	0.00	12,959.00	0.00	12,959.00	0.00	S/L	10.00
393-00 POWER OPERATED EQU			222,709.00	0.00 c	0.00	222,709.00	0.00	222,709.00	0.00		
	310 Power Generation Equi		222,709.00	0.00 c	0.00	222,709.00	0.00	222,709.00	0.00		
Group: 311 Pumping Equipment											
Location: 311-00 PUMPING EQUIPMENT											
481	PULSE FEEDER PUMP	6/30/08	12,982.12	0.00	0.00	3,801.90	370.92	4,172.82	8,809.30	S/L	35.00
511	PUMPING EQUIPMENT	9/09/10	5,196.00	0.00	0.00	2,684.60	259.80	2,944.40	2,251.60	S/L	20.00
311-00 PUMPING EQUIPMENT			18,178.12	0.00 c	0.00	6,486.50	630.72	7,117.22	11,060.90		
Location: 311-20 ELECT PUMP EQUIP											
247	ELECTRIC PUMPING EQUIPMENT	1/01/71	9,100.00	0.00	0.00	9,100.00	0.00	9,100.00	0.00	S/L	40.00
248	ELECTRIC PUMPING EQUIPMENT	1/01/78	86,906.00	0.00	0.00	76,040.93	2,172.65	78,213.58	8,692.42	S/L	40.00
249	ELECTRIC PUMPING EQUIPMENT	1/01/80	132.00	0.00	0.00	118.46	3.30	121.76	10.24	S/L	40.00
250	ELECTRIC PUMPING EQUIPMENT	1/01/82	310,976.00	0.00	0.00	250,343.28	7,774.40	258,117.68	52,858.32	S/L	40.00
251	ELECTRIC PUMPING EQUIPMENT	1/01/83	80.00	0.00	0.00	68.40	2.00	70.40	9.60	S/L	40.00
252	ELECTRIC PUMPING EQUIPMENT	7/01/86	4,822.00	0.00	0.00	3,441.91	120.55	3,562.46	1,259.54	S/L	40.00
253	ELECTRIC PUMPING EQUIPMENT	7/01/87	21,807.00	0.00	0.00	15,153.86	545.18	15,699.04	6,107.96	S/L	40.00
254	ELECTRIC PUMPING EQUIPMENT	7/01/88	47,340.00	0.00	0.00	31,956.70	1,183.50	33,140.20	14,199.80	S/L	40.00
255	ELEC PUMP EQUIP VAUGHN	2/28/00	210,000.00	0.00	0.00	93,450.00	5,250.00	98,700.00	111,300.00	S/L	40.00
451	ELECTRIC PUMPING EQUIPMENT	6/30/07	12,099.00	0.00	0.00	3,569.23	302.48	3,871.71	8,227.29	S/L	40.00
510	PUMPING EQUIPMENT	7/01/10	119,530.00	0.00	0.00	62,753.25	5,976.50	68,729.75	50,800.25	S/L	20.00
702	Tencarva Machine Con	2/25/20	34,369.22	0.00	0.00	1,432.05	1,718.46	3,150.51	31,218.71	S/L	20.00
311-20 ELECT PUMP EQUIP			857,161.22	0.00 c	0.00	547,428.07	25,049.02	572,477.09	284,684.13		
Location: 363-90 ELECTRIC PUMPING &											
535	4 LIFT STATION PUMPS	7/01/01	50,000.00	0.00	0.00	50,000.00	0.00	50,000.00	0.00	S/L	5.00
536	494 SIMPLEX GRINDER PUMPS	7/01/01	573,534.00	0.00	0.00	573,534.00	0.00	573,534.00	0.00	S/L	7.00
537	PUMPS	7/01/02	181,524.00	0.00	0.00	181,524.00	0.00	181,524.00	0.00	S/L	7.00
538	PUMPS	7/01/03	14.66	0.00	0.00	14.66	0.00	14.66	0.00	S/L	7.00
539	PUMPS	7/01/04	176,355.02	0.00	0.00	176,355.02	0.00	176,355.02	0.00	S/L	7.00
540	PUMPS	7/01/05	38,309.88	0.00	0.00	38,309.88	0.00	38,309.88	0.00	S/L	7.00
541	PUMPS	7/01/06	35,467.15	0.00	0.00	35,467.15	0.00	35,467.15	0.00	S/L	7.00
542	PUMPS	7/01/07	35,948.28	0.00	0.00	35,948.28	0.00	35,948.28	0.00	S/L	7.00
543	PUMPS	7/01/08	38,848.78	0.00	0.00	38,848.78	0.00	38,848.78	0.00	S/L	7.00
544	PUMPS	7/01/09	994,788.29	0.00	0.00	994,788.29	0.00	994,788.29	0.00	S/L	35.00
545	PUMPS	7/01/10	96,812.32	0.00	0.00	96,812.32	0.00	96,812.32	0.00	S/L	7.00
577	Electric Pumping Equipment	7/01/11	285,174.91	0.00	0.00	104,903.62	8,147.85	113,051.47	172,123.44	S/L	35.00
592	Electric Pumping Equipment	7/01/12	117,262.80	0.00	0.00	104,280.14	12,982.66	117,262.80	0.00	S/L	7.00
605	ELECTRIC PUMP	6/30/13	58,930.03	0.00	0.00	22,098.75	2,946.50	25,045.25	33,884.78	S/L	20.00
617	Electric Pumping Equipment	6/30/14	93,744.16	0.00	0.00	30,466.86	4,687.21	35,154.07	58,590.09	S/L	20.00
629	Electric Pumping Equipment	6/30/15	110,792.66	0.00	0.00	30,467.97	5,539.63	36,007.60	74,785.06	S/L	20.00
648	ELECTRIC PUMPING EQUIP	6/30/16	140,362.97	0.00	0.00	31,581.67	7,018.15	38,599.82	101,763.15	S/L	20.00
656	ELECTRIC PUMPING EQUIP	6/30/17	140,381.08	0.00	0.00	12,283.35	3,509.53	15,792.88	124,588.20	S/L	40.00
665	ELECTRIC PUMPING EQUIP	6/30/18	87,778.89	0.00	0.00	10,972.35	4,388.94	15,361.29	72,417.60	S/L	20.00
700	ELECTRIC PUMPING EQUIPMENT	6/30/19	350,746.32	0.00	0.00	26,305.98	17,537.32	43,843.30	306,903.02	S/L	20.00
733	electric pump equip	6/30/21	86,789.70	0.00 c	0.00	0.00	2,169.74	2,169.74	84,619.96	S/L	20.00
363-90 ELECTRIC PUMPING &			3,693,565.90	0.00 c	0.00	2,594,963.07	68,927.53	2,663,890.60	1,029,675.30		

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
Location: 393-90 COMMUNICATION EQUI											
719	ELECTRIC PUMPING EQUIP (WW)	6/30/20	196,418.16	0.00	0.00	4,910.45	9,820.91	14,731.36	181,686.80	S/L	20.00
393-90 COMMUNICATION EQUI			196,418.16	0.00 c	0.00	4,910.45	9,820.91	14,731.36	181,686.80		
	311 Pumping Equipment		4,765,323.40	0.00 c	0.00	3,153,788.09	104,428.18	3,258,216.27	1,507,107.13		
Group: 320 Water Treatment Equip											
Location: 320-30 WATER TRTMT EQUIP											
411	WATER TREATMENT EQUIPMENT	1/01/76	72.00	0.00	0.00	72.00	0.00	72.00	0.00	S/L	25.00
412	WATER TREATMENT EQUIPMENT	1/01/78	243,428.00	0.00	0.00	243,428.00	0.00	243,428.00	0.00	S/L	25.00
413	WATER TREATMENT EQUIPMENT	1/01/79	906.00	0.00	0.00	776.28	18.12	794.40	111.60	S/L	50.00
414	WATER TREATMENT EQUIPMENT	1/01/80	594.00	0.00	0.00	594.00	0.00	594.00	0.00	S/L	25.00
415	WATER TREATMENT EQUIPMENT	1/01/82	347.00	0.00	0.00	347.00	0.00	347.00	0.00	S/L	25.00
416	WATER TREATMENT EQUIPMENT	1/01/83	316.00	0.00	0.00	316.00	0.00	316.00	0.00	S/L	25.00
417	PRESSURE RECORDERS	1/01/84	1,093.00	0.00	0.00	1,093.00	0.00	1,093.00	0.00	S/L	25.00
418	CHEMICAL FEEDERS	1/01/84	8,027.00	0.00	0.00	8,027.00	0.00	8,027.00	0.00	S/L	25.00
419	AIR PAC	7/01/86	1,196.00	0.00	0.00	1,196.00	0.00	1,196.00	0.00	S/L	25.00
420	JAR TEST MACHINE	7/01/86	759.00	0.00	0.00	759.00	0.00	759.00	0.00	S/L	25.00
421	AIR COMPRESSOR	7/01/86	5,000.00	0.00	0.00	5,000.00	0.00	5,000.00	0.00	S/L	25.00
422	CHEMICAL FEEDER	7/01/86	5,305.00	0.00	0.00	5,305.00	0.00	5,305.00	0.00	S/L	25.00
423	PRESSURE RECOEDER	7/01/89	326.00	0.00	0.00	326.00	0.00	326.00	0.00	S/L	25.00
424	(2) RECORDERS	9/14/92	649.00	0.00	0.00	649.00	0.00	649.00	0.00	S/L	20.00
425	CHOLRINE MACHINE	7/01/93	2,285.00	0.00	0.00	2,285.00	0.00	2,285.00	0.00	S/L	25.00
426	AIR COMPRESSOR	5/31/94	1,495.00	0.00	0.00	1,495.00	0.00	1,495.00	0.00	S/L	20.00
427	CHEMICAL PUMP	8/31/94	1,001.00	0.00	0.00	1,001.00	0.00	1,001.00	0.00	S/L	25.00
428	WATER TREATMENT EQUIPMENT	11/06/95	656.00	0.00	0.00	621.06	18.74	639.80	16.20	S/L	35.00
429	RECORDER	5/21/96	573.00	0.00	0.00	573.00	0.00	573.00	0.00	S/L	20.00
430	WATER TREATMENT EQUIPMENT	6/30/99	12,445.00	0.00	0.00	9,994.05	355.57	10,349.62	2,095.38	S/L	35.00
431	CHEMICAL FEED ADDITION-SEC8-3.	11/13/00	191,041.00	0.00	0.00	149,558.51	5,458.31	155,016.82	36,024.18	S/L	35.00
432	WATER TREATMENT EQUIPMENT	7/01/01	2,461.00	0.00	0.00	1,827.71	70.31	1,898.02	562.98	S/L	35.00
433	WATER TREATMENT EQUIPMENT	7/01/04	22,500.00	0.00	0.00	13,564.30	642.86	14,207.16	8,292.84	S/L	35.00
498	NEW WATER PLANT	6/30/08	6,189,620.23	0.00	0.00	1,934,256.37	154,740.51	2,088,996.88	4,100,623.35	S/L	40.00
502	WATER TREATMENT EQUIPMENT	6/30/09	31,442.00	0.00	0.00	12,666.62	898.34	13,564.96	17,877.04	S/L	35.00
667	WATER TREATMENT EQUIPMENT	6/30/18	128,739.85	0.00	0.00	9,195.70	3,678.28	12,873.98	115,865.87	S/L	35.00
320-30 WATER TRTMT EQUIP			6,852,277.08	0.00 c	0.00	2,404,926.60	165,881.04	2,570,807.64	4,281,469.44		
	320 Water Treatment Equip		6,852,277.08	0.00 c	0.00	2,404,926.60	165,881.04	2,570,807.64	4,281,469.44		
Group: 330 Dist. Reservoirs & St											
Location: 330-40 DIST RES/STANDPIPE											
265	DIST RESERVOIRS & STANDPIPES	7/01/04	89,959.77	0.00	0.00	29,686.80	1,799.20	31,486.00	58,473.77	S/L	50.00
266	DISTB. RESERVOIRS & STANDPIPES	1/01/78	309,159.00	0.00	0.00	262,781.42	6,183.18	268,964.60	40,194.40	S/L	50.00
267	DISTB. RESERVOIRS & STANDPIPES	1/01/79	37,509.00	0.00	0.00	31,129.42	750.18	31,879.60	5,629.40	S/L	50.00
268	DISTB. RESERVOIRS & STANDPIPES	1/01/80	8,317.00	0.00	0.00	6,813.46	166.34	6,979.80	1,337.20	S/L	50.00
269	DISTB. RESERVOIRS & STANDP	7/01/86	217,958.00	0.00	0.00	150,389.04	4,359.16	154,748.20	63,209.80	S/L	50.00
270	DIST RESERVOIR & STANDPIPE	7/01/02	850.00	0.00	0.00	323.00	17.00	340.00	510.00	S/L	50.00
271	DIST RESERVOIRS & STANDPIPE	7/01/03	775,776.26	0.00	0.00	271,521.77	15,515.53	287,037.30	488,738.96	S/L	50.00
272	FENCE AT PLANT	7/01/87	6,495.00	0.00	0.00	4,353.10	129.90	4,483.00	2,012.00	S/L	50.00
273	TANK-CONDEM, LAND	7/01/88	7,540.00	0.00	0.00	4,903.20	150.80	5,054.00	2,486.00	S/L	50.00
274	WATER TANK	7/01/89	21,851.00	0.00	0.00	13,766.38	437.02	14,203.40	7,647.60	S/L	50.00
275	RESERVOIRS AND STANDPIPES	7/01/90	308.00	0.00	0.00	186.04	6.16	192.20	115.80	S/L	50.00
276	VAUGHN RIDGE TANK	2/28/00	577,509.00	0.00	0.00	242,553.42	11,550.18	254,103.60	323,405.40	S/L	50.00
330-40 DIST RES/STANDPIPE			2,053,232.03	0.00 c	0.00	1,018,407.05	41,064.65	1,059,471.70	993,760.33		
	330 Dist. Reservoirs & St		2,053,232.03	0.00 c	0.00	1,018,407.05	41,064.65	1,059,471.70	993,760.33		
Group: 331 Trans & Dist											
Location: 331-40 TRANS & DIST MAINS											
277	TRANSPORTATION & DISTB. MAINS	1/01/71	478,716.00	0.00	0.00	478,716.00	0.00	478,716.00	0.00	S/L	40.00
278	TRANSPORTATION & DISTB. MAINS	1/01/71	2,820.00	0.00	0.00	2,783.60	36.40	2,820.00	0.00	S/L	50.00
279	TRANSPORTATION & DISTB. MAINS	1/01/72	5,541.00	0.00	0.00	5,378.58	110.82	5,489.40	51.60	S/L	50.00
280	TRANSPORTATION & DISTB. MAINS	1/01/73	8,611.00	0.00	0.00	8,176.18	172.22	8,348.40	262.60	S/L	50.00
281	TRANSPORTATION & DISTB. MAINS	1/01/74	13,390.00	0.00	0.00	12,456.20	267.80	12,724.00	666.00	S/L	50.00
282	TRANSPORTATION & DISTB. MAINS	1/01/75	2,332.00	0.00	0.00	2,129.16	46.64	2,175.80	156.20	S/L	50.00
283	TRANSPORTATION & DISTB. MAINS	1/01/76	4,894.00	0.00	0.00	4,357.72	97.88	4,455.60	438.40	S/L	50.00
284	TRANSPORTATION & DISTB. MAINS	1/01/76	23,117.00	0.00	0.00	20,567.46	462.34	21,029.80	2,087.20	S/L	50.00
285	TRANSPORTATION & DISTB. MAINS	1/01/77	8,196.00	0.00	0.00	7,132.48	163.92	7,296.40	899.60	S/L	50.00
286	TRANSPORTATION & DISTB. MAINS	1/01/78	564,370.00	0.00	0.00	479,706.60	11,287.40	490,994.00	73,376.00	S/L	50.00
287	TRANSPORTATION & DISTB. MAINS	1/01/79	35,911.00	0.00	0.00	29,802.18	718.22	30,520.40	5,390.60	S/L	50.00
288	TRANSPORTATION & DISTB. MAINS	1/01/80	14,145.00	0.00	0.00	11,601.10	282.90	11,884.00	2,261.00	S/L	50.00
289	TRANSPORTATION & DISTB. MAINS	1/01/81	32,591.00	0.00	0.00	25,749.58	651.82	26,401.40	6,189.60	S/L	50.00
290	TRANSPORTATION & DISTB. MAINS	1/01/81	25,229.00	0.00	0.00	19,935.02	504.58	20,439.60	4,789.40	S/L	50.00
291	TRANSPORTATION & DISTB. MAINS	1/01/82	8,512.00	0.00	0.00	6,635.56	170.24	6,805.80	1,706.20	S/L	50.00
292	TRANSPORTATION & DISTB. MAINS	1/01/83	56,767.00	0.00	0.00	43,137.46	1,135.34	44,272.80	12,494.20	S/L	50.00
293	TRANSPORTATION & DISTB. MAINS	1/01/84	54,324.00	0.00	0.00	40,193.12	1,086.48	41,279.60	13,044.40	S/L	50.00
294	TRANSMISSION & DIST MA	1/01/85	29,910.00	0.00	0.00	21,532.80	598.20	22,131.00	7,779.00	S/L	50.00
295	TRANSMISSION & DIST. MA	7/01/86	81,085.00	0.00	0.00	55,953.30	1,621.70	57,575.00	23,510.00	S/L	50.00
296	TRANSMISSION & DIST MA	7/01/87	10,667.00	0.00	0.00	7,142.46	213.34	7,355.80	3,311.20	S/L	50.00
297	TRANS. & DIST MAINS	7/01/88	1,353,276.00	0.00	0.00	879,635.88	27,065.52	906,701.40	446,574.60	S/L	50.00
298	TRANS AND DIST MAINS	7/01/90	11,597.00	0.00	0.00	7,074.86	231.94	7,306.80	4,290.20	S/L	50.00

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
299	TRANS. & DIST MAINS	7/01/91	3,894.00	0.00	0.00	2,298.72	77.88	2,376.60	1,517.40	S/L	50.00
300	TRANS. AND DIST MAINS	7/01/92	345,515.00	0.00	0.00	196,940.70	6,910.30	203,851.00	141,664.00	S/L	50.00
301	TRANS AND DIST MAINS	7/01/93	118,225.00	0.00	0.00	68,574.50	2,364.50	70,939.00	47,286.00	S/L	50.00
302	TRANS & DIST MAINS	7/01/94	67,464.00	0.00	0.00	35,754.32	1,349.28	37,103.60	30,360.40	S/L	50.00
303	TRANS & DIST MAINS	7/01/95	530,642.00	0.00	0.00	270,627.96	10,612.84	281,240.80	249,401.20	S/L	50.00
304	TRANS & DIST MAINS	7/01/96	31,751.00	0.00	0.00	15,558.38	635.02	16,193.40	15,557.60	S/L	50.00
305	TRANS & DIST MAINS	7/01/97	60,545.00	0.00	0.00	28,456.10	1,210.90	29,667.00	30,878.00	S/L	50.00
306	TRANS & DIST MAINS	7/01/98	6,798.00	0.00	0.00	3,059.24	135.96	3,195.20	3,602.80	S/L	50.00
307	TRANS & DIST MAINS	7/01/99	22,966.00	0.00	0.00	9,875.08	459.32	10,334.40	12,631.60	S/L	50.00
308	TRANS & DIST MAINS	7/01/00	724,853.00	0.00	0.00	304,438.14	14,497.06	318,935.20	405,917.80	S/L	50.00
309	TRANS & DIST MAINS	7/01/01	238,976.00	0.00	0.00	95,589.88	4,779.52	100,369.40	138,606.60	S/L	50.00
310	TRANS & DISTB MAINS	7/01/02	459,261.00	0.00	0.00	174,518.96	9,185.22	183,704.18	275,556.82	S/L	50.00
311	TRANS & DIST MAINS	7/01/03	278,089.63	0.00	0.00	97,331.33	5,561.79	102,893.12	175,196.51	S/L	50.00
312	TRANS & DIST MAINS	7/01/04	263,548.63	0.00	0.00	86,971.01	5,270.97	92,241.98	171,306.65	S/L	50.00
313	TRANS & DIST MAINS	7/01/05	2,690,484.17	0.00	0.00	834,050.04	53,809.68	887,859.72	1,802,624.45	S/L	50.00
314	TRANS & DIST MAINS	7/01/06	144,562.54	0.00	0.00	41,923.13	2,891.25	44,814.38	99,748.16	S/L	50.00
452	TRANS & DIST MAINS.	7/01/07	17,758.85	0.00	0.00	4,794.93	355.18	5,150.11	12,608.74	S/L	50.00
482	TRANS & DIST MAINS.	7/01/08	1,809,866.34	0.00	0.00	452,466.62	36,197.33	488,663.95	1,321,202.39	S/L	50.00
503	TRANSMISSION & DIST MAINS.	6/30/09	94,613.01	0.00	0.00	21,760.99	1,892.26	23,653.25	70,959.76	S/L	50.00
512	TRANS & DIST MAINS.	7/10/10	68,496.50	0.00	0.00	25,686.21	1,369.93	27,056.14	41,440.36	S/L	50.00
569	Trans & Dist Mains	7/01/11	20,737.24	0.00	0.00	3,940.03	414.74	4,354.77	16,382.47	S/L	50.00
579	Trans & Dist Mains	7/01/12	28,561.53	0.00	0.00	4,855.46	571.23	5,426.69	23,134.84	S/L	50.00
598	TRANSM & DISTRIB MAINS	6/30/13	81,177.96	0.00	0.00	10,147.27	1,352.97	11,500.24	69,677.72	S/L	60.00
607	TRANS & MAINS	6/30/14	11,742.08	0.00	0.00	1,272.05	195.70	1,467.75	10,274.33	S/L	60.00
620	TRANS DIST MAINS	6/30/15	7,346.25	0.00	0.00	673.42	122.44	795.86	6,550.39	S/L	60.00
631	TRANS & MAINS	6/30/16	54,295.56	0.00	0.00	4,072.18	904.93	4,977.11	49,318.45	S/L	60.00
650	TRANS & MAINS	6/30/17	15,739.52	0.00	0.00	1,101.77	314.79	1,416.56	14,322.96	S/L	50.00
668	TRANSIMISSION AND DISTRIBUTION M	6/30/18	18,089.20	0.00	0.00	904.45	361.78	1,266.23	16,822.97	S/L	50.00
684	TRANSMISSION AND DISTRIBUTION M	6/30/19	15,361.41	0.00	0.00	460.84	307.23	768.07	14,593.34	S/L	50.00
703	Capitalized Labor	6/30/20	16,517.39	0.00	0.00	412.93	825.87	1,238.80	15,278.59	S/L	20.00
723	Trans & Mains	2/09/21	5,790.54	0.00 c	0.00	0.00	265.40	265.40	5,525.14	S/L	20.00
331-40 TRANS & DIST MAINS			11,079,669.35	0.00 c	0.00	4,968,313.94	212,128.97	5,180,442.91	5,899,226.44		
	331 Trans & Dist		11,079,669.35	0.00 c	0.00	4,968,313.94	212,128.97	5,180,442.91	5,899,226.44		
Group: 333 Services											
Location:											
546	LATERAL KITS	7/01/01	61,399.00	0.00	0.00	61,399.00	0.00	61,399.00	0.00	S/L	10.00
547	VALVE BOXES	7/01/01	8,398.00	0.00	0.00	8,398.00	0.00	8,398.00	0.00	S/L	10.00
548	56,264 SERVICE LINES	7/01/01	140,660.00	0.00	0.00	121,319.00	14,066.00	135,385.00	5,275.00	S/L	10.00
549	SERVICES	7/01/01	533.00	0.00	0.00	533.00	0.00	533.00	0.00	S/L	10.00
550	SERVICES	7/01/02	23,192.00	0.00	0.00	23,192.00	0.00	23,192.00	0.00	S/L	10.00
551	SERVICES	7/01/03	11,217.13	0.00	0.00	11,217.13	0.00	11,217.13	0.00	S/L	10.00
552	SERVICES	7/01/04	11,325.49	0.00	0.00	11,325.49	0.00	11,325.49	0.00	S/L	10.00
553	SERVICES	7/01/05	41,599.93	0.00	0.00	41,599.93	0.00	41,599.93	0.00	S/L	10.00
554	SERVICES	7/01/06	29,328.98	0.00	0.00	29,328.98	0.00	29,328.98	0.00	S/L	10.00
555	SERVICES	7/01/07	32,002.29	0.00	0.00	32,002.29	0.00	32,002.29	0.00	S/L	10.00
556	SERVICES	7/01/08	130,689.98	0.00	0.00	130,689.98	0.00	130,689.98	0.00	S/L	10.00
557	SERVICES	7/01/09	146,685.33	0.00	0.00	146,685.33	0.00	146,685.33	0.00	S/L	10.00
558	SERVICES	7/01/10	89,191.17	0.00	0.00	89,191.17	0.00	89,191.17	0.00	S/L	10.00
575	Services	7/01/11	100,803.64	0.00	0.00	95,763.42	5,040.22	100,803.64	0.00	S/L	10.00
591	Services	7/01/12	130,537.73	0.00	0.00	88,112.96	13,053.77	101,166.73	29,371.00	S/L	10.00
603	SERVICES	6/30/13	49,701.95	0.00	0.00	18,224.05	3,313.46	21,537.51	28,164.44	S/L	15.00
616	Services	6/30/14	86,856.56	0.00	0.00	16,130.53	2,481.62	18,612.15	68,244.41	S/L	35.00
628	Services	6/30/15	123,379.82	0.00	0.00	19,388.27	3,525.14	22,913.41	100,466.41	S/L	35.00
647	SERVICES	6/30/16	99,326.46	0.00	0.00	44,696.92	9,932.65	54,629.57	44,696.89	S/L	10.00
655	SERVICES	6/30/17	144,917.47	0.00	0.00	16,907.03	4,830.58	21,737.61	123,179.86	S/L	30.00
664	SERVICES	6/30/18	38,148.87	0.00	0.00	4,768.60	1,907.44	6,676.04	31,472.83	S/L	20.00
699	SERVICES	6/30/19	120,411.80	0.00	0.00	6,020.59	4,013.73	10,034.32	110,377.48	S/L	30.00
717	SERVICES (WW)	6/30/20	160,819.72	0.00	0.00	2,680.33	5,360.66	8,040.99	152,778.73	S/L	30.00
732	Services WW	6/30/21	70,784.70	0.00 c	0.00	0.00	1,179.74	1,179.74	69,604.96	S/L	30.00
No Location			1,851,911.02	0.00 c	0.00	1,019,574.00	68,705.01	1,088,279.01	763,632.01		
Location: 333-40 SERVICES											
315	SERVICES	1/01/71	81,120.00	0.00	0.00	81,120.00	0.00	81,120.00	0.00	S/L	20.00
316	SERVICES	1/01/71	1,040.00	0.00	0.00	1,040.00	0.00	1,040.00	0.00	S/L	20.00
317	SERVICES	1/01/72	3,496.00	0.00	0.00	3,496.00	0.00	3,496.00	0.00	S/L	20.00
318	SERVICES	1/01/73	3,349.00	0.00	0.00	3,349.00	0.00	3,349.00	0.00	S/L	20.00
319	SERVICES	1/01/74	4,059.00	0.00	0.00	4,059.00	0.00	4,059.00	0.00	S/L	20.00
320	SERVICES	1/01/75	10,675.00	0.00	0.00	10,675.00	0.00	10,675.00	0.00	S/L	20.00
321	SERVICES	1/01/76	3,921.00	0.00	0.00	3,921.00	0.00	3,921.00	0.00	S/L	20.00
322	SERVICES	1/01/77	7,020.00	0.00	0.00	7,020.00	0.00	7,020.00	0.00	S/L	20.00
323	SERVICES	1/01/78	11,394.00	0.00	0.00	11,394.00	0.00	11,394.00	0.00	S/L	20.00
324	SERVICES	1/01/79	8,995.00	0.00	0.00	8,995.00	0.00	8,995.00	0.00	S/L	20.00
325	SERVICES	1/01/80	12,453.00	0.00	0.00	12,453.00	0.00	12,453.00	0.00	S/L	20.00
326	SERVICES	1/01/81	7,257.00	0.00	0.00	7,257.00	0.00	7,257.00	0.00	S/L	20.00
327	SERVICES	1/01/82	12,842.00	0.00	0.00	12,842.00	0.00	12,842.00	0.00	S/L	20.00
328	SERVICES	1/01/83	22,936.00	0.00	0.00	22,936.00	0.00	22,936.00	0.00	S/L	20.00
329	SERVICES	1/01/84	14,604.00	0.00	0.00	14,604.00	0.00	14,604.00	0.00	S/L	20.00
330	SERVICES	1/01/85	21,688.00	0.00	0.00	21,688.00	0.00	21,688.00	0.00	S/L	20.00
331	SERVICES	7/01/86	17,831.00	0.00	0.00	17,831.00	0.00	17,831.00	0.00	S/L	20.00

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
332	SERVICES	7/01/87	22,312.00	0.00	0.00	22,312.00	0.00	22,312.00	0.00	S/L	20.00
333	SERVICES	7/01/88	18,231.00	0.00	0.00	18,231.00	0.00	18,231.00	0.00	S/L	20.00
334	SERVICES	7/01/89	25,224.00	0.00	0.00	25,224.00	0.00	25,224.00	0.00	S/L	20.00
335	SERVICES	7/01/90	15,970.00	0.00	0.00	15,970.00	0.00	15,970.00	0.00	S/L	20.00
336	SERVICES	7/01/91	25,005.00	0.00	0.00	25,005.00	0.00	25,005.00	0.00	S/L	20.00
337	SERVICES	7/01/92	52,292.00	0.00	0.00	52,292.00	0.00	52,292.00	0.00	S/L	20.00
338	SERVICES	7/01/93	41,578.00	0.00	0.00	41,578.00	0.00	41,578.00	0.00	S/L	20.00
339	SERVICES	7/01/94	36,691.00	0.00	0.00	36,691.00	0.00	36,691.00	0.00	S/L	20.00
340	SERVICES	7/01/95	42,574.00	0.00	0.00	42,574.00	0.00	42,574.00	0.00	S/L	30.00
341	SERVICES	7/01/96	59,841.00	0.00	0.00	59,841.00	0.00	59,841.00	0.00	S/L	30.00
342	SERVICES	7/01/97	46,053.00	0.00	0.00	46,053.00	0.00	46,053.00	0.00	S/L	30.00
343	SERVICES	7/01/98	36,553.00	0.00	0.00	36,553.00	0.00	36,553.00	0.00	S/L	30.00
344	SERVICES	7/01/99	44,506.00	0.00	0.00	44,134.85	371.15	44,506.00	0.00	S/L	30.00
345	SERVICES	7/01/00	44,834.00	0.00	0.00	43,340.15	1,493.85	44,834.00	0.00	S/L	30.00
346	SERVICES	7/01/01	38,330.00	0.00	0.00	35,136.35	1,277.67	36,414.02	1,915.98	S/L	30.00
347	SERVICES	7/01/02	68,512.00	0.00	0.00	59,377.45	2,283.73	61,661.18	6,850.82	S/L	30.00
348	SERVICES	7/01/03	73,176.63	0.00	0.00	57,931.48	2,439.22	60,370.70	12,805.93	S/L	30.00
349	SERVICES	7/01/04	58,560.82	0.00	0.00	43,432.61	1,952.03	45,384.64	13,176.18	S/L	30.00
350	SERVICES	7/01/05	60,973.81	0.00	0.00	42,173.55	2,032.46	44,206.01	16,767.80	S/L	30.00
351	SERVICES	7/01/06	75,865.96	0.00	0.00	48,680.70	2,528.87	51,209.57	24,656.39	S/L	30.00
453	SERVICES	7/01/07	84,231.70	0.00	0.00	22,742.51	1,684.63	24,427.14	59,804.56	S/L	50.00
483	SERVICES	7/01/08	60,435.80	0.00	0.00	32,736.08	2,014.53	34,750.61	25,685.19	S/L	30.00
504	SERVICES	6/30/09	60,144.26	0.00	0.00	29,570.92	2,004.81	31,575.73	28,568.53	S/L	30.00
513	SERVICES	7/01/10	20,177.98	0.00	0.00	8,911.95	672.60	9,584.55	10,593.43	S/L	30.00
570	Services	7/01/11	47,620.30	0.00	0.00	29,365.84	1,587.34	30,953.18	16,667.12	S/L	30.00
580	Services	7/01/12	48,857.57	0.00	0.00	25,243.11	1,628.59	26,871.70	21,985.87	S/L	30.00
599	SERVICES	6/30/13	11,820.59	0.00	0.00	2,216.33	295.51	2,511.84	9,308.75	S/L	40.00
608	SERVICES	6/30/14	23,999.11	0.00	0.00	3,899.87	599.98	4,499.85	19,499.26	S/L	40.00
621	SERVICES	6/30/15	51,233.86	0.00	0.00	7,044.67	1,280.85	8,325.52	42,908.34	S/L	40.00
632	SERVICES	6/30/16	48,542.28	0.00	0.00	5,461.02	1,213.56	6,674.58	41,867.70	S/L	40.00
651	SERVICES	6/30/17	103,228.03	0.00	0.00	12,043.26	3,440.93	15,484.19	87,743.84	S/L	30.00
669	SERVICES	6/30/18	47,052.24	0.00	0.00	3,921.02	1,568.41	5,489.43	41,562.81	S/L	30.00
683	SERVICES	6/30/19	35,797.66	0.00	0.00	1,789.89	1,193.26	2,983.15	32,814.51	S/L	30.00
704	SERVICES	6/30/20	30,678.79	0.00	0.00	511.31	1,022.63	1,533.94	29,144.85	S/L	30.00
724	Services	6/30/21	21,626.45	0.00 c	0.00	0.00	360.44	360.44	21,266.01	S/L	30.00
333-40 SERVICES			1,827,209.84	0.00 c	0.00	1,226,668.92	34,947.05	1,261,615.97	565,593.87		
		333 Services	3,679,120.86	0.00 c	0.00	2,246,242.92	103,652.06	2,349,894.98	1,329,225.88		
Group: 334 Meters & Meter Instal											
Location: 334-40 METERS											
352	METERS	1/01/71	4,613.00	0.00	0.00	4,613.00	0.00	4,613.00	0.00	S/L	20.00
353	METERS	1/01/72	39.00	0.00	0.00	39.00	0.00	39.00	0.00	S/L	20.00
354	METERS	1/01/73	9,233.00	0.00	0.00	9,233.00	0.00	9,233.00	0.00	S/L	20.00
355	METERS	1/01/74	4,361.00	0.00	0.00	4,361.00	0.00	4,361.00	0.00	S/L	20.00
356	METERS	1/01/75	9,006.00	0.00	0.00	9,006.00	0.00	9,006.00	0.00	S/L	20.00
357	METERS	1/01/76	3,427.00	0.00	0.00	3,427.00	0.00	3,427.00	0.00	S/L	20.00
358	METERS	1/01/77	16,147.00	0.00	0.00	16,147.00	0.00	16,147.00	0.00	S/L	20.00
359	METERS	1/01/78	8,753.00	0.00	0.00	8,753.00	0.00	8,753.00	0.00	S/L	20.00
360	METERS	1/01/79	10,180.00	0.00	0.00	10,180.00	0.00	10,180.00	0.00	S/L	20.00
361	METERS	1/01/80	26,866.00	0.00	0.00	26,866.00	0.00	26,866.00	0.00	S/L	20.00
362	METERS	1/01/81	8,870.00	0.00	0.00	8,870.00	0.00	8,870.00	0.00	S/L	20.00
363	METERS	1/01/82	12,223.00	0.00	0.00	12,223.00	0.00	12,223.00	0.00	S/L	20.00
364	METERS	1/01/83	11,055.00	0.00	0.00	11,055.00	0.00	11,055.00	0.00	S/L	20.00
365	METERS	1/01/84	12,966.00	0.00	0.00	12,966.00	0.00	12,966.00	0.00	S/L	20.00
366	METERS	7/01/86	11,825.00	0.00	0.00	11,825.00	0.00	11,825.00	0.00	S/L	20.00
367	METERS	7/01/87	4,127.00	0.00	0.00	4,127.00	0.00	4,127.00	0.00	S/L	20.00
368	METERS	7/01/89	5,412.00	0.00	0.00	5,412.00	0.00	5,412.00	0.00	S/L	20.00
369	METERS	7/01/90	21,940.00	0.00	0.00	21,940.00	0.00	21,940.00	0.00	S/L	20.00
370	METERS	7/01/91	5,230.00	0.00	0.00	5,230.00	0.00	5,230.00	0.00	S/L	20.00
371	METERS	7/01/92	7,281.00	0.00	0.00	7,281.00	0.00	7,281.00	0.00	S/L	20.00
372	METERS	7/01/93	19,442.00	0.00	0.00	19,442.00	0.00	19,442.00	0.00	S/L	20.00
373	METERS	7/04/94	1,565.00	0.00	0.00	1,565.00	0.00	1,565.00	0.00	S/L	20.00
374	METERS	7/01/95	14,968.00	0.00	0.00	14,968.00	0.00	14,968.00	0.00	S/L	35.00
375	METERS	7/01/97	14,924.00	0.00	0.00	14,924.00	0.00	14,924.00	0.00	S/L	35.00
376	METERS	7/01/99	34,122.00	0.00	0.00	33,024.95	974.91	33,999.86	122.14	S/L	35.00
377	METERS	7/01/00	50,283.00	0.00	0.00	47,409.40	1,436.66	48,846.06	1,436.94	S/L	35.00
378	METERS	7/01/01	66,762.00	0.00	0.00	59,608.85	1,907.49	61,516.34	5,245.66	S/L	35.00
379	METERS	7/01/02	143,868.00	0.00	0.00	121,259.75	4,110.51	125,370.26	18,497.74	S/L	35.00
380	METERS	7/01/03	53,047.51	0.00	0.00	40,732.95	1,515.64	42,248.59	10,798.92	S/L	35.00
381	METERS	7/01/04	36,137.08	0.00	0.00	25,941.23	1,032.49	26,973.72	9,163.36	S/L	35.00
382	METERS	7/01/05	120,746.28	0.00	0.00	80,641.21	3,449.89	84,091.10	36,655.18	S/L	35.00
383	METERS	7/01/06	33,969.45	0.00	0.00	20,988.27	970.56	21,958.83	12,010.62	S/L	35.00
455	METERS	7/01/07	76,011.82	0.00	0.00	43,163.87	2,171.77	45,335.64	30,676.18	S/L	35.00
484	METERS	7/01/08	21,073.30	0.00	0.00	10,912.97	602.09	11,515.06	9,558.24	S/L	35.00
505	METERS	6/30/09	31,888.38	0.00	0.00	14,919.23	911.10	15,830.33	16,058.05	S/L	35.00
514	METERS	7/01/10	64,793.34	0.00	0.00	27,074.38	1,851.24	28,925.62	35,867.72	S/L	35.00
571	Meters	7/01/11	24,642.79	0.00	0.00	9,065.03	704.08	9,769.11	14,873.68	S/L	35.00
581	Meters	7/01/12	75,317.27	0.00	0.00	23,940.11	2,151.92	26,092.03	49,225.24	S/L	35.00
600	METERS	6/30/13	35,912.71	0.00	0.00	5,985.45	798.06	6,783.51	29,129.20	S/L	45.00
609	METER & METER INSTALLATIONS	6/30/14	113,875.04	0.00	0.00	16,448.64	2,530.56	18,979.20	94,895.84	S/L	45.00

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
622	METER & METER INSTALLATION	6/30/15	16,246.92	0.00	0.00	1,985.72	361.04	2,346.76	13,900.16	S/L	45.00
633	METERS & INSTALLATION	6/30/16	19,505.96	0.00	0.00	1,950.61	433.47	2,384.08	17,121.88	S/L	45.00
652	METERS	6/30/17	80,682.78	0.00	0.00	8,068.27	2,305.22	10,373.49	70,309.29	S/L	35.00
670	METERS	6/30/18	85,518.03	0.00	0.00	6,108.43	2,443.37	8,551.80	76,966.23	S/L	35.00
685	METERS	6/30/19	22,431.74	0.00	0.00	961.36	640.91	1,602.27	20,829.47	S/L	35.00
705	METERS	6/30/20	35,327.09	0.00	0.00	504.67	1,009.35	1,514.02	33,813.07	S/L	35.00
725	Meters	6/30/21	10,597.79	0.00 c	0.00	0.00	151.40	151.40	10,446.39	S/L	35.00
334-40 METERS			1,497,213.28	0.00 c	0.00	845,148.35	34,463.73	879,612.08	617,601.20		
Location: 334-41 METER INSTALLATION											
384	METER INSTALLATION	1/01/72	8,901.00	0.00	0.00	8,901.00	0.00	8,901.00	0.00	S/L	20.00
385	METER INST.	7/01/90	1,168.00	0.00	0.00	1,168.00	0.00	1,168.00	0.00	S/L	20.00
334-41 METER INSTALLATION			10,069.00	0.00 c	0.00	10,069.00	0.00	10,069.00	0.00		
	334 Meters & Meter Instal		1,507,282.28	0.00 c	0.00	855,217.35	34,463.73	889,681.08	617,601.20		
Group: 335 Hydrants											
Location: 335-40 HYDRANTS											
386	HYDRANTS	1/01/71	7,375.00	0.00	0.00	7,375.00	0.00	7,375.00	0.00	S/L	20.00
387	HYDRANTS	1/01/76	546.00	0.00	0.00	546.00	0.00	546.00	0.00	S/L	20.00
388	HYDRANTS	1/01/77	217.00	0.00	0.00	217.00	0.00	217.00	0.00	S/L	20.00
389	HYDRANTS	1/01/78	46,133.00	0.00	0.00	46,133.00	0.00	46,133.00	0.00	S/L	20.00
390	HYDRANTS	1/01/82	300.00	0.00	0.00	300.00	0.00	300.00	0.00	S/L	20.00
391	HYDRANTS	7/01/86	614.00	0.00	0.00	614.00	0.00	614.00	0.00	S/L	20.00
392	HYDRANTS	7/01/89	1,021.00	0.00	0.00	1,021.00	0.00	1,021.00	0.00	S/L	20.00
393	HYDRANTS	7/01/91	3,310.00	0.00	0.00	3,310.00	0.00	3,310.00	0.00	S/L	20.00
394	HYDRANTS	7/01/92	79.00	0.00	0.00	79.00	0.00	79.00	0.00	S/L	20.00
395	HYDRANTS	7/01/93	42.00	0.00	0.00	42.00	0.00	42.00	0.00	S/L	20.00
396	HYDRANTS	7/01/98	5,941.00	0.00	0.00	5,941.00	0.00	5,941.00	0.00	S/L	40.00
397	HYDRANTS	7/01/01	7,174.00	0.00	0.00	6,277.55	179.35	6,456.90	717.10	S/L	40.00
398	HYDRANTS	7/01/02	2,151.00	0.00	0.00	1,775.05	53.78	1,828.83	322.17	S/L	40.00
399	HYDRANTS	7/01/03	4,053.91	0.00	0.00	3,040.50	101.35	3,141.85	912.06	S/L	40.00
400	HYDRANTS	7/01/04	7,935.32	0.00	0.00	5,554.75	198.38	5,753.13	2,182.19	S/L	40.00
401	HYDRANTS	7/01/06	25,967.08	0.00	0.00	15,580.23	649.18	16,229.41	9,737.67	S/L	40.00
454	HYDRANTS	7/01/07	8,792.00	0.00	0.00	4,835.60	219.80	5,055.40	3,736.60	S/L	40.00
485	HYDRANTS	7/01/08	6,349.91	0.00	0.00	3,175.00	158.75	3,333.75	3,016.16	S/L	40.00
506	HYDRANTS	6/30/09	6,531.78	0.00	0.00	2,939.28	163.29	3,102.57	3,429.21	S/L	40.00
515	HYDRANTS	7/01/10	10,979.28	0.00	0.00	4,391.68	274.48	4,666.16	6,313.12	S/L	40.00
582	HYDRANTS	7/01/12	8,869.29	0.00	0.00	2,660.76	221.73	2,882.49	5,986.80	S/L	40.00
610	HYDRANTS	6/30/14	10,191.69	0.00	0.00	2,038.32	254.79	2,293.11	7,898.58	S/L	40.00
634	HYDRANTS	6/30/16	1,950.00	0.00	0.00	438.75	97.50	536.25	1,413.75	S/L	20.00
671	HYDRANTS	6/30/18	17,781.72	0.00	0.00	1,111.35	444.54	1,555.89	16,225.83	S/L	40.00
686	HYDRANTS	6/30/19	19,550.71	0.00	0.00	733.15	488.77	1,221.92	18,328.79	S/L	40.00
335-40 HYDRANTS			203,855.69	0.00 c	0.00	120,129.97	3,505.69	123,635.66	80,220.03		
	335 Hydrants		203,855.69	0.00 c	0.00	120,129.97	3,505.69	123,635.66	80,220.03		
Group: 339 Other Plant & Equip											
Location: 339-20 TEMPORARY DAMS											
256	TEMPORARY DAMS	1/01/71	21,732.00	0.00	0.00	21,732.00	0.00	21,732.00	0.00	S/L	50.00
339-20 TEMPORARY DAMS			21,732.00	0.00 c	0.00	21,732.00	0.00	21,732.00	0.00		
	339 Other Plant & Equip		21,732.00	0.00 c	0.00	21,732.00	0.00	21,732.00	0.00		
Group: 340 Office Furn. & Equip											
Location: 340-50 OFFICE FURN/EQUIP											
17	FILING CABNET, SAFE, DESK	1/01/75	382.00	0.00	0.00	382.00	0.00	382.00	0.00	S/L	10.00
18	FENCE	1/01/81	1,678.00	0.00	0.00	1,678.00	0.00	1,678.00	0.00	S/L	10.00
20	OFFICE FURN. & EQUIPMENT	1/01/82	1,017.00	0.00	0.00	1,017.00	0.00	1,017.00	0.00	S/L	10.00
21	FENCE	1/01/84	3,179.00	0.00	0.00	3,179.00	0.00	3,179.00	0.00	S/L	10.00
22	AIR CONDITIONER	1/01/84	965.00	0.00	0.00	965.00	0.00	965.00	0.00	S/L	10.00
23	HEAT PUMP	1/01/85	2,820.00	0.00	0.00	2,820.00	0.00	2,820.00	0.00	S/L	10.00
24	COPIER	1/01/85	1,844.00	0.00	0.00	1,844.00	0.00	1,844.00	0.00	S/L	10.00
25	COMPUTER SOFTWARE	1/01/88	8,300.00	0.00	0.00	8,300.00	0.00	8,300.00	0.00	S/L	10.00
26	OFFICE FURNITURE	1/01/88	3,942.00	0.00	0.00	3,942.00	0.00	3,942.00	0.00	S/L	10.00
27	4 DESKS, 2 CHAIRS	5/09/88	650.00	0.00	0.00	650.00	0.00	650.00	0.00	S/L	10.00
28	CALCULATOR, 3 CHAIRS	8/08/88	642.00	0.00	0.00	642.00	0.00	642.00	0.00	S/L	10.00
29	5 CUSTOM BLINDS	11/14/88	366.00	0.00	0.00	366.00	0.00	366.00	0.00	S/L	10.00
30	DESK-PEGGY'S OFFICE	6/01/89	2,175.00	0.00	0.00	2,175.00	0.00	2,175.00	0.00	S/L	10.00
31	DESK-ELMO'S OFFICE	6/01/89	1,400.00	0.00	0.00	1,400.00	0.00	1,400.00	0.00	S/L	10.00
32	TABLE-COMPUTER ROOM	6/01/89	540.00	0.00	0.00	540.00	0.00	540.00	0.00	S/L	10.00
33	TABLE	6/01/89	400.00	0.00	0.00	400.00	0.00	400.00	0.00	S/L	10.00
34	APPLIANCES - VARIOUS	5/19/89	4,033.00	0.00	0.00	4,033.00	0.00	4,033.00	0.00	S/L	10.00
35	OFFICE FURNITURE	2/21/89	2,361.00	0.00	0.00	2,361.00	0.00	2,361.00	0.00	S/L	10.00
37	OFFICE FURNITURE	3/13/89	1,240.00	0.00	0.00	1,240.00	0.00	1,240.00	0.00	S/L	10.00
38	COMPUTER EQUIPMENT	7/01/89	25,090.00	0.00	0.00	25,090.00	0.00	25,090.00	0.00	S/L	10.00
39	TABLE 4-CHAIRS	5/17/89	270.00	0.00	0.00	270.00	0.00	270.00	0.00	S/L	10.00
41	COMPUTER EQUIPMENT	7/10/89	1,220.00	0.00	0.00	1,220.00	0.00	1,220.00	0.00	S/L	10.00
42	10 CHAIRS-NEW OFFICE	8/14/89	500.00	0.00	0.00	500.00	0.00	500.00	0.00	S/L	10.00
43	2 COMPUTER SCREENS	11/13/89	1,219.00	0.00	0.00	1,219.00	0.00	1,219.00	0.00	S/L	10.00
44	COMPUTER & SOFTWARE	7/01/90	3,157.00	0.00	0.00	3,157.00	0.00	3,157.00	0.00	S/L	10.00

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
45	TYPEWRITER & 2 FOLDING TABLES	7/01/90	472.00	0.00	0.00	472.00	0.00	472.00	0.00	S/L	10.00
46	OFFICE BLINDS	7/01/90	2,430.00	0.00	0.00	2,430.00	0.00	2,430.00	0.00	S/L	10.00
47	COMPUTER TERMINAL	4/01/93	575.00	0.00	0.00	575.00	0.00	575.00	0.00	S/L	10.00
48	COMPUTER PROGRAM-AP & GL	5/01/93	1,490.00	0.00	0.00	1,490.00	0.00	1,490.00	0.00	S/L	10.00
49	COMPUTER	3/11/91	2,020.00	0.00	0.00	2,020.00	0.00	2,020.00	0.00	S/L	10.00
50	(2) TYPEWRITERS	11/11/91	1,250.00	0.00	0.00	1,250.00	0.00	1,250.00	0.00	S/L	10.00
51	COMPUTER PROGRAM-WO	10/01/93	1,500.00	0.00	0.00	1,500.00	0.00	1,500.00	0.00	S/L	10.00
52	COMPUTER	11/01/93	1,920.00	0.00	0.00	1,920.00	0.00	1,920.00	0.00	S/L	10.00
53	SOFTWARE	7/01/92	5,880.00	0.00	0.00	5,880.00	0.00	5,880.00	0.00	S/L	10.00
54	COMPUTER	7/01/92	20,125.00	0.00	0.00	20,125.00	0.00	20,125.00	0.00	S/L	10.00
55	COMPUTER	7/01/93	1,390.00	0.00	0.00	1,390.00	0.00	1,390.00	0.00	S/L	10.00
56	PRINTER	9/01/93	695.00	0.00	0.00	695.00	0.00	695.00	0.00	S/L	10.00
57	OKIDATA PRINTER	3/14/94	525.00	0.00	0.00	525.00	0.00	525.00	0.00	S/L	10.00
60	DESK AND SHELVES	4/30/94	400.00	0.00	0.00	400.00	0.00	400.00	0.00	S/L	10.00
61	SOFTWARE	2/28/94	475.00	0.00	0.00	475.00	0.00	475.00	0.00	S/L	10.00
62	EMB DEVICE	4/30/94	695.00	0.00	0.00	695.00	0.00	695.00	0.00	S/L	10.00
63	128K RAM-FOR EMB DEVICES	10/01/95	1,480.00	0.00	0.00	1,480.00	0.00	1,480.00	0.00	S/L	10.00
64	EMB DEVICE	7/01/95	695.00	0.00	0.00	695.00	0.00	695.00	0.00	S/L	10.00
65	OFFICE FURNITURE-EULA'S OFFICE	1/11/96	800.00	0.00	0.00	800.00	0.00	800.00	0.00	S/L	10.00
66	TABLE-PEGGY'S OFFICE	1/15/96	225.00	0.00	0.00	225.00	0.00	225.00	0.00	S/L	10.00
67	ENTRA/P133/MONITOR/PRINTER	3/22/96	4,336.00	0.00	0.00	4,336.00	0.00	4,336.00	0.00	S/L	10.00
68	AIR CONDITIONER 3 1/2 TON	6/10/97	1,810.00	0.00	0.00	1,810.00	0.00	1,810.00	0.00	S/L	10.00
69	P.C.	8/26/97	2,250.00	0.00	0.00	2,250.00	0.00	2,250.00	0.00	S/L	10.00
71	DESK CABINETS & TOPS	8/26/97	1,150.00	0.00	0.00	1,150.00	0.00	1,150.00	0.00	S/L	10.00
72	COMPUTER HARDWARE	3/01/98	18,715.00	0.00	0.00	18,715.00	0.00	18,715.00	0.00	S/L	10.00
74	PC & PRINTER	2/20/99	1,495.00	0.00	0.00	1,495.00	0.00	1,495.00	0.00	S/L	10.00
75	EMB HANDHELDS	7/06/99	1,504.00	0.00	0.00	1,504.00	0.00	1,504.00	0.00	S/L	10.00
76	HAND HLE METER READERS	3/31/00	7,770.00	0.00	0.00	7,770.00	0.00	7,770.00	0.00	S/L	10.00
77	COMPUTER & PRINER	3/24/00	1,847.00	0.00	0.00	1,847.00	0.00	1,847.00	0.00	S/L	10.00
78	PAUL'S OFFICE FURNITURE	5/01/00	1,854.00	0.00	0.00	1,854.00	0.00	1,854.00	0.00	S/L	10.00
79	(3) SCANNERS	5/02/00	3,285.00	0.00	0.00	3,285.00	0.00	3,285.00	0.00	S/L	10.00
80	OKIPACEMARK4410 PRINTER	2/28/01	2,995.00	0.00	0.00	2,995.00	0.00	2,995.00	0.00	S/L	10.00
81	COMPUTER AND PRINTER	5/31/01	2,045.00	0.00	0.00	2,045.00	0.00	2,045.00	0.00	S/L	10.00
83	PLANT PRINTER	5/31/02	2,789.00	0.00	0.00	2,789.00	0.00	2,789.00	0.00	S/L	10.00
84	COMPUTER (PAUL)	6/30/02	1,880.00	0.00	0.00	1,880.00	0.00	1,880.00	0.00	S/L	10.00
85	24 PRINTER	1/31/03	3,029.00	0.00	0.00	3,029.00	0.00	3,029.00	0.00	S/L	10.00
86	OFFICE EQUIPMENT	4/30/03	1,090.00	0.00	0.00	1,090.00	0.00	1,090.00	0.00	S/L	10.00
87	FURNITURE (BRAD'S OFFICE)	7/31/03	1,503.00	0.00	0.00	1,503.00	0.00	1,503.00	0.00	S/L	10.00
88	DELL COMPUTER	10/31/03	2,887.00	0.00	0.00	2,887.00	0.00	2,887.00	0.00	S/L	10.00
89	COMPUTER (BRAD)	11/30/03	1,049.00	0.00	0.00	1,049.00	0.00	1,049.00	0.00	S/L	10.00
90	COMPUTER - PLANT	7/01/04	2,976.00	0.00	0.00	2,976.00	0.00	2,976.00	0.00	S/L	10.00
91	PRINTER/RELOAD SYSTEM/MEMORY-	7/01/04	2,078.00	0.00	0.00	2,078.00	0.00	2,078.00	0.00	S/L	10.00
92	COMPUTER & PRINTER - LAB	7/01/04	1,873.00	0.00	0.00	1,873.00	0.00	1,873.00	0.00	S/L	10.00
93	COMPUTER SYSTEM, MODEM, TERMI	7/01/04	2,065.00	0.00	0.00	2,065.00	0.00	2,065.00	0.00	S/L	10.00
94	(10) 17 LCD MONITORS, SERVER UPGI	7/01/04	15,935.00	0.00	0.00	15,935.00	0.00	15,935.00	0.00	S/L	10.00
95	COMPUTER, MONITOR, WIRELESS NE	7/01/05	4,402.00	0.00	0.00	4,402.00	0.00	4,402.00	0.00	S/L	10.00
96	COMPUTER	7/01/06	3,781.90	0.00	0.00	3,781.90	0.00	3,781.90	0.00	S/L	10.00
435	COMPUTER DESK & CABINETS	4/27/07	2,100.00	0.00	0.00	2,100.00	0.00	2,100.00	0.00	S/L	20.00
436	DESK & CABINET	4/05/07	2,809.00	0.00	0.00	2,809.00	0.00	2,809.00	0.00	S/L	20.00
437	TRAVERSE SOFTWARE	3/30/07	2,385.00	0.00	0.00	2,385.00	0.00	2,385.00	0.00	S/L	10.00
486	CHAIRS	3/31/08	5,308.35	0.00	0.00	5,308.35	0.00	5,308.35	0.00	S/L	20.00
487	OFFICE COPIER	8/30/08	3,039.00	0.00	0.00	3,039.00	0.00	3,039.00	0.00	S/L	10.00
507	UNITED SYSTEMS	6/30/09	29,851.17	0.00	0.00	26,866.08	1,492.56	28,358.64	1,492.53	S/L	20.00
516	OFFICE FURNITURE	7/01/10	5,312.98	0.00	0.00	4,250.40	265.65	4,516.05	796.93	S/L	20.00
567	FURNACE	1/01/81	625.00	0.00	0.00	625.00	0.00	625.00	0.00	S/L	10.00
572	Office Furniture and Equipment	9/09/11	1,682.69	0.00	0.00	1,149.82	84.13	1,233.95	448.74	S/L	20.00
583	Office Furniture and Equipment	7/01/12	12,092.97	0.00	0.00	7,255.80	604.65	7,860.45	4,232.52	S/L	20.00
597	HVAC UNIT	11/07/13	11,725.00	0.00	0.00	3,991.48	556.95	4,548.43	7,176.57	S/L	20.00
611	OFFICE EQUIPMENT	6/30/14	30,806.79	0.00	0.00	12,322.72	1,540.34	13,863.06	16,943.73	S/L	20.00
623	OFFICE EQUIPTMENT	6/30/15	3,950.00	0.00	0.00	2,172.50	395.00	2,567.50	1,382.50	S/L	10.00
653	OFFICE FURNITURE	9/21/17	3,805.99	0.00	0.00	1,236.95	380.60	1,617.55	2,188.44	S/L	10.00
672	OFFICE FURNITURE	6/30/18	37,707.25	0.00	0.00	9,426.82	3,770.73	13,197.55	24,509.70	S/L	10.00
687	OFFICE FURNITURE	6/30/19	32,975.34	0.00	0.00	4,946.30	3,297.53	8,243.83	24,731.51	S/L	10.00
706	OFFICE FURNITURE	9/30/20	11,981.25	0.00	0.00	299.53	1,198.13	1,497.66	10,483.59	S/L	10.00
340-50 OFFICE FURN/EQUIP			410,983.68	0.00 c	0.00	303,010.65	13,586.27	316,596.92	94,386.76		
	340 Office Furn. & Equip		410,983.68	0.00 c	0.00	303,010.65	13,586.27	316,596.92	94,386.76		
Group: 341 Trans. Equipment											
Location: 341-50 TRANS EQUIP											
19	1992 GMC TRUCK	11/13/91	15,169.00	0.00	0.00	15,169.00	0.00	15,169.00	0.00	S/L	4.00
104	1993 GMC TRUCK	6/01/93	11,869.00	0.00	0.00	11,869.00	0.00	11,869.00	0.00	S/L	4.00
108	1996 INT'L TRUCK	7/03/95	37,464.00	0.00	0.00	37,464.00	0.00	37,464.00	0.00	S/L	4.00
110	96 F-250 P/U TRUCK	4/09/96	19,029.00	0.00	0.00	19,029.00	0.00	19,029.00	0.00	S/L	4.00
112	97 GMC SIERRA 4-WD P/U TRUCK	6/30/97	18,919.00	0.00	0.00	18,919.00	0.00	18,919.00	0.00	S/L	4.00
113	98 GMC 2 TON TRUCK	6/30/98	41,247.00	0.00	0.00	41,247.00	0.00	41,247.00	0.00	S/L	4.00
116	ONE TON TRUCK	7/02/99	25,307.00	0.00	0.00	25,307.00	0.00	25,307.00	0.00	S/L	4.00
118	2001 SERVICE PICK UP TRUCK	6/30/01	27,751.00	0.00	0.00	27,751.00	0.00	27,751.00	0.00	S/L	4.00
123	TRUCK & TRAILER	2/28/02	62,376.00	0.00	0.00	62,376.00	0.00	62,376.00	0.00	S/L	4.00
124	04 FORD PU SERVICE BODY & AUTO C	12/01/03	15,392.95	0.00	0.00	15,392.95	0.00	15,392.95	0.00	S/L	4.00
125	04 FORD PU	11/30/03	25,054.00	0.00	0.00	25,054.00	0.00	25,054.00	0.00	S/L	4.00

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
126	DODGE PU	10/31/03	27,154.00	0.00	0.00	27,154.00	0.00	27,154.00	0.00	S/L	4.00
129	2004 FORD F150	7/01/04	13,980.00	0.00	0.00	13,980.00	0.00	13,980.00	0.00	S/L	4.00
131	2005 GMC SIERRA 1500	7/01/04	15,070.75	0.00	0.00	15,070.75	0.00	15,070.75	0.00	S/L	4.00
132	CRANE FOR SERVICE TRUCK	7/01/04	811.61	0.00	0.00	811.61	0.00	811.61	0.00	S/L	4.00
133	???	7/01/05	36,189.14	0.00	0.00	36,189.14	0.00	36,189.14	0.00	S/L	4.00
134	05 FORD EXPLORER (BLUE)	7/01/06	19,999.00	0.00	0.00	19,999.00	0.00	19,999.00	0.00	S/L	4.00
217	GPS DATEBASE	8/31/03	3,333.33	0.00	0.00	3,333.33	0.00	3,333.33	0.00	S/L	10.00
222	MOLE HAMMERHEAD	7/01/05	4,140.00	0.00	0.00	4,140.00	0.00	4,140.00	0.00	S/L	15.00
449	2007 FORD F-150	6/22/07	19,980.00	0.00	0.00	19,980.00	0.00	19,980.00	0.00	S/L	4.00
450	2007 FORD F-150	6/22/07	19,980.00	0.00	0.00	19,980.00	0.00	19,980.00	0.00	S/L	4.00
490	DUMP TRUCK	12/31/08	56,880.00	0.00	0.00	56,880.00	0.00	56,880.00	0.00	S/L	10.00
585	GMC G7 TANKER	1/19/12	7,000.00	0.00	0.00	7,000.00	0.00	7,000.00	0.00	S/L	7.00
586	2012 FORD F-150	6/01/12	17,363.00	0.00	0.00	17,363.00	0.00	17,363.00	0.00	S/L	7.00
587	2012 FORD F-150	6/01/12	17,363.00	0.00	0.00	17,363.00	0.00	17,363.00	0.00	S/L	7.00
593	2013 FORD F-150 4WD	5/14/13	25,711.00	0.00	0.00	23,140.00	0.00	23,140.00	2,571.00	S/L	7.00
594	2013 FORD F-150 4WD	5/14/13	25,711.00	0.00	0.00	23,140.00	0.00	23,140.00	2,571.00	S/L	7.00
612	2014 FORD 150 4WD	5/12/14	21,402.00	0.00	0.00	21,402.00	0.00	21,402.00	0.00	S/L	7.00
613	FORD F-150 2WD	2/24/14	17,967.00	0.00	0.00	17,539.19	427.81	17,967.00	0.00	S/L	7.00
614	FORD F-150 2 WD	2/24/14	17,967.00	0.00	0.00	17,539.19	427.81	17,967.00	0.00	S/L	7.00
625	TRUCK	6/30/15	14,630.00	0.00	0.00	11,495.00	2,090.00	13,585.00	1,045.00	S/L	7.00
626	FORD F-150 4WD SUPEPRCAB	6/16/15	8,499.00	0.00	0.00	6,677.77	1,214.14	7,891.91	607.09	S/L	7.00
627	PUMPER	6/30/15	5,000.00	0.00	0.00	3,928.59	714.29	4,642.88	357.12	S/L	7.00
636	2016 FORD F150	2/09/16	25,456.00	0.00	0.00	25,031.73	424.27	25,456.00	0.00	S/L	5.00
637	2016 FORD F150	2/09/16	25,456.00	0.00	0.00	25,031.73	424.27	25,456.00	0.00	S/L	5.00
638	2017 FORD F150	12/12/16	21,256.00	0.00	0.00	17,359.07	3,896.93	21,256.00	0.00	S/L	5.00
640	2016 FORD F150 4X2	8/16/16	23,656.00	0.00	0.00	20,501.87	3,154.13	23,656.00	0.00	S/L	5.00
657	2017 F150 #61409	5/05/17	29,534.00	0.00	0.00	21,658.27	5,906.80	27,565.07	1,968.93	S/L	5.00
658	2017 F150 #61410	5/05/17	29,534.00	0.00	0.00	21,658.27	5,906.80	27,565.07	1,968.93	S/L	5.00
659	2017 RANGER RT188 BOAT & TRAILER	5/22/17	19,890.00	0.00	0.00	14,254.50	3,978.00	18,232.50	1,657.50	S/L	5.00
660	2017 SUPER DUTY F35	6/30/17	27,445.00	0.00	0.00	19,211.50	5,489.00	24,700.50	2,744.50	S/L	5.00
661	MOUNT 1 KNAPHEIDE SERVICE #EE10	6/30/17	15,895.00	0.00	0.00	11,126.50	3,179.00	14,305.50	1,589.50	S/L	5.00
673	2018 FORD 150 #70941	7/23/18	29,680.00	0.00	0.00	14,345.33	5,936.00	20,281.33	9,398.67	S/L	5.00
675	2019 FORD F-35 #39603	11/20/18	29,067.00	0.00	0.00	12,111.25	5,813.40	17,924.65	11,142.35	S/L	5.00
689	2019 FORD ESCAPE #85466	8/15/19	23,905.00	0.00	0.00	6,773.08	4,781.00	11,554.08	12,350.92	S/L	5.00
690	2019 FORD F-350 UPGRADE #39603	5/11/19	21,395.00	0.00	0.00	7,131.67	4,279.00	11,410.67	9,984.33	S/L	5.00
691	DUMP TRUCK	4/02/19	35,000.00	0.00	0.00	12,250.00	7,000.00	19,250.00	15,750.00	S/L	5.00
693	2019 Ford F-150 #34675	9/04/19	29,992.00	0.00	0.00	7,997.87	5,998.40	13,996.27	15,995.73	S/L	5.00
694	2019 Ford F-150 #83930	10/07/19	21,520.00	0.00	0.00	5,380.00	4,304.00	9,684.00	11,836.00	S/L	5.00
695	2019 Ford F-150 #63761	4/22/19	28,991.00	0.00	0.00	9,663.67	5,798.20	15,461.87	13,529.13	S/L	5.00
707	2020 FF-150 #34108	8/19/20	30,246.00	0.00	0.00	2,016.40	6,049.20	8,065.60	22,180.40	S/L	5.00
708	2020 F-150 #34107	8/19/20	30,246.00	0.00	0.00	2,016.40	6,049.20	8,065.60	22,180.40	S/L	5.00
709	2020 F-150 #80828	7/30/20	30,541.00	0.00	0.00	2,545.08	6,108.20	8,653.28	21,887.72	S/L	5.00
710	2020 F-150 #80829	7/30/20	30,541.00	0.00	0.00	2,545.08	6,108.20	8,653.28	21,887.72	S/L	5.00
711	2020 F-150 #37598	2/25/20	29,992.00	0.00	0.00	4,998.67	5,998.40	10,997.07	18,994.93	S/L	5.00
712	2020 F-150 #37600	2/25/20	29,992.00	0.00	0.00	4,998.67	5,998.40	10,997.07	18,994.93	S/L	5.00
713	2020 F-350 #08259	2/25/20	40,943.00	0.00	0.00	6,823.83	8,188.60	15,012.43	25,930.57	S/L	5.00
714	2020 F-150 #37601	2/18/20	29,992.00	0.00	0.00	4,998.67	5,998.40	10,997.07	18,994.93	S/L	5.00
715	UPGRADE - 2020 F-350 #08259	5/29/20	19,295.00	0.00	0.00	2,251.08	3,859.00	6,110.08	13,184.92	S/L	5.00
726	Ford Truck	3/11/21	32,317.00	0.00 c	0.00	0.00	5,386.17	5,386.17	26,930.83	S/L	5.00
727	Ford Truck	7/29/21	25,828.56	0.00 c	0.00	0.00	2,152.38	2,152.38	23,676.18	S/L	5.00
728	Ford Truck	8/18/21	25,995.00	0.00 c	0.00	0.00	1,733.00	1,733.00	24,262.00	S/L	5.00
729	Ford Truck	11/12/21	35,139.00	0.00 c	0.00	0.00	1,171.30	1,171.30	33,967.70	S/L	5.00
730	Ford Truck	11/12/21	35,139.00	0.00 c	0.00	0.00	1,171.30	1,171.30	33,967.70	S/L	5.00
341-50 TRANS EQUIP			1,559,587.34	0.00 c	0.00	968,363.71	147,115.00	1,115,478.71	444,108.63		
Location: 392-00 TRANSPORTATION EQU											
100	1992 GMC TRUCK	11/13/91	15,169.00	0.00	0.00	15,169.00	0.00	15,169.00	0.00	S/L	4.00
392-00 TRANSPORTATION EQU			15,169.00	0.00 c	0.00	15,169.00	0.00	15,169.00	0.00		
	341 Trans. Equipment		1,574,756.34	0.00 c	0.00	983,532.71	147,115.00	1,130,647.71	444,108.63		
Group: 344 Lab Equipment											
Location: 344-50 LAB EQUIP											
137	LABORATORY EQUIPMENT	1/01/77	1,820.00	0.00	0.00	1,820.00	0.00	1,820.00	0.00	S/L	5.00
138	MICROSCOPE	1/01/84	818.00	0.00	0.00	818.00	0.00	818.00	0.00	S/L	5.00
139	PORTABLE TESTER	7/01/90	1,496.00	0.00	0.00	1,496.00	0.00	1,496.00	0.00	S/L	5.00
140	LABORTARY EQUIPMENT	2/10/92	2,007.00	0.00	0.00	2,007.00	0.00	2,007.00	0.00	S/L	5.00
141	METER TEST TANK	3/03/92	1,750.00	0.00	0.00	1,750.00	0.00	1,750.00	0.00	S/L	5.00
142	METER TESTER	9/01/93	364.00	0.00	0.00	364.00	0.00	364.00	0.00	S/L	5.00
143	LAB EQUIPMENT	7/01/04	23,991.33	0.00	0.00	23,991.33	0.00	23,991.33	0.00	S/L	5.00
641	LAB EQUIPMENT	5/24/16	3,041.96	0.00	0.00	1,394.25	304.20	1,698.45	1,343.51	S/L	10.00
677	LAB EQUIPMENT	6/30/18	6,439.90	0.00	0.00	3,219.95	1,287.98	4,507.93	1,931.97	S/L	5.00
344-50 LAB EQUIP			41,728.19	0.00 c	0.00	36,860.53	1,592.18	38,452.71	3,275.48		
	344 Lab Equipment		41,728.19	0.00 c	0.00	36,860.53	1,592.18	38,452.71	3,275.48		
Group: 345 Power Operated											
Location: 345-50 POWER OP EQUIP											
130	TOOL BOXES & BEDMATS FOR NEW TI	7/01/04	957.00	0.00	0.00	957.00	0.00	957.00	0.00	S/L	4.00
144	POWER DR. EQUIP. BACKHOE	10/01/74	5,000.00	0.00	0.00	5,000.00	0.00	5,000.00	0.00	S/L	10.00
145	BORING MACHINE	8/01/74	3,731.00	0.00	0.00	3,731.00	0.00	3,731.00	0.00	S/L	10.00

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
147	1986 BORING MACHINE	7/01/86	6,220.00	0.00	0.00	6,220.00	0.00	6,220.00	0.00	S/L	10.00
149	AUGERS	11/07/91	3,154.00	0.00	0.00	3,154.00	0.00	3,154.00	0.00	S/L	10.00
150	AUGERS	8/10/92	3,333.00	0.00	0.00	3,333.00	0.00	3,333.00	0.00	S/L	10.00
152	GUTTER	6/08/92	856.00	0.00	0.00	856.00	0.00	856.00	0.00	S/L	10.00
153	STEAM JENNY	6/18/92	587.00	0.00	0.00	587.00	0.00	587.00	0.00	S/L	10.00
154	BACKHOE BUCKET	7/13/92	450.00	0.00	0.00	450.00	0.00	450.00	0.00	S/L	10.00
155	3/4 AIR MOLE	9/30/98	4,324.00	0.00	0.00	4,324.00	0.00	4,324.00	0.00	S/L	10.00
156	AUGER	9/30/98	2,557.00	0.00	0.00	2,557.00	0.00	2,557.00	0.00	S/L	10.00
157	STRAW BLOWER	12/31/98	2,200.00	0.00	0.00	2,200.00	0.00	2,200.00	0.00	S/L	10.00
158	PUMP	6/30/95	630.00	0.00	0.00	630.00	0.00	630.00	0.00	S/L	10.00
159	TEST PUMP W/HONDA ENG	4/22/96	1,915.00	0.00	0.00	1,915.00	0.00	1,915.00	0.00	S/L	10.00
160	97 CASE 580S/L BACKHOE	10/31/97	53,150.00	0.00	0.00	53,150.00	0.00	53,150.00	0.00	S/L	10.00
161	BORING MACHINE	3/22/00	11,719.00	0.00	0.00	11,719.00	0.00	11,719.00	0.00	S/L	10.00
162	J. DEERE BACKHOE 310SE	6/16/00	53,925.00	0.00	0.00	53,925.00	0.00	53,925.00	0.00	S/L	10.00
163	USED TRACTOR	5/31/01	6,500.00	0.00	0.00	6,500.00	0.00	6,500.00	0.00	S/L	10.00
164	EXCAVATOR	10/31/02	76,040.00	0.00	0.00	76,040.00	0.00	76,040.00	0.00	S/L	10.00
165	DRILL/AUGER	5/31/02	5,540.00	0.00	0.00	5,540.00	0.00	5,540.00	0.00	S/L	10.00
166	DITCH WITCH	10/31/02	7,147.00	0.00	0.00	7,147.00	0.00	7,147.00	0.00	S/L	10.00
167	HOLE HOG	9/30/03	5,042.00	0.00	0.00	5,042.00	0.00	5,042.00	0.00	S/L	10.00
170	CUMMINS DIESEL 40-KN MOBILE GEN	7/01/04	10,000.00	0.00	0.00	10,000.00	0.00	10,000.00	0.00	S/L	10.00
171	HOLEHOG	7/01/04	4,436.89	0.00	0.00	4,436.89	0.00	4,436.89	0.00	S/L	10.00
172	MITSUBISHI FX503041 FORKLIFT	7/01/04	19,260.00	0.00	0.00	19,260.00	0.00	19,260.00	0.00	S/L	10.00
173	JOHN DEERE 310 BACKHOE	7/01/04	22,680.11	0.00	0.00	22,680.11	0.00	22,680.11	0.00	S/L	10.00
174	WOODS BB72 6' MOWER STUMP JUM	7/01/06	1,275.15	0.00	0.00	1,275.15	0.00	1,275.15	0.00	S/L	15.00
446	J X 70 CASE IH TRACTOR	8/06/07	19,900.00	0.00	0.00	19,900.00	0.00	19,900.00	0.00	S/L	15.00
447	STIHL TS-400 WITH BLADES	11/05/07	1,156.30	0.00	0.00	1,156.30	0.00	1,156.30	0.00	S/L	15.00
488	2008 DODGE RAM PICKUP	3/31/08	26,186.00	0.00	0.00	26,186.00	0.00	26,186.00	0.00	S/L	4.00
489	2008 DODGE RAM PICKUP	3/31/08	26,186.00	0.00	0.00	26,186.00	0.00	26,186.00	0.00	S/L	4.00
491	TWO CASH REGISTERS	2/29/08	968.40	0.00	0.00	968.40	0.00	968.40	0.00	S/L	20.00
492	FORKLIFT	6/30/08	21,800.00	0.00	0.00	21,800.00	0.00	21,800.00	0.00	S/L	15.00
493	JOHN DEERE BACKHOE	12/31/08	79,000.00	0.00	0.00	79,000.00	0.00	79,000.00	0.00	S/L	15.00
595	JOHN DEERE MOWER	4/25/13	5,287.55	0.00	0.00	3,588.23	334.90	3,923.13	1,364.42	S/L	15.00
642	POWERE OPERATED EQUIPMENT	4/14/16	4,510.00	0.00	0.00	2,142.25	451.00	2,593.25	1,916.75	S/L	10.00
345-50 POWER OP EQUIP			497,623.40	0.00 c	0.00	493,556.33	785.90	494,342.23	3,281.17		
	345 Power Operated		497,623.40	0.00 c	0.00	493,556.33	785.90	494,342.23	3,281.17		
Group: 346 Comm. Equipment											
Location: 346-50 COMM EQUIP											
175	COMMUNICATION EQUIPMENT	12/01/74	2,991.00	0.00	0.00	2,991.00	0.00	2,991.00	0.00	S/L	10.00
176	RADIOS	12/01/75	1,040.00	0.00	0.00	1,040.00	0.00	1,040.00	0.00	S/L	4.00
177	COMMUNICATION EQUIPMENT	6/13/77	122.00	0.00	0.00	122.00	0.00	122.00	0.00	S/L	4.00
178	COMMUNICATION EQUIPMENT	6/13/77	1,331.00	0.00	0.00	1,331.00	0.00	1,331.00	0.00	S/L	4.00
179	COMMUNICATION EQUIPMENT	1/01/79	707.00	0.00	0.00	707.00	0.00	707.00	0.00	S/L	4.00
180	COMMUNICATION EQUIPMENT	1/01/80	713.00	0.00	0.00	713.00	0.00	713.00	0.00	S/L	4.00
181	COMMUNICATION EQUIPMENT	1/01/83	2,895.00	0.00	0.00	2,895.00	0.00	2,895.00	0.00	S/L	4.00
182	RADIOS	1/01/84	9,863.00	0.00	0.00	9,863.00	0.00	9,863.00	0.00	S/L	4.00
183	RADIOS	7/01/88	1,339.00	0.00	0.00	1,339.00	0.00	1,339.00	0.00	S/L	4.00
184	(2) TRUCK RADIOS	12/09/91	1,206.00	0.00	0.00	1,206.00	0.00	1,206.00	0.00	S/L	4.00
185	POLES FOR TELEMETERY	9/12/97	363.00	0.00	0.00	363.00	0.00	363.00	0.00	S/L	4.00
186	POLES FOR TELEMETRY	1/07/98	34,586.00	0.00	0.00	34,586.00	0.00	34,586.00	0.00	S/L	4.00
187	TELEMETRY	5/12/98	7,124.00	0.00	0.00	7,124.00	0.00	7,124.00	0.00	S/L	4.00
188	TELEMETRY	2/11/99	6,836.00	0.00	0.00	6,836.00	0.00	6,836.00	0.00	S/L	4.00
189	TELEMETRY	5/30/99	4,500.00	0.00	0.00	4,500.00	0.00	4,500.00	0.00	S/L	4.00
190	RADIOS FOR NEW TRUCKS	7/01/04	2,628.00	0.00	0.00	2,628.00	0.00	2,628.00	0.00	S/L	4.00
191	HAND HELD UNITS	7/01/04	2,118.00	0.00	0.00	2,118.00	0.00	2,118.00	0.00	S/L	4.00
584	TELEMETRY	7/01/12	2,980.00	0.00	0.00	2,533.00	298.00	2,831.00	149.00	S/L	10.00
346-50 COMM EQUIP			83,342.00	0.00 c	0.00	82,895.00	298.00	83,193.00	149.00		
Location: 393-90 COMMUNICATION EQUI											
559	TELEMETRY	7/01/01	16,356.00	0.00	0.00	16,356.00	0.00	16,356.00	0.00	S/L	10.00
618	Communication Equipment	6/30/14	18,500.00	0.00	0.00	12,025.00	1,850.00	13,875.00	4,625.00	S/L	10.00
393-90 COMMUNICATION EQUI			34,856.00	0.00 c	0.00	28,381.00	1,850.00	30,231.00	4,625.00		
	346 Comm. Equipment		118,198.00	0.00 c	0.00	111,276.00	2,148.00	113,424.00	4,774.00		
Group: 347 Misc Equip											
Location: 347-50 MISCELLANEOUS											
596	TILLER	7/24/13	1,500.00	0.00	0.00	704.58	95.00	799.58	700.42	S/L	15.00
643	TW8800 DIGITAL LINE TRACER	6/09/16	3,179.45	0.00	0.00	2,914.50	264.95	3,179.45	0.00	S/L	5.00
644	TRIMBLE HANDHELD SCANNER	8/08/16	14,145.50	0.00	0.00	6,247.60	1,414.55	7,662.15	6,483.35	S/L	10.00
645	WORKFLOW SOFTWARE	8/04/16	7,340.00	0.00	0.00	3,241.83	734.00	3,975.83	3,364.17	S/L	10.00
646	ITRON FC300 RECEIVER	8/29/16	22,433.00	0.00	0.00	9,720.97	2,243.30	11,964.27	10,468.73	S/L	10.00
654	COMMUNICATION EQUIPMENT	5/04/17	2,385.25	0.00	0.00	2,186.47	198.78	2,385.25	0.00	S/L	4.00
678	MISC EQUIUPMENT	6/30/18	11,302.97	0.00	0.00	2,825.75	1,130.30	3,956.05	7,346.92	S/L	10.00
688	MISC EQUIPMENT	6/30/19	211,994.00	0.00	0.00	31,799.10	21,199.40	52,998.50	158,995.50	S/L	10.00
716	MISC EQUIP	6/30/20	52,392.23	0.00	0.00	2,619.61	5,239.22	7,858.83	44,533.40	S/L	10.00
731	Misc equipment	6/30/21	53,591.91	0.00 c	0.00	0.00	2,679.60	2,679.60	50,912.31	S/L	10.00
347-50 MISCELLANEOUS			380,264.31	0.00 c	0.00	62,260.41	35,199.10	97,459.51	282,804.80		
	347 Misc Equip		380,264.31	0.00 c	0.00	62,260.41	35,199.10	97,459.51	282,804.80		

Asset	Property Description	Date In Service	Tax Cost	Sec 179 Exp Current = c	Tax Bonus Amt	Tax Prior Depreciation	Tax Current Depreciation	Tax End Depr	Tax Net Book Value	Tax Method	Tax Period
Group: 348 Other Tan. Equip											
Location:											
444	ASPHALT CUTTER	3/05/07	2,500.00	0.00	0.00	2,500.00	0.00	2,500.00	0.00	S/L	15.00
445	HANDHELD METER READERS	4/26/07	5,180.00	0.00	0.00	5,180.00	0.00	5,180.00	0.00	S/L	15.00
494	WAREHOUSE ALARM	2/29/08	4,557.00	0.00	0.00	4,557.00	0.00	4,557.00	0.00	S/L	15.00
495	LCD MONITOR	2/29/08	272.62	0.00	0.00	272.62	0.00	272.62	0.00	S/L	5.00
496	OVERBILT TRAILER	7/31/08	25,457.00	0.00	0.00	25,457.00	0.00	25,457.00	0.00	S/L	15.00
508	MISC. EQUIPMENT	6/30/09	1,665.00	0.00	0.00	1,637.25	27.75	1,665.00	0.00	S/L	15.00
No Location			39,631.62	0.00 c	0.00	39,603.87	27.75	39,631.62	0.00		
Location: 347-50 MISCELLANEOUS											
192	PATROL BOAT	4/30/02	17,166.00	0.00	0.00	17,166.00	0.00	17,166.00	0.00	S/L	10.00
193	MISCELLANEOUS EQUIPMENT	1/01/71	4,615.00	0.00	0.00	4,615.00	0.00	4,615.00	0.00	S/L	6.00
194	STEAM JENNY	1/01/80	2,500.00	0.00	0.00	2,500.00	0.00	2,500.00	0.00	S/L	3.00
195	FEEDER	1/01/81	4,000.00	0.00	0.00	4,000.00	0.00	4,000.00	0.00	S/L	10.00
196	LAWN MOWER	1/01/81	1,000.00	0.00	0.00	1,000.00	0.00	1,000.00	0.00	S/L	10.00
197	MISCELLANEOUS EQUIPMENT	1/01/83	464.00	0.00	0.00	464.00	0.00	464.00	0.00	S/L	10.00
198	MISCELLANEOUS EQUIPMENT	1/01/83	450.00	0.00	0.00	450.00	0.00	450.00	0.00	S/L	10.00
202	SIGN - NEW OFFICE	7/01/89	612.00	0.00	0.00	612.00	0.00	612.00	0.00	S/L	10.00
203	CAMERA	4/08/91	761.00	0.00	0.00	761.00	0.00	761.00	0.00	S/L	10.00
204	ICE MACHINE	5/03/91	625.00	0.00	0.00	625.00	0.00	625.00	0.00	S/L	10.00
205	WELDER	4/28/92	450.00	0.00	0.00	450.00	0.00	450.00	0.00	S/L	10.00
206	METER DEVICES	2/01/93	6,280.00	0.00	0.00	6,280.00	0.00	6,280.00	0.00	S/L	10.00
207	TRAILER BED	9/30/94	9,450.00	0.00	0.00	9,450.00	0.00	9,450.00	0.00	S/L	10.00
208	AIR COMPRESSOR	11/30/94	9,965.00	0.00	0.00	9,965.00	0.00	9,965.00	0.00	S/L	10.00
209	FLAT BED TRAILER	3/02/95	9,950.00	0.00	0.00	9,950.00	0.00	9,950.00	0.00	S/L	10.00
210	PORTAFLOW	11/27/96	5,628.00	0.00	0.00	5,628.00	0.00	5,628.00	0.00	S/L	10.00
212	6FT SWEEPSTER BROOM	12/01/97	3,116.00	0.00	0.00	3,116.00	0.00	3,116.00	0.00	S/L	10.00
213	TILLER-5'AGR TECH	4/29/97	1,450.00	0.00	0.00	1,450.00	0.00	1,450.00	0.00	S/L	10.00
215	FLAT BED TRAILER	10/16/97	9,950.00	0.00	0.00	9,950.00	0.00	9,950.00	0.00	S/L	10.00
216	HOLE HAMMER	9/30/01	4,456.00	0.00	0.00	4,456.00	0.00	4,456.00	0.00	S/L	10.00
218	GPS EQUIP (MAP SYNC)	8/31/03	6,340.00	0.00	0.00	6,340.00	0.00	6,340.00	0.00	S/L	10.00
219	MISCELLANEOUS	7/01/04	1,000.00	0.00	0.00	1,000.00	0.00	1,000.00	0.00	S/L	10.00
220	NEW HAMMERHEAD	7/01/05	3,740.00	0.00	0.00	3,740.00	0.00	3,740.00	0.00	S/L	15.00
223	GATOR 7 X 18' TRLR	7/01/06	4,395.00	0.00	0.00	4,395.00	0.00	4,395.00	0.00	S/L	15.00
588	To balance to WTB	7/01/05	14,936.86	0.00	0.00	14,936.86	0.00	14,936.86	0.00	S/L	10.00
347-50 MISCELLANEOUS			123,299.86	0.00 c	0.00	123,299.86	0.00	123,299.86	0.00		
	348 Other Tan. Equip		162,931.48	0.00 c	0.00	162,903.73	27.75	162,931.48	0.00		
Group: 355 Flow Measuring Device											
Location: 355-90 FLOW MEASURING DEV											
560	2 FLOW MEASURING DEVICES	7/01/01	11,720.00	0.00	0.00	11,720.00	0.00	11,720.00	0.00	S/L	5.00
561	FLOW MEASURING DEVICES	7/01/04	516.62	0.00	0.00	516.62	0.00	516.62	0.00	S/L	5.00
718	FLOW MEASURING (WW)	6/30/20	9,985.50	0.00	0.00	998.55	1,997.10	2,995.65	6,989.85	S/L	5.00
355-90 FLOW MEASURING DEV			22,222.12	0.00 c	0.00	13,235.17	1,997.10	15,232.27	6,989.85		
	355 Flow Measuring Device		22,222.12	0.00 c	0.00	13,235.17	1,997.10	15,232.27	6,989.85		
Group: 362 Receiving Walls/Pumps											
Location: 362-90 REC. WELLS & PUMPS											
562	RECEIVING WELLS/PUMP PIT	7/01/01	75,000.00	0.00	0.00	36,563.00	1,875.00	38,438.00	36,562.00	S/L	40.00
563	RECEIVING WELLS/PUMP PIT	7/01/05	4,258.50	0.00	0.00	1,650.13	106.46	1,756.59	2,501.91	S/L	40.00
564	RECEIVING WELLS/PUMP PIT	7/01/06	3,409.30	0.00	0.00	1,235.84	85.23	1,321.07	2,088.23	S/L	40.00
565	RECEIVING WELLS/PUMP PIT	7/01/09	24,548.90	0.00	0.00	7,057.78	613.72	7,671.50	16,877.40	S/L	40.00
566	RECEIVING WELLS	7/01/10	20,982.42	0.00	0.00	5,507.88	524.56	6,032.44	14,949.98	S/L	40.00
576	Receiving Wells & Pumps	7/01/11	15,920.00	0.00	0.00	3,781.00	398.00	4,179.00	11,741.00	S/L	40.00
604	REC WALLS & PUMPS	6/30/13	4,680.00	0.00	0.00	1,170.00	156.00	1,326.00	3,354.00	S/L	30.00
362-90 REC. WELLS & PUMPS			148,799.12	0.00 c	0.00	56,965.63	3,758.97	60,724.60	88,074.52		
	362 Receiving Walls/Pumps		148,799.12	0.00 c	0.00	56,965.63	3,758.97	60,724.60	88,074.52		
	Grand Total		55,340,519.89	0.00 c	0.00	25,020,158.16	1,297,782.50	26,317,940.66	29,022,579.23		

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 23

Responding Witness: Dewayne Lewis

Q-23. Provide a complete description of the utility's Other Post-Employment Benefits package(s) provided to its employees.

A-23. Wood Creek District employees are provided Other Post-Employment Benefits ("OPEBs") through the County Employees Retirement System Non-Hazardous, a cost-sharing multiple-employer defined benefit pension plan administered by the County Employees Retirement System ("CERS"), an agency of the Commonwealth of Kentucky. Under the provisions of the KRS 78.782, the CERS Board of Trustees administers CERS and has the authority to establish and amend benefit provisions. CERS provides hospital and medical insurance for eligible members receiving benefits from the pension plan.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 24

Responding Witness: Dewayne Lewis

Q-24. Provide a complete description of the financial reporting and ratemaking treatment of the utility's pension costs.

A-24. A description of the financial reporting of Wood Creek District's financial reporting of its employee pension costs is set forth in Notes 10 and 11 of the Independent Auditors' Report and Financial Statements for the Years Ended December 31, 2021 and 2020. These Notes are attached as Attachment 24.

Only actual payments made to the County Employees Retirement System during the test-period are considered for ratemaking purposes.

NOTE 10 – RETIREMENT PLAN – (continued)

	Deferred Outflows of Resources	Deferred Inflows of Resources
Diffeences between expected and actual experience	$ 159,891	$ -
Changes in assumptions	250,371	-
Net difference between projected and actual earnings on pension plan investments	277,931	117,483
Changes in proportion and differences between District contributions and proportionate share of contibutions	314,996	-
District contributions subsequent to the measurement date	273,160	-
Total	$1,276,349	$ 117,483

The $273,160 reported as deferred outflows of resources related to pensions resulting from District contributions subsequent to the measurement date were recognized as a reduction of the net pension liability in the year ended December 31, 2020. Other amounts reported as deferred outflows of resources and deferred inflows related to pensions will be recognized in pension expense as follows:

Year ended June 30:	
2021	$ 435,468
2022	295,116
2023	90,683
2024	64,439
	$ 885,706

Actuarial assumptions—The total pension liability in the June 30, 2020 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

	CERS
Inflation	2.30%
Projected salary increases	3.3-10.3%
Investment rate of return, net of investement expense & inflation	6.25%

NOTE 10 – RETIREMENT PLAN – (continued)

Discount rate—For CERS, the discount rate used to measure the total pension liability was 6.25%. The projection of cash flows used to determine the discount rate assumed that contributions from plan employees and employers will be made at statutory contribution rates. Projected inflows from investment earnings were calculated using the long-term assumed investment return of 6.25%. The long-term investment rate of return was applied to all periods of projected benefit payments to determine the total pension liability.

Sensitivity of CERS proportionate share of net pension liability to changes in the discount rate—The following table presents the net pension liability of the District, calculated using the discount rates selected by the pension system, as well as what the District's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current rate.

	1% Decrease	Current Discount Rate	1% Increase
CERS	5.25%	6.25%	7.25%
District's proportionate share of net pension liabilty	$ 7,907,170	$ 6,411,821	$ 5,173,615

Pension plan fiduciary net position — Detailed information about the pension plan's fiduciary net position is available in the separately issued financial reports of CERS.

The District's total payroll subject to CERS for the years ended December 31, 2021, 2020, and 2019 was $2,492,836, $2,339,030 and $2,126,922 respectively. The District's matching contributions to CERS for the years ended December 31, 2021, 2020, and 2019 was $599,776, $562,771, and $499,837 respectively.

NOTE 11 – OTHER POSTEMPLOYMENT BENEFITS PLAN

General information about the County Employees Retirement System Non-Hazardous (CERS)

Plan description—Employees are provided OPEBs through the County Employees Retirement System Non-Hazardous (CERS), a cost-sharing multiple-employer defined benefit pension plan administered by the Kentucky Retirement System, an agency of the Commonwealth of Kentucky. Under the provisions of the Kentucky Revised Statute (KRS) Section 61.645, the Board of Trustees of the Kentucky Retirement System administers CERS and has the authority to establish and amend benefit provisions. The Kentucky Retirement System issues a publicly available financial report that includes financial statements and required supplementary information for CERS. That report may be obtained from http://kyret.ky.gov/.

Benefits provided—CERS provides hospital and medical insurance for eligible members receiving benefits from the pension plan. Employees are vested in the plan after five years' service. For plan purposes, employees are grouped into two groups, based on hire date. Members who reach a minimum vesting period of 10 years, and began participating on, or after, July 1, 2003, earn $10 per month for

NOTE 11 - OTHER POSTEMPLOYMENT BENEFITS PLAN-CONTINUED

insurance benefits at retirement for every year of earned service without regard to a maximum dollar amount. For members participating prior to July 1, 2003, are paid up to a maximum of $13.18 per month for every year of earned service. The percentage of the maximum monthly benefit paid is based on years of service as follows:

Years of Service	Paid by Insurance Fund (%)
20+ years	100.00%
15-19 years	75.00%
10-14 years	50.00%
4-9 years	25.00%
Less than 4 years	0.00%

Contributions—Required contributions by the employee are based on the tier:

Tier 1	Participation date	Before September 1, 2008
	Contribution percentage	0.00%
Tier 2	Participation date	September 1, 2008 - December 31, 2013
	Contribution percentage	1%
Tier 3	Participation date	After December 31, 2013
	Contribution percentage	1%

OPEB Liabilities, OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEBs

At June 30, 2021, the District reported a liability of $2,018,034 for its proportionate share of the collective net OPEB liability that reflected a reduction for state OPEB support provided to the District. The collective net OPEB liability was measured as of June 30, 2019, and the total OPEB liability used to calculate the collective net OPEB liability was based on projection of the District's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating employers, actuarially determined. At June 30, 2020 the District's proportion was .083597 percent.

For the year ended June 30, 2021, the District recognized OPEB expense of $200,307. At June 30, 2021, the District reported deferred outflows of resources and deferred inflows of resources related to OPEBs from the following sources:

See table on next page

NOTE 11 - OTHER POSTEMPLOYMENT BENEFITS PLAN-CONTINUED

	Deferred Outflows of Resources	Deferred Inflows of Resources
Diffeences between expected and actual experience	$ 337,171	$ 337,434
Changes in assumptions	351,019	2,135
Net difference between projected and actual earnings on pension plan investments	108,253	41,178
Changes in proportion and differences between District contributions and proportionate share of contibutions	112,262	1,487
District contributions subsequent to the measurement date	67,370	-
Total	$ 976,075	$ 382,234

Of the total amount reported as deferred outflows of resources related to OPEB, $67,370 resulting from District contributions subsequent to the measurement date and before the end of the fiscal year will be included as a reduction of the collective net OPEB liability in the year ended June 30, 2021. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in the District's OPEB expense as follows:

Year ended June 30:	
2021	$ 137,575
2022	157,425
2023	119,343
2024	113,692
2025	(1,564)
	$ 526,471

The long-term expected rate of return on OPEB plan investments was determined using a log-normal distributions analysis in which best-estimate ranges of expected future real rates of return (expected returns, net of OPEB plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation.

Discount rate – The Discount rate used to measure the total OPEB liability was 5.34%. The projection of cash flows used to determine the discount rate assumed that plan member contributions will be made at the current contribution rates and the employer contributions will be made at statutorily required rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to

NOTE 11 - OTHER POSTEMPLOYMENT BENEFITS PLAN-CONTINUED

make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB liability.

The following table presents the District's proportionate share of the collective net OPEB liability of the System, calculated using the discount rate of 5.34%, as well as what the District's proportionate share of the collective net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (4.34%) or 1-percentage-point higher (6.34%) than the current rate:

	1% Decrease	Current Discount Rate	1% Increase
CERS	4.34%	5.34%	6.34%
District's proportionate share of net pension liabilty	$ 2,592,581	$ 2,018,034	$ 1,546,139

Sensitivity of the District's proportionate share of the collective net OPEB liability to changes in the healthcare cost trend rates – The following presents the District's proportionate share of the collective net OPEB liability, as well as what the District's proportionate share of the collective net OPEB liability would be if it were calculated using healthcare cost trend rates that were 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	1% Decrease	Healthcare Trend Rate	1% Increase
CERS			
District's proportionate share of net pension liabilty	$ 1,562,463	$ 2,018,034	$ 2,570,880

OPEB plan fiduciary net position – Detailed information about the OPEB plan's fiduciary net position is available in the separately issued TRS financial report.

NOTE 12 – PRIOR PERIOD ADJUSTMENT

At January 1, 2020, management made a reclassification between the Water Fund's beginning net position and the Wastewater Fund beginning net position in the amount of $17,157. This was due to a reclass of a fixed asset from the prior period. Our opinion has not been modified with respect to this adjustment. This adjustment was made for the year ended December 31, 2020.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 25

Responding Witness: Dewayne Lewis

Q-25. Provide detailed descriptions of all early retirement plans or other staff reduction programs the utility has offered or intends to offer its employees during either the test year or the forecasted test period. Include all cost-benefit analyses associated with these programs.

A-25. Wood Creek District did not have any early retirement plan or other staff reduction program during the test period and has no current plans to implement such programs. Please note Wood Creek District's application is based upon a historical test period, not a forecasted test period.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 26

Responding Witness: Dewayne Lewis

Q-26. Provide all current labor contracts and the most recent labor contracts previously in effect.

A-26. Wood Creek District has no written union or labor contracts.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 27

Responding Witness: Dewayne Lewis

Q-27. Provide the information requested in Schedule H for budgeted and actual numbers of full- and part-time employees, regular wages, overtime wages, and total wages by employee group, by month, for the three most recent calendar years, and the test year. Explain any variance exceeding 5 percent.

A-27. See Attachment 27. Please note Wood Creek District's application is based upon a historical test period, not a forecasted test period. Budgeted information and variances between budgeted and actual information is not relevant.

WOOD CREEK WATER DISTRICT
PAYROLL ANALYSIS BY GROUP

Board of Commissioners:

2019

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
3	0	18,000.00	0.00	18,000.00

2020

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
3	0	18,000.00	0.00	18,000.00

2021

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
4	0	16,000.00	0.00	16,000.00

WOOD CREEK WATER DISTRICT
PAYROLL ANALYSIS BY GROUP

Water Treatment Plant employees

2019

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
11	2	394,962.24	56,266.84	451,229.08

2020

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
11	2	451,631.72	68,921.23	520,552.95

2021

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
11	1	467,656.11	72,480.67	540,136.78

WOOD CREEK WATER DISTRICT
PAYROLL ANALYSIS BY GROUP

Transmission and Distribution employees

2019

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
22	6	916,825.86	137,398.71	1,054,224.57

2020

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
20	1	866,668.38	105,265.06	971,933.44

2021

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
21	10	875,251.11	116,704.31	991,955.42

WOOD CREEK WATER DISTRICT
PAYROLL ANALYSIS BY GROUP

Customer Service employees

2019

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
14	4	470,011.03	7,888.30	477,899.33

2020

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
14	3	535,478.00	5,800.00	541,278.00

2021

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
15	4	583,630.95	11,506.18	595,137.13

WOOD CREEK WATER DISTRICT
PAYROLL ANALYSIS BY GROUP

Management employees

2019

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
4	0	288,650.00	969.39	289,619.39

2020

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
4	0	305,536.00	159.75	305,695.75

2021

# of full-time employees	# of part-time employees	Regular Wages	Overtime Wages	Total Wages
4	0	306,374.64	8,379.93	314,754.57

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 28

Responding Witness: Dewayne Lewis

Q-28. For each employee group, state the amount, percentage increase, and effective dates for general wage increases and, separately, for merit increases granted or to be granted in the past two calendar years, the test year, and the forecasted test period.

A-28. Wood Creek District's application uses a historical test period. There is no forecasted test period.

Members of Board of Commissioners: No salary increases have occurred or are planned for the periods in question.

Water Treatment Plant Employees:

a. Effective April 17, 2019, the hourly wage rate of all employees whose wage rate was less than $16.00 was increased to $16.00.

b. The hourly wage of any employee who during the period in question obtained a Drinking Water Treatment Plant Operator certification was increased $1.00 upon obtaining that certification.

c. Wood Creek District awarded wage increases to employees who were assigned additional job duties or received appropriate or useful accreditations.

d. A three (3) percent wage increase was awarded to all employees effective February 8, 2021.

Transmission and Distribution Employees:

a. Effective April 17, 2019, the hourly wage rate of all employees whose wage rate was less than $16.00 was increased to $16.00.

b. The hourly wage of any employee who during the period in question obtained a Drinking Water Distribution Operator certification was increased $1.00 upon obtaining that certification.

c. The hourly wage of any employee who during the period in question obtained a Wastewater Collection System Operator certification was increased $1.00 upon obtaining that certification.

d. The hourly wage of any employee who during the period in question obtained a Commercial Driver's License was increased $1.00 upon obtaining that license.

e. Wood Creek District awarded wage increases to employees who were assigned additional job duties or received appropriate or useful accreditations.

f. A three (3) percent wage increase was awarded to all employees effective February 8, 2021.

Customer Service Employees:

a. Effective April 17, 2019, the hourly wage rate of all employees whose wage rate was less than $16.00 was increased to $16.00.

b. Wood Creek District awarded wage increases to employees who were assigned additional job duties or received appropriate or useful accreditations.

c. A three (3) percent wage increase was awarded to all employees effective February 8, 2021.

Management Employees:

a. A three (3) percent wage increase was awarded to all employees effective February 8, 2021.

b. Effective October 8, 2020, Assistant Superintendent's hourly wage rate was increased $0.75.

c. Effective October 8, 2020, Assistant Office Manager's hourly wage rate was increased $1.00.

d. Effective November 15, 2019, Assistant Office Manager's hourly wage rate was increased $1.00 for completing Utility Management Institute course of instruction.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 29

Responding Witness: Dewayne Lewis

Q-29. For the test year and three most recent calendar years, provide a schedule reflecting the job title, duties and responsibilities of each executive officer, the number of employees who report to each officer, and to whom each officer reports, and the percentage annual increase and the effective date of each increase. For employees elected to executive officer status since the test year in the utility's most recent rate case, provide the salaries for the persons they replaced.

A-29. Wood Creek District has no executive officers unless the members of its Board of Commissioners are considered Executive Officers. Each Commissioner receives $500 per month ($6,000 annually). The Laurel County Fiscal Court established this salary level many years ago and it remains unchanged.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 30

Responding Witness: Dewayne Lewis

Q-30. Provide, in the format provided in Schedule I, the following information for the utility's compensation and benefits, for the three most recent calendar years and the test year. Provide the information individually for each corporate officer and by category for Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly. Provide the amounts, in gross dollars, separately for total company operations and jurisdictional operations.

a. Regular salary or wages.

b. Overtime pay.

c. Excess vacation payout.

d. Standby/Dispatch pay.

e. Bonus and incentive pay.

f. Any other forms of incentives, including stock options or forms of deferred compensation (specify).

g. Other amounts paid and reported on the employees' W-2 (specify).

h. Healthcare benefit cost.

(1) Amount paid by the utility.

(2) Amount paid by the employee.

i. Dental benefits cost.

(1) Amount paid by the utility.

(2) Amount paid by the employee.

j. Vision benefits cost.

(1) Amount paid by the utility.

(2) Amount paid by the employee.

k. Life insurance cost.

(1) Amount paid by the utility.

(2) Amount paid by the employee.

l. Accidental death and disability benefits.

(1) Amount paid by the utility.

(2) Amount paid by the employee.

m. Defined Benefit Retirement cost.

(1) Amount paid by the utility.

(2) Amount paid by the employee.

n. Defined Contribution – 401(k) or similar plan cost. Provide the amount paid by the utility.

o. Cost of any other benefit available to an employee, including fringe benefits (specify).

A-30. See Excel Workbook Q30_CompensationAndBenefits.xlsx. A copy of this workbook is embedded in this Response and has also been filed separately with this Response.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 31

Responding Witness: Dewayne Lewis

Q-31. For each benefit listed in Item 41 (sic) above for which an employee is required to pay part of the cost, provide a detailed explanation as to how the employee contribution rate was determined.

A-31. Wood Creek District assumes the reference to Item 41 is intended to refer to Item 30.

With the exception of retirement pension benefits, Wood Creek District employees are not required to contribute to the cost of any benefit. The Kentucky General Assembly and the Kentucky Public Pension Authority establish the employee contribution rate for the employee retirement plan.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 32

Responding Witness: Dewayne Lewis

Q-32. Provide a listing of all health care plan categories, dental plan categories, and vision plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees (e.g., single, family, etc.). Include the associated employee contribution rates and employer contribution rates of the total premium cost for each category, and each plan's deductible(s) amounts.

A-32. Wood Creek District provides health insurance coverage to each full-time employee. The details of this coverage are set forth in the Certificate of Coverage, which is found at Attachment 33 of this Response. The coverage's provisions regarding deductibles are found at pages 14-15.

Wood Creek District does not provide health insurance coverage to the members of its Board of Commissioners nor does it not provide dental or vision insurance coverage to its employees or the members of its Board of Commissioners.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 33

Responding Witness: Dewayne Lewis

Q-33. Provide each medical insurance policy that the utility currently maintains.

A-33. See Attachment 33.

Certificate of Coverage

(Referred to as “Booklet” in the following pages)

Anthem Blue Access PPO Option AA1 with Rx Option T1

01-01-2022

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

Anthem Health Plans of Kentucky, Inc.

13550 Triton Park Boulevard
Louisville, KY 40223

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) pathology; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to you if Anthem does not have an In-Network Provider in your area who can perform the services you require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Anthem is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount. In addition to your In-Network cost-shares, the Out-of-Network Provider can also charge you for the difference between the Maximum Allowed Amount and their billed charges.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Complaint and Appeals Process" section of this Benefit Book.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

- Protections with respect to Surprise Billing Claims by Providers;
- Estimates on what Out-of-Network Providers may charge for a particular service;
- Information on contacting state and federal agencies in case you believe a Provider has violated the No Surprise Billing Act's requirements.

Upon request, Anthem will provide you with a paper copy of the type of information you request from the above list.

Anthem, either through its price comparison tool on anthem.com or through Member Services at the phone number on the back of your ID card, will allow you to get:

- Cost sharing information that you would be responsible for, for a service from a specific In-Network Provider;
- A list of all In-Network Providers;
- Cost sharing information on an Out-of-Network Provider's services based on Anthem's reasonable estimate based on what Anthem would pay an Out-of-Network Provider for the service.

In addition, Anthem will provide access through its website to the following information:

- In-Network negotiated rates;

- Historical Out-of-Network rates; and
- Drug pricing information.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

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

Statement of Rights under the Women's Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Group.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- 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 financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and

pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If 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 may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.

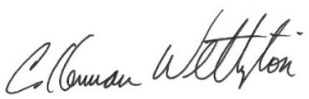

Table of Contents

Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26.

Deductible	**In-Network**	**Out-of-Network**
Per Member	$100	$300
Per Family – All other Members combined	$300	$900

Deductible	**In-Network**	**Out-of-Network**
The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.		

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays	80%	50%
Member Pays	20%	50%
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. Except for Surprise Billing Claims, if you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	**In-Network**	**Out-of-Network**
Per Member	$1,300	$3,900
Per Family – All other Members combined	$2,600	$7,800
The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. The Out-of-Pocket Limit does not include amounts you pay for the following benefits: • Out-of-Network Human Organ and Tissue Transplant services. • Services listed under "Vision Services for Members Age 21 and Older". No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	20% Coinsurance after Deductible	
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details. Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.		
Ambulance Services (Ground)	20% Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details. Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.		
Autism Services	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Chiropractor Services	See "Therapy Services."	

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Congenital Defects and Birth Abnormalities	Benefits are based on the setting in which Covered Services are received.	
Dental Services (Only when related to accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care." Benefits for diabetic education are based on the setting in which Covered Services are received.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Services		
• Preferred Reference Labs	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)		
• Durable Medical Equipment*	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Orthotics	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthetics*	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Medical and Surgical Supplies*	50% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
*****Diabetic equipment and supplies are covered under the "Diabetic Equipment, Education and Supplies" section of this Schedule. Benefits for mastectomy supplies and prosthetics are subject to the Plan's regular Coinsurance.		
Hearing Aid Benefit Maximum for Members under 18 years of age:	One hearing aid per ear every 36 months In- and Out-of-Network combined	
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$300 Copayment per visit then 20% Coinsurance Copayment waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	20% Coinsurance	
• Emergency Room Doctor Charge (Mental Health / Substance Abuse)	20% Coinsurance	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	
As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable. Please refer to the Notice at the beginning of this Booklet for more details.		
Gene Therapy Services • Precertification required	Benefits are based on the setting in which Covered Services are received.	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services" for details on Benefit Maximums.	

Benefits	In-Network	Out-of-Network
Home Care		
• Home Care Visits	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Home Dialysis	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Home Infusion Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Specialty Prescription Drugs	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Home Care Services / Supplies	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Private Duty Nursing	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined The limit includes Private Duty Nursing and Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation) given as part of the Home Care benefit. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Home Infusion Therapy	See “Home Care.”	
Hospice Care		
• Home Hospice Care	No Copayment, Deductible, or Coinsurance	
• Bereavement	No Copayment, Deductible, or Coinsurance	
• Inpatient Hospice	No Copayment, Deductible, or Coinsurance	
• Outpatient Hospice	No Copayment, Deductible, or Coinsurance	
• Respite Care	No Copayment, Deductible, or Coinsurance	
This Plan’s Hospice benefit will meet or exceed Medicare’s Hospice benefit. If you use an Out-of-Network Provider, that Provider may also bill you for any charges over Medicare’s Hospice benefit unless your claim involves a Surprise Billing Claim.		

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Benefit Maximum for Newborn 100% Human Diet	Unlimited	
• Skilled Nursing Facility	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Rehabilitation	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
Ancillary Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Maternity	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services."	
Mental Health and Substance Abuse Services		
• Inpatient Mental Health / Substance Abuse Facility Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Residential Treatment Center Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Inpatient Mental Health / Substance Abuse Provider Services (e.g., Doctor and other professional Providers)	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Outpatient Mental Health / Substance Abuse Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Outpatient Mental Health / Substance Abuse Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Mental Health / Substance Abuse Office Visits (Including In-Person and/or Telehealth Services / Virtual Visits*) *Please see the "Office Visits" section for Mental Health and Substance Abuse Virtual Visits received from our Online Provider, LiveHealth Online.	$20 Copayment per visit	50% Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy	See "Therapy Services."	
Office Visits If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Including In-Person and/or Telehealth Services / Virtual Visits)	$20 Copayment per visit	50% Coinsurance after Deductible
• Preferred Primary Care Physician / Provider (PCP) (Including In-Person and/or Telehealth Services / Virtual Visits)	$10 Copayment per visit	
• Specialty Care Physician / Provider (SCP) (Including In-Person and/or Telehealth Services / Virtual Visits)	$50 Copayment per visit	50% Coinsurance after Deductible
• Retail Health Clinic Visit	$20 Copayment per visit	50% Coinsurance after Deductible
• Virtual Visits from our Online Provider, LiveHealth Online, (whether accessed directly or through our mobile app, website, or Anthem-enabled device) – Includes Mental Health & Substance Abuse Virtual Visits	$10 Copayment per visit	
• Virtual Visits for Specialty Care Services from our Online Provider, LiveHealth Online, (whether accessed directly or through our mobile app, website, or Anthem-enabled device)	$50 Copayment per visit	

Benefits	In-Network	Out-of-Network
• Medical Chats and Virtual Visits (Including Primary Care) from our Online Provider, K Health, through its affiliated Provider groups, via our mobile app, website, or Anthem-enabled device	No Copayment, Deductible, or Coinsurance	
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	$20 Copayment per visit	50% Coinsurance after Deductible
• Nutritional Counseling for Eating Disorders	$20 Copayment per visit	50% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serums) A $10 Copayment for allergy injections will be applied when the injection(s) is billed by itself. The PCP or SCP office visit Copayment / Coinsurance will apply if an office visit is billed with an allergy injection.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Diagnostic X-ray	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Other Diagnostic Tests (including Hearing and EKG)	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery (including anesthesia)	See PCP / Preferred PCP / SCP Copayment	50% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy*	$20 Copayment per visit	50% Coinsurance after Deductible
– Physical Therapy*	$20 Copayment per visit	50% Coinsurance after Deductible
– Occupational Therapy*	$20 Copayment per visit	50% Coinsurance after Deductible
– Speech Therapy	$20 Copayment per visit	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
– Dialysis	$50 Copayment per visit	50% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	See PCP / Preferred PCP / SCP Copayment	50% Coinsurance after Deductible
– Cardiac Rehabilitation	$50 Copayment per visit	50% Coinsurance after Deductible
– Pulmonary Therapy	$50 Copayment per visit	50% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
*If you get Covered Services from a Chiropractor, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician for an office visit.		
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Outpatient Facility Services		
• Facility Surgery Charge	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Facility Surgery Lab	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Facility Surgery X-ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Diagnostic Tests (EKG, EEG, etc.)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Therapy:		
– Chiropractic / Osteopathic / Manipulative Therapy*	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Physical Therapy*	$20 Copayment per visit	50% Coinsurance after Deductible
– Occupational Therapy*	$20 Copayment per visit	50% Coinsurance after Deductible
– Speech Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Dialysis	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Cardiac Rehabilitation	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Pulmonary Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
*If you get Covered Services from a Chiropractor, you will not have to pay an outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician for an office visit.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Therapy	See “Therapy Services.”	

Benefits	In-Network	Out-of-Network
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.	
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Please see the "What's Covered" section for additional detail on IRS guidelines.		
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" and "Therapy Services" for details on Benefit Maximums.	
Respiratory Therapy	See "Therapy Services."	
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical & Occupational Therapy	20 visits per Benefit Period	
• Speech Therapy	20 visits per Benefit Period	
• Manipulation Therapy	12 visits per Benefit Period	
• Cardiac Rehabilitation	36 visits per Benefit Period	
• Pulmonary Rehabilitation	20 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: The limits for physical, occupational and speech therapy will not apply if you get care as part of the Autism Services benefit.		
Note: When you get physical, occupational, speech therapy, cardiac rehabilitation, or pulmonary rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Note: If pulmonary rehabilitation is given as part of physical therapy, the Physical Therapy limit will apply instead of the Pulmonary Rehabilitation limit.		
Transplant Services	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.”	
Urgent Care Services (Office Visits)		
• Urgent Care Office Visit Charge	$20 Copayment per visit	50% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
A $10 Copayment for allergy injections will be applied when the injection(s) is billed by itself. The PCP or SCP urgent care office visit Copayment / Coinsurance will apply if an urgent care office visit is billed with an allergy injection.		
• Diagnostic Lab (other than reference labs)	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Diagnostic X-ray	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Other Diagnostic Tests (including Hearing and EKG)	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery (including anesthesia)	$20 Copayment per visit	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Virtual Visits and Telehealth Services	See the “Office Visits” section. For Mental Health and Substance Abuse Services, also refer to the “Mental Health and Substance Abuse Services” section.	
Vision Services For Members Through Age 20 **Note:** To receive the In-Network benefit, you must use a Blue View Vision Provider. Visit our website or call the number on your ID card for help in finding a Blue View Vision Provider.		
• Routine Eye Exam Limited to one exam per Member every Benefit Period	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Vision Services For Members Age 21 and Older **Note:** To receive the In-Network benefit, you must use a Blue View Vision Provider. Visit our website or call the number on your ID card for help in finding a Blue View Vision Provider.		

Benefits	In-Network	Out-of-Network
• Routine Eye Exam Limited to one exam per Member every Benefit Period	$0 Copayment	Reimbursed up to $42
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Centers of Excellence (COE) Transplant Providers

Blue Distinction Center Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery.

In-Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant.

Out of Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	**In-Network Transplant Provider**	**Out-of-Network Transplant Provider**
	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	**In-Network Transplant Provider Facility**	**Out-of-Network Transplant Provider Facility**
• **Precertification required**	During the Transplant Benefit Period, No Copayment, Deductible, or Coinsurance. Before and after the Transplant Benefit Period,	During the Transplant Benefit Period, You will pay 50% Coinsurance after Deductible. During the Transplant Benefit Period, Covered

		Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will **not** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you **will** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.

Covered Transplant Procedure during the Transplant Benefit Period	**In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**	**Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**
	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	No Copayment, Deductible, or Coinsurance	Not covered
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per transplant. In-Network only. Benefits are not available Out-of-Network.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant In- and Out-of-Network combined**.**	
Live Donor Health Services	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days **Note:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy	30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Note: Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.		
Level 1 Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$10 Copayment per Prescription Drug	50% Coinsurance
Tier 2 Prescription Drugs	$35 Copayment per Prescription Drug	50% Coinsurance
Tier 3 Prescription Drugs	$75 Copayment per Prescription Drug	50% Coinsurance
Tier 4 Prescription Drugs	25% Coinsurance to a maximum of $350 per Prescription Drug	50% Coinsurance
Level 2 Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$20 Copayment per Prescription Drug	50% Coinsurance
Tier 2 Prescription Drugs	$45 Copayment per Prescription Drug	50% Coinsurance
Tier 3 Prescription Drugs	$85 Copayment per Prescription Drug	50% Coinsurance

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Tier 4 Prescription Drugs	25% Coinsurance to a maximum of $450 per Prescription Drug	50% Coinsurance
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$25 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$105 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$225 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	25% Coinsurance to a maximum of $350 per Prescription Drug	Not covered

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

Note: As required by Kentucky law, your maximum cost share (e.g. Copayment, Deductible, or Coinsurance) for a covered Prescription Drug that contains insulin will not be more than $30 per Prescription for a 30-day supply.

How Your Plan Works

Introduction

Your Plan is a PPO plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

To find an In-Network Provider for this Plan, please see "How to Find a Provider in the Network," later in this section.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level.

If you receive Covered Services from an Out-of-Network Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, Covered Services will be covered at the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have complete authority to decide the Medical Necessity of the service. If you disagree with our determination, you have the right to file an appeal as described in the "Complaint and Appeals Process" section.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member.
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.

2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments unless your claim involves a Surprise Billing Claim;

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim;

3. You will have to pay for services that are not Medically Necessary;

4. You will have to pay for non-Covered Services;

5. You may have to file claims; and

6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

As soon as you enroll in this Plan, you should download our mobile app. You can find details on how to do this on our website, www.anthem.com.

Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, www.anthem.com, or through an Anthem-enabled device.

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in our mobile app or through an Anthem-enabled device.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

If an Out-of-Network Provider meets our enrollment criteria and is willing to meet the terms and conditions of our Provider agreement, that Provider has the right to become an In-Network Provider for this Plan. They will not become an In-Network Provider, however, until they have signed the required Provider agreement.

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.

Continuity of Care

If your In-Network Provider leaves our network (for any reason other than termination for quality), you may be able to continue seeing that Provider for a limited time and still get In-Network benefits. This could happen if you have a disability, a congenital condition, or you are past the twenty-fourth week of pregnancy through the postpartum period or in an active course of treatment. For purposes of this section, an "active course of treatment" is an ongoing course of treatment for a life threatening condition, a serious acute condition (such as chemotherapy, radiation therapy and post-operative visits), and a health condition for which a Physician attests that discontinuing care by the current Physician would worsen the condition or interfere with anticipated outcomes. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by us regarding a request for Continuity of Care is subject to the process described in "Complaint and Appeals Process." Continuity of care under this section will end the earlier of completion of treatment, 90 days after the effective date of termination or non-renewal, nine months if you have been diagnosed with a terminal illness at the time of termination, or in the case of pregnancy, six weeks following delivery.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if

applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

For the Deductible, the credit applies for the same or overlapping benefit periods and will be given for costs you paid toward the deductible of the Group's prior carrier or plan in the 90 days before the Group's effective date with us. You will also receive credit for any satisfaction or partial satisfaction of waiting periods under the Group's prior carrier or plan.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard," which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care/setting/place of care will not be Medically Necessary if they are given in a higher level of care/setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imagining center, infusion center, Ambulatory Surgical Facility, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if you have not tried other clinically equivalent treatments that are more cost effective and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

  Precertification – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

  For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a

vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay / Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Provider must get Precertification when required
Out of Network/ Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
BlueCard Provider	Member **(Except for Inpatient Admissions)**	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain precertification for all Inpatient Admissions.**

Provider Network Status	Responsibility to Get Precertification	Comments
NOTE: For an Emergency Care admission, precertification is not required. However, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the "Complaint and Appeals Process" section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Urgent Pre-Service Review	24 hours from the receipt of all necessary information
Non-Urgent Pre-Service Review	5 calendar days from the receipt of all necessary information
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of all necessary information
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	24 hours from the receipt of all necessary information
Non-Urgent Continued Review for ongoing outpatient treatment	5 calendar days from the receipt of all necessary information
Post-Service Review	5 calendar days from the receipt of all necessary information

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic**.**

Important Information

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Member Services number on the back of your ID card.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

Acute Care at Home Programs

Anthem has programs available that offer acute care to Members where they live as an alternative to staying in a Facility, when the Member's condition and the Covered Services to be delivered, are appropriate for the home setting. We refer to these programs as Acute Care at Home Programs. These programs provide care for active, short-term treatment of a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally delivered by teams of health care Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Care Services benefit, are only available in certain Service Areas, and are only provided if the Member's home meets accessibility requirements.

Covered Services provided by Acute Care at Home Programs may include Physician services (either in-person or via telehealth), diagnostic services, surgery, home care services, home infusion therapy, Prescription Drugs administered by a Provider, therapy services, and follow-up care in the community. Prescription Drugs at a Retail or Mail Order Pharmacy are not included in these Programs. Benefits for those Drugs are described under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section. Acute Care at Home Programs may also include services required to set up telehealth technology for in-home patient monitoring, and may include coverage for meals.

Members who qualify for these programs will be contacted by our Provider, who will discuss how treatment will be structured, and what costs may be required for the services. Benefit limits that might otherwise apply to outpatient or home care services, (e.g., home care visits, physical therapy, etc.), may not apply to these programs.

Your participation in these programs is voluntary. If you choose to participate, your Provider will discuss the length of time that benefits are available under the program (e.g., the Acute Care at Home Benefit Period) when you enroll. The Acute Care at Home Benefit Period typically begins on the date your Acute Care at Home Provider sets up services in your home, and lasts until the date you are discharged from the Program.

Any Covered Services received before or after the Acute Care at Home Benefit Period will be covered according to the other benefits of this Plan.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services." As a result, you should read all sections that might apply to your claims.

You should also know that many Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. **For services to be covered, they must be provided in the lowest level of care that is medically appropriate.** The costs of services will often vary depending on the setting you choose, and the choice of setting can result in a change in the amount you need to pay or even in a denial for the services. Please see the "Schedule of Benefits" and the "Getting Approval for Benefits" sections for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-

Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select no benefits will be available. Please see the "Schedule of Benefits" for the maximum benefit.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include trips to:

a) A Doctor's office or clinic;
b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Services

Your Plan also covers the diagnosis and treatment of Autism Spectrum Disorders. Autism Spectrum Disorders are a physical, mental, or cognitive illness or disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). They include any of the pervasive developmental disorders, Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Benefits for Members diagnosed with an Autism Spectrum Disorder include the following:

1. Medical care from by a licensed Provider.

2. Habilitative or rehabilitative care. This includes counseling and guidance services, therapy, treatment programs, and applied behavior analysis.

3. Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy, if this Plan includes Pharmacy benefits, and Medically Necessary services to determine the need or effectiveness of the Drugs.

4. Psychiatric care.

5. Psychological care given by a licensed Provider.

6. Therapy from licensed speech therapists, occupational therapists, or physical therapists; and

7. Applied behavior analysis prescribed or ordered by a licensed Provider.

No benefits are available under this section for services, supplies, or equipment:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Given to the Member by a publicly funded program;
- Given by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
- For services given by people who are not licensed as required by law.

Behavioral Health Services

See “Mental Health and Substance Abuse Services” later in this section.

Breast Cancer Treatment

This Plan covers services to treat breast cancer including chemotherapy, high-dose chemotherapy with autologous bone marrow transplants or stem cell transplants, mastectomies, prosthetics, and reconstructive services needed after the mastectomy. Please see the rest of the Booklet for details on how each benefit is covered.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractor Services

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or

treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials, which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service;
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Congenital Defects and Birth Abnormalities

Covered Services include the treatment of medically-diagnosed congenital defects and birth abnormalities.

Dental Services

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Other Dental Services

The Plan will also cover Hospital or Ambulatory Surgical Facility charges and anesthesia for dental care if the Member is:

1. Under the age of 9;
2. Has a serious mental or physical condition; or
3. Has significant behavioral problems.

The Member's Provider must certify that hospitalization or general anesthesia is required to safely and effectively give the dental care. Benefits do not include routine dental care or treatment of dental conditions not covered by the Plan.

Diabetes Equipment, Education, and Supplies

Benefits are available for medical services, supplies, equipment, insulin, and Prescription Drugs needed to treat diabetes. Covered Services also include diabetic self-management training and education programs, including medical nutrition therapy.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.

- Genetic tests, when allowed by us. Certain genetic tests for cancer are covered under the "Preventive Care" benefit. Please see that section for details.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the

amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Orthotics may only be replaced once per year, when Medically Necessary. However, additional replacements will be allowed:

- For Members under age 18, when needed as a result of rapid growth, or
- For Members of any age, when an appliance is damaged and cannot be repaired.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

1) Artificial limbs and accessories.
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
3) Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5) Restoration prosthesis (composite facial prosthesis).
6) Wigs needed after cancer treatment.
7) Cochlear implants.
8) Hearing aids and related services for Members under age 18. Benefits include Medically Necessary hearing aids, including bone-anchored hearing aids, for Members under age 18. Benefits also include services to assess, select, adjust or fit the hearing aid. You can get Covered Services from a licensed audiologist or a licensed hearing instrument specialist.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant women, placing the women's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

"Emergency Care" means a medical or behavioral health exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable as described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Your cost shares will be based on the Maximum Allowed Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details on how this will impact your benefits.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See "Getting Approval for Benefits" for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

ii. Services provided by a non-approved Provider or at a non-approved Facility; or

iii. Services not approved in advance through Precertification.

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see "Therapy Services" later in this section for further details.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor, an advanced practice registered nurse, or a Physician's assistant, and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services (except for Manipulation Therapy, which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing services.

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member’s death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member’s death.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

Please call our Transplant Department as soon as you think you may need a transplant, to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a

transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Centers of Excellence (COE) Transplant Providers

- **Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for transplant care delivery.

- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for transplant care delivery.

In-Network Transplant Provider

A Provider that we have chosen and designated as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence for Transplant by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts the day of a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,

- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.
- Newborn diet. Covered Services include a 100% human diet to supplement the mother’s expressed breast milk or donor milk with a milk fortifier if the diet is:

    1. Prescribed for the prevention of Necrotizing Enterocolitis and associated comorbidities; and

2. Administered under the direction of a physician.

"100% human diet**"** means supplementing the mother's expressed breast milk or donor milk with a milk fortifier. **"**Milk fortifier**"** means a commercially prepared human milk fortifier made from concentrated 100% human milk.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Endometriosis and Endometritis

Your Plan also covers the diagnosis and treatment of endometriosis and endometritis.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

    - Observation and assessment by a physician weekly or more often,
    - Rehabilitation and therapy.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs.

- **Virtual Visits** as described under the “Virtual Visits and Telehealth Services” section.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Virtual Visits as described under the "Virtual Visits and Telehealth Services" section.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments, or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:

    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer,
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children, and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    a. Women's contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."
    b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
    c. Gestational diabetes screening.

5. Preventive care services for smoking cessation and tobacco cessation as recommended by the United States Preventive Services Task Force including:

    a. Counseling
    b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy, subject to age limits defined by the Food and Drug Administration (FDA)
    c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches (subject to age limits defined by FDA guidelines).

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

   a. Aspirin

   b. Folic acid supplement

   c. Bowel preparations

   Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Covered Services also include these services as required by state law:

- Routine bone density testing for women.
- Routine colorectal cancer exams and related lab tests as specified in the most recent version of the American Cancer Society guidelines.
- Routine screening mammograms.
- Annual pap smears for women.
- Genetic tests for cancer risk if recommended by the most recent guidelines published by the National Comprehensive Cancer Network (NCCN).

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as "the agencies"). Details on those guidelines can be found on the IRS's website at the following link:

https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see "Therapy Services" in this section for further details.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the "Preventive Care" section in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

This Plan does not cover extraction of teeth, surgery for impacted teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services.

- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy** – Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services" earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits and Telehealth Services

Covered Services include virtual Telehealth visits that are appropriately provided through the internet via video or telephone (audio-only). This includes visits with Providers who also provide services in person, as well as online-only Providers.

- "Medical Chat" means Covered Services accessed through a secure and compliant application, according to applicable legal requirements, such as texting or chat services provided through our mobile app, website, or Anthem-enabled device.

- "Telehealth" means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging through our mobile app, website, or Anthem-enabled device; interactive store and forward (asynchronous) technology; or remote patient monitoring technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

  "Remote patient monitoring" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

Benefits do not include the use of facsimile, texting (outside of our mobile app, website, or Anthem-enabled device), electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, or benefit precertification.

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

Vision Services for Members Through Age 20

The vision benefits described in this section only apply to Members through age 20. Benefits will continue through the end of the month that the Member turns 21.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee.

Vision Services for Members Age 21 and Older

The vision benefits described in this section only apply to Members age 21 or older.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Getting Approval for Benefits" for more details.

If precertification is denied you have the right to file an appeal as outlined in the "Complaint and Appeals Process" section of this Booklet.

Designated Pharmacy Provider

Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change upon advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Provider in a medical setting (e.g., doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if prior authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.
- Use of a Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied you have the right to file an appeal as outlined in the "Complaint and Appeals Process" section of this Booklet.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin*
  *As required by Kentucky law, your maximum cost share (e.g. Copayment, Deductible, or Coinsurance) for a covered Prescription Drug that contains insulin will not be more than $30 per Prescription for a 30-day supply.
- Insulin supplies and equipment used to administer insulin.
- Continuous glucose monitoring systems.*
  ***Note:** Each component of the monitoring system will be subject to a separate Copayment / Coinsurance.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Self-administered anti-cancer Drugs. As required by Kentucky law, your maximum cost-share (e.g., Copayment, Deductible, or Coinsurance) will not be more than $100 per Prescription for a 30-day supply.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Therapeutic food, formulas, supplements, and low-protein modified food products needed to treat inborn errors of metabolism or genetic conditions when given under the direction of a Doctor. Prior Authorization is required.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription, subject to age limits defined by the Food and Drug Administration (FDA). These products will be covered under the "Preventive Care" benefit.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Where You Can Get Prescription Drugs

Your Plan has three levels of coverage. To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy. If you get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and you may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When you go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), you pay a lower Copayment / Coinsurance on Covered Services than when you go to other In-Network Pharmacies.

Level 2 In-Network Pharmacies. When you go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), you pay a higher Copayment / Coinsurance on Covered Services than when you go to a Level 1 In-Network Pharmacy.

Level 3 Out of-Network Pharmacies. When you go to Level 3 Out of Network Pharmacies, you will pay the highest Copayment/Coinsurance because these pharmacies are not in our network.

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Important Note: If the utilization guidelines of a Prescription Drug(s) suggest there are patterns of its over-utilization or misuse, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Complaint and Appeals Process” section of this Booklet.

In addition, if the utilization guidelines for Controlled Substance Prescription Drug(s) suggest there are patterns of its over-utilization or misuse, your selection of In-Network Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Provider. We will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers we offer within 31 days, we will select a single In-Network Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Complaint and Appeals Process” section of this Booklet.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy

When you use the PBM's Specialty Pharmacy its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

Please note: To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., oral, injection, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage based upon medication dosage, dosage forms, manufacturer, and administration methods (i.e., oral, injection, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

If you or your Doctor believes you need a certain Prescription Drug not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the Drugs on the List. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

As required by Kentucky law, this Plan will cover refills of prescription eye drops as follows:

- For a 30-day supply, between 25 and 30 days from the later of a) the original date the prescription was filled, or b) the date you received your most recent refill.

- For a 90-day supply, between 80 and 90 days from the later of a) the original date the prescription was filled, or b) the date you received your most recent refill.

- The Plan will also cover one additional bottle of drops every 3 months when the additional bottle is requested by you or your prescribing Provider at the time the original prescription is filled, and the Provider indicates on the prescription that the additional bottle is needed by you for use in a day care center or school.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you out of pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

Rebate Impact on Prescription Drugs You get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by you from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowable Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time you purchase the Prescription Drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim will not be adjusted if the later determined rebate value is higher or lower than our original estimate.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery.

   This Exclusion does not apply to abortions performed to preserve the life of the female upon whom the abortion is performed.

2. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience when you are a direct participant.

3. **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include fees for educational brochures or calling you to give you test results.

4. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

5. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes:

   a. Acupuncture,
   b. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
   c. Holistic medicine,
   d. Homeopathic medicine,
   e. Hypnosis,
   f. Aroma therapy,
   g. Massage and massage therapy,
   h. Reiki therapy,
   i. Herbal, vitamin or dietary products or therapies,
   j. Naturopathy,
   k. Thermography,
   l. Orthomolecular therapy,
   m. Contact reflex analysis,
   n. Bioenergial synchronization technique (BEST),
   o. Iridology-study of the iris,
   p. Auditory integration therapy (AIT),

q. Colonic irrigation,
r. Magnetic innervation therapy,
s. Electromagnetic therapy.

6. **Autopsies** Autopsies and post-mortem testing.
7. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
8. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
9. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
10. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.
11. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
12. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
13. **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
14. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
15. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy or to surgery to correct congenital defects and birth abnormalities.
16. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
17. **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence. This Exclusion also does not apply unless the Member is incarcerated in a local penal institution or in the custody of a local law enforcement officer as a result of a conviction for a felony.

18. **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
19. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
20. **Delivery Charges** Charges for delivery of Prescription Drugs.
21. **Dental Devices for Snoring** Oral appliances for snoring.
22. **Dental Treatment** Excluded treatment includes preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

    - Removing, restoring, or replacing teeth;
    - Medical care or surgery for dental problems (except as listed under the "Dental Services," "Oral Surgery," or "Temporomandibular (TMJ) and Craniomandibular Joint Services" benefits);
    - Services to help dental clinical outcomes.

    Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.
23. **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
24. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan, based upon FDA labeling.
25. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
26. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
27. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
28. **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
29. **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.
30. **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Please see "Additional Information about Experimental / Investigational Services" at the end of this section for more details.
31. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This Exclusion does not apply to lenses needed after a covered eye surgery as described in the "Prosthetics" benefit.
32. **Eye Exercises** Orthoptics and vision therapy.

33. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
34. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
35. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including:
    a) Cleaning and soaking the feet.
    b) Applying skin creams to care for skin tone.
    c) Other services that are given when there is not an illness, injury or symptom involving the foot.
36. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
37. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
38. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

    This Exclusion does not apply to a Member incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.

39. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
40. **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
41. **Home Care**
    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    b) Food, housing, homemaker services and home delivered meals.
42. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
43. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
44. **Infertility Treatment** Testing or treatment related to infertility.
45. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
46. **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

47. **Medical Chats Not Provided through Our Mobile App, Website, or Anthem-Enabled Device** Texting or chat services provided through a service other than our mobile app, website, or Anthem-enabled device.

48. **Medical Equipment, Devices, and Supplies**

    a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

    b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

    c) Non-Medically Necessary enhancements to standard equipment and devices.

    d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

    e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What's Covered” section.

    f) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.

49. **Medicare** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the "Medicare" section in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

50. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

51. **Non-approved Drugs** Drugs not approved by the FDA.

52. **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

53. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

54. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to therapeutic food, formulas, supplements, and low-protein modified food products covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit or to the newborn diet covered under the “Inpatient Services” benefit.

55. **Off label use** Off label use unless we approve it.

56. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

57. **Personal Care, Convenience and Mobile/Wearable Devices**

    a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.

    b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).

    c) Home workout or therapy equipment, including treadmills and home gyms.

    d) Pools, whirlpools, spas, or hydrotherapy equipment.

    e) Hypoallergenic pillows, mattresses, or waterbeds.

f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

58. **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

59. **Prosthetics** Prosthetics for sports or cosmetic purposes.

60. **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center**.** This Exclusion includes procedures, equipment, services, supplies or charges for the following:

    a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

    b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

    c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

61. **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

62. **Sanctioned or Excluded Providers** Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

63. **Services Not Appropriate for Virtual Telehealth Visits** Services that require in-person contact and/or equipment that cannot be provided remotely.

64. **Sexual Dysfunction** Services or supplies for male or female sexual problems.

65. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

66. **Sterilization** Services to reverse an elective sterilization.

67. **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including the bea**r**ing of a child by another woman for an infertile couple).

68. **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

69. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs. This Exclusion does not apply to the travel and lodging services covered under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services" benefit.

70. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

71. **Vision Services** Vision services not described as Covered Services in this Booklet.

72. **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
73. **Weight Loss Programs** Programs, whether or not under medical supervision.

    This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
74. **Weight Loss Surgery** Bariatric surgery. This includes Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.
75. **Wilderness or other outdoor camps and/or programs.**

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
4. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
5. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
9. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section

"Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.

10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan, based upon FDA labeling.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
14. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.
16. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
17. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
18. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
19. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
20. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
21. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
22. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
23. **Non-approved Drugs** Drugs not approved by the FDA.
24. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
25. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements. This Exclusion includes nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. This Exclusion does not apply to therapeutic food, formulas, supplements, and low-protein modified food products covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit or to the newborn diet covered under the "Inpatient Services" benefit.
26. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

27. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
28. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under state or federal law with a Prescription.
29. **Sanctioned or Excluded Providers** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
30. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
31. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
32. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Additional Information About Experimental / Investigational Services

We will find any Drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service, or supply (i.e., any service or supply) to be Experimental / Investigational if we find that one or more of the following criteria apply when the service or supply is given:

- It cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- It has been determined by the FDA to be contraindicated for the specific use; or
- It is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- It is given as part of informed consent documents that describe the service or supply as Experimental / Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the service or supply is under evaluation.

Any service or supply not deemed Experimental / Investigational based on the criteria above may still be deemed Experimental / Investigational by us. In determining whether a service or supply is Experimental / Investigational, we will consider the information described below and assess whether:

- the scientific evidence is conclusive concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigational settings.

The information we consider or evaluate to determine whether a service or supply is Experimental / Investigational under the above criteria may include one or more items from the following list, which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same service or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will apply our medical policy to identify and weigh all information and determine all questions about whether a service or supply is Experimental / Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangements" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Except for Surprise Billing Claims, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

**Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Please refer to that section for further details.*

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Medical Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

Except for Surprise Billing Claims, we will calculate the Maximum Allowed Amount for Covered Services you receive from an Out-of-Network Provider using one of the following:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount or if your claim involves a Surprise Billing Claim.

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount unless your claim involves a Surprise

Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

- *You choose an In-Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The In-Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.*

- *You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; your Coinsurance responsibility for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050.* ***In addition****, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total Out of Pocket charge would be $450 plus an additional $1000, for a total of* ***$1450****.*

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and we will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you

can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. We will send the form to you within 15 days. If you do not receive the claims form within 15 days, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Out-of-Network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

Claims will be paid within 30 days of the date we get the completed claim and proof of loss.

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, we will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting Approval for Benefits” section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Coordination of Benefits When Members Are Insured Under More Than One Plan

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. Will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but

2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. Group insurance or group-type coverage whether insured or uninsured. This shall not include the medical benefits coverage in a group, group-type, and individual motor vehicle “no-fault” and traditional automobile “fault” type contracts. This does include prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.

3. Coverage under a governmental Plan or coverage required or provided by law except Medicaid.

4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.

5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" does not include any of the following:

1. Group or group-type fixed indemnity medical expense reimbursement policies.

2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

Primary plan means a plan whose benefits shall be determined without taking the existence of any other plan into consideration if:

1. The plan either has no order of benefits determination requirements, or

2. All plans that cover the person use the order of benefits determination requirements as listed in the Order of Benefit Determination Rules section.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense - a health care service or expense including Deductibles, Coinsurance or Copayment, that is covered in full or in part by any of the plans covering the person.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and Preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its Contract, is not obligated to pay for providing those services.

Allowable Expense does not include the amount that is subject to the Primary high-deductible health plan’s deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986**.**

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and

2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Subscriber or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

   A. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

      1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      2. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

   B. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      1. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

      2. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;

      3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

      4. If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         a. The Plan covering the Custodial parent;

         b. The Plan covering the spouse of the Custodial parent;

         c. The Plan covering the non-custodial parent; and then

         d. The Plan covering the spouse of the non-custodial parent.

   3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

   4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.

   5. Active/Inactive Subscriber. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.

6. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

    a. First, the benefits of a Plan covering the person as an employee, Subscriber or Subscriber or as that person's Dependent;

    b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable Expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Allowable Expense.

When this Plan is Secondary, you will receive credit during the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. A combined benefit from all Plans greater than the Allowable Expense; or

2. More benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts we need to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan is more than it should have paid under this provision, we may recover the excess from one or more of:

1. The persons we have paid or for whom we paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery. A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have first priority for the full amount of benefits we have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them.
- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full our subrogation claim and any claim still held by you, our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs you incur without our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.

Reimbursement

If you obtain a Recovery and we have not been repaid for the benefits we paid on your behalf, we shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must promptly reimburse us to the extent of benefits we paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, we shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to us immediately upon your receipt of the Recovery.
- Any Recovery you obtain must not be dissipated or disbursed until such time as we have been repaid in accordance with these provisions.
- You must reimburse us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount we paid on your behalf is not repaid or otherwise recovered by us; or
    2. You fail to cooperate.

- In the event that you fail to disclose to us the amount of your settlement, we shall be entitled to deduct the amount of our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount we have paid or the amount of your settlement, whichever is less, directly from the Providers to whom we have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and we would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by us.
- You must cooperate with us in the investigation, settlement and protection of our rights.
- You must not do anything to prejudice our rights.
- You must send us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify us if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify us if a trial is commenced, if a settlement occurs, or if potentially dispositive motions are filed in a case.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

We are entitled to recover attorney's fees and costs incurred in enforcing this provision.

Member Rights and Responsibilities

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network health care Providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and Federal laws.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of health care Providers.
  - Your rights and responsibilities.
  - The rules of your health Plan.
  - The way your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care you receive.
  - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.
- Give us, your Doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health insurance benefits you have along with your coverage with us.

- Inform Member Services if you have any changes to your name, address or family members covered under your Plan.

If you would like more information, have comments, or would like to contact us, please go to www.anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We want to provide high quality benefits and customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Complaint and Appeals Process

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

(If you need assistance in Spanish to understand this document, you may request it for free by calling Member Services at the number on Your Identification Card.)

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. Our Member Services representatives are specially trained to answer your questions about our health plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Deductible, Coinsurance, or Copayment amounts;
- Specific claims or services you have received;
- Doctors or Hospitals in the network;
- Authorizations; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the appeals process. A complaint process also exists to help you understand the Plan's determinations.

The Complaint Process

A complaint procedure is available to provide reasonable, informative responses to complaints that you may have about us. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from us of our procedures and contracts. We invite you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Providers in our networks.

If you have a complaint or problem concerning benefits or services, please contact us. Please refer to your Identification Card for our address and telephone number. You may send in your complaint by letter or by phone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Process

An appeal is a formal request from you that asks us to change a previous determination. If you are notified in writing of any Adverse Determination or Coverage Denial, you will be advised of your right to an internal appeal and an external review if appropriate. You also have a right to appeal if we fail to make a Utilization Review determination and provide written notice within the required time frame if our failure to make a determination or provide notice of a determination within the required time frame is as a result of circumstances beyond our control. For purposes of this section:

- Coverage Denial means our determination that a service, treatment, Drug or device is specifically limited or excluded under this Booklet.

- Adverse Determination means our denial, reduction, or termination of a benefit (either in whole or in part) based on any of the following:

- A determination that you are not eligible to participate in the Plan, including the denial, reduction, or termination of a benefit (in whole or in part) as a result of a utilization review;
- A determination that the benefit is Experimental / Investigational or not Medically Necessary;
- A determination that the benefit is not a covered benefit under the Plan; or
- A determination that the benefit is excluded due to a limitation in the Plan.

Adverse Determination includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit.

The internal appeals process may be initiated by you, your authorized representative, or a Provider acting on your behalf within 60 days of the date you get our written notice of an Adverse Determination, a Coverage Denial or any other adverse decision we made, but must be filed within six months of the date you get the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by you relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the appeal.

In addition, we will also provide you, free of charge, with any new or additional evidence we will consider, rely upon, or generate in connection with the claim, as well as our rationale for making any Adverse Determination. We will provide this as soon as possible and sufficiently in advance of the date on which the final Adverse Determination is due, by law, to give you a reasonable opportunity to respond prior to that date.

You will continue to get coverage under the Plan pending the outcome of the internal appeal, as long as you remain eligible for coverage. If you have undertaken an ongoing course of treatment, we will only reduce or terminate it after giving you advance notice.

If a representative is seeking an appeal on your behalf, we must get a signed Designation of Representation (DOR) form from you. The appeal process will not begin until we get the properly completed DOR form. The only exception to this is if a Physician requests an expedited internal appeal on your behalf, the Physician will be deemed to be your representative for the purpose of filing the expedited internal appeal even though we did not get the signed form. We will forward a Designation of Representation form to you to complete in all other situations.

We will ensure that appeals are reviewed in a manner designed to ensure the independence and partiality of the individuals responsible for reviewing your request (referred to as qualified reviewers). The qualified reviewers will not be the same people who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision. If the internal appeal is related to an Adverse Determination or any other adverse decision that is based in whole or in part on a medical judgment, at least one person conducting the appeal will be a licensed Physician (or if the determination involves services rendered by a Chiropractor or Optometrist, a Chiropractor or Optometrist licensed in Kentucky) unless a nurse can approve the request. If the appeal is related to a medical or surgical specialty or subspecialty, upon your request of the request of your authorized representative or Provider, at least one person conducting the appeal will be a board eligible or certified Physician in the appropriate specialty or subspecialty.

Within a reasonable time given the medical circumstances and no later than 30 days after we get a written or an oral request for appeal, we will send a written decision to you or your authorized representative and, if applicable, your Provider.

If we fail to resolve the appeal with the required time, you may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de

minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between you and us.

Expedited Appeals

An expedited appeal is deemed necessary when you are hospitalized, or in the opinion of the treating Provider (or any Physician with knowledge of your medical condition), review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the your health or, with respect to a pregnant woman, your health or your unborn child's health in serious jeopardy;
- Subjecting you to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions;
- Serious dysfunction of a bodily organ or part; or
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

In addition, Members in urgent care situations and Members receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

The Plan, applying a prudent layperson standard, may also determine that an appeal may be expedited. The request for an expedited internal appeal may be in writing or an oral request, followed up by an abbreviated written request by you, your authorized representative or Provider acting on your behalf. We have the right to require verification from the treating Provider (or other Physician with knowledge of your medical condition), that your condition warrants an expedited internal appeal.

The process for the expedited internal appeal is similar to the standard internal appeal, except that we will communicate our decision to you or your authorized representative as soon as possible taking into account the medical urgency of the situation, but no later than 72 hours after receipt of the request for an expedited internal appeal. All necessary information, including our decision on review, shall be transmitted between us and you or your authorized representative by phone, facsimile, or other available similarly expeditious method.

If our decision is to uphold a Coverage Denial, you, your authorized representative or a Provider acting on behalf of and with your consent may contact the Kentucky Department of Insurance, Health and Life Division, 500 Mero Street, 2 SE 11, P.O. Box 517, Frankfort, KY 40602, and request a review of our decision. The Department will make a determination as to whether the service should or should not be covered. If the Department determines the disputed service should be covered, it may direct us to either pay the service or offer external review to resolve the issue.

External Review by an Independent Review Entity

You, your authorized representative, or a Provider acting on your behalf and with your consent may request an external review of an Adverse Determination if the following criteria are met:

- The internal appeal process outlined above was completed or jointly waived by you and us or we failed to make a decision within 30 days of receiving the written appeal or within 72 hours of receiving the request for an expedited appeal; and

- You were covered under this Plan on the date of service or, if a prospective denial, you were eligible to receive benefits under this Plan on the date the proposed service was requested.

The request for an external review of an Adverse Determination must be sent to us within 4 months of the date you get our written decision rendered under the internal appeals process. As part of the request, you shall provide written consent authorizing the independent review entity to get all medical records from us and any Provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

We will determine if your request qualifies for independent review and will refer all eligible requests to the Kentucky Department of Insurance, who will assign an independent review entity. Independent review entities are assigned on a rotating basis so that we do not have the same independent review entity for two consecutive external reviews. We will inform you in writing of the independent review entity that will conduct the review and inform you of your right to submit additional information to the independent review entity within 5 days. If the independent review entity receives the information within 5 days they will include it in their review and forward a copy to us within one day. We will also forward all information required to be considered for an external review to the independent review entity within three business days of assignment.

You will be assessed a filing fee of $25 to be paid to the independent review entity. This fee may be waived if the independent review entity determines that the fee creates a financial hardship on you. The fee shall be refunded if the independent review entity finds in your favor. If you send in multiple requests for external review within a one-year period, you will not have to pay more than $75 per year in filing fees. We will pay the rest of the cost of the external review.

The independent review entity will send a written decision to you within 21 days from the date they get of all information required from us. An extension of up to 14 days may be allowed if agreed to by you and us. In no event will the independent review entity take longer than 45 days to complete their review.

You will not be able to get an external review of an Adverse Determination if:

- Your Adverse Determination has previously gone through the external review process and the independent review entity found in our favor; and

- No new relevant clinical information has been sent to us since the independent review entity found in our favor.

If a dispute arises between us and you about the right to an external review, you may file a complaint with the Kentucky Department of Insurance. Within five days of the date they get your complaint, the Department will make a decision. They may direct us to send the dispute to an independent review entity for an external review if they find that the dispute involves denial of coverage based on Medical Necessity or the service being Experimental / Investigational and all other external review requirements have been met.

Expedited External Reviews

External reviews shall be done in an expedited manner by the independent review entity if you are hospitalized, or if, in the opinion of the treating Provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing your health or, with respect to a pregnant woman, your health or your unborn child’s health in serious jeopardy;
- Subjecting you to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Expedited reviews are also available if you are requesting review of a decision that a recommended or requested service is Experimental / Investigational and your Physician certifies in writing that the requested service would be significantly less effective if not promptly initiated.

You may pursue an expedited external review while simultaneously pursuing an expedited internal appeal.

The request for an expedited external review may be in writing or an oral request, followed up by an abbreviated written request, by you, your authorized representative or a Provider acting on your behalf and with your consent. Requests for expedited external review shall be sent by us to the independent review entity within 24 hours of receipt. We will call the independent review entity to confirm that a specialist is available and that the review has been accepted.

For expedited external review, a decision shall be made by the independent review entity within 24 hours of getting all information required from us. An extension of up to 24 hours may be allowed if agreed to by you and us. We will provide notice to the independent review entity and to you the same day that the Adverse Determination has been assigned to an independent review entity for expedited review. In no event will the independent review entity take longer than 72 hours to complete their review.

The Decision of the Independent Review Entity

The independent review entity shall provide you, your treating Provider, the Kentucky Department of Insurance and us a decision which shall include:

- The findings for either us or you regarding each issue under review;
- A summary of the proposed service, treatment, drug, device or supply for which the review was performed;
- The relevant provisions in the Plan and how they were applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Records provided to independent review organizations are handled as confidential records.

The decision of the independent review entity will be binding on us and you except to the extent that there are remedies available under applicable state or federal law.

Who to Contact for Appeals and External Review

The request for an internal appeal or an external review and supporting documentation must be sent to the address or phone number below or to the appeal address or phone number provided on your written notice of an adverse decision:

Position:	Appeals Coordinator
Address:	P.O. Box 105568, Atlanta, GA 30348
Phone:	Please see the number on the back of your ID card.

The person holding the position named above will process your request.

We encourage you to submit any requests for appeals or external review in writing. The request should describe the problem in detail. Please attach copies of bills, medical records, or other appropriate documents to support your position.

You must file appeals on a timely basis. You are encouraged to file internal appeals within 60 days of the date you get our initial decision, and must file internal appeals within six months of the date you get our

initial decision. If the right to external review exists as described above, you must file the external review request within 4 months of the date you received our final decision on your internal appeal.

Medical Services

We are not liable for Covered Services that you do or do not get from a Provider. You shall have no claim against us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) perform the duties of your principal occupation for the Group.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.

- The Subscriber's Domestic Partner, if Domestic Partner coverage is allowed under the Group's Plan. Please contact the Group to determine if Domestic Partners are eligible under this Plan. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that he or she is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

  For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

  Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

  To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to a mental or physical impairment. The Dependent's incapacity must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse or Domestic Partner;
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described below.

Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you should submit an application / change form to the Group within 31 days to add the newborn to your Plan.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

If additional Premium is required, your newborn's coverage will only continue past the initial 31 days if you send us the application / change form and pay the additional premium within 31 days of the birth.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order.

We will cover your child under this Plan once we get the application from you, the child's other parent, the Cabinet for Health and Family Services.

After the child is covered, and as long as you are eligible under this Plan, we will continue to cover the child unless we get satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another health plan that provides comparable health coverage.

A child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”);
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms. We will return any unearned Premium as required by Kentucky law.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to

void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.

- If you choose to terminate your coverage.

- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.

- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." 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 you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Subscribers:	
Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Dependents:	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
For Dependent Children:	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group 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 Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to

no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides Cobra Continuation Coverage

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

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. 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.)

Continuation of Coverage Under Kentucky Law

Any Subscriber whose coverage in this Plan ends may continue coverage for themselves and for any Dependents if the Subscriber was covered under this Plan, or a group plan it replaced, for at least 3 months. Coverage will be continued at the Group Premium rate.

The Subscriber will be sent an offer of continued coverage at his or her last known address. To continue coverage, the Subscriber must send in the Premium and written application for coverage no later than:

- 31 days after coverage ends if the Subscriber is given a written notice of the continuation option when their coverage ends; or

- As soon as possible after they have been given written notice of the continuation privilege if the Subscriber did not get notice when their coverage ended; but

- In no event, later than 60 days after the initial 31-day continuation period ends.

Continuation of coverage will end on the earlier of:

- 18 months from the date the Subscriber's coverage would have otherwise ended under the Group Contract because their employment or membership in the Group ended;

- The date through which the Subscriber timely paid the Group Premium rate; or

- The date this coverage ends and is not replaced within 31 days by other coverage.

Continuation of coverage will be available to a surviving spouse and Dependent children if the Subscriber dies or divorces. Continuation of coverage will also be available to any covered Dependent child whose coverage ends because they have reached the age limit under this Plan.

Please note that this continuation of coverage is not available to Members that are covered by, or eligible for, Medicare or other group coverage.

Conversion

Any Member (e.g., the Subscriber or his / her Dependents) that is covered under this Plan, or any Group plan it replaced, for at least 3 months may buy a conversion health plan when coverage under this Plan ends. The conversion health plan will have benefits similar this Plan.

We will send the offer of the conversion plan to the Subscriber at their last known address. To buy the coverage, we must get the Premium and written application for the conversion plan no later than:

- 31 days after coverage ends if the Subscriber is given written notice of conversion option when their coverage ends; or

- 60 days after the Subscriber is given written notice of the conversion plan option, if we failed to send the offer when their coverage originally ended.

Please note that conversion coverage is not available to Members eligible for, or covered by, Medicare or another group plan, or for Members covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy. It also is not available if issuing the conversion contract will make the Member over insured according to our rules.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
    a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
    b) 14 days after completing military service for leaves of 31 to 180 days,
    c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting / probationary periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

Benefits After the Group Contract Ends

If you are Totally Disabled on the date the Group Contract ends and you are not eligible for another health plan, you can continue to get Covered Services for the Total Disability. Benefits will continue until the earliest of the following:

1. Your Total Disability ends;
2. You get coverage for the Total Disability under another group policy;
3. You get the maximum benefits under this Plan; or
4. 12 months have passed since the Group Contract ended.

Benefits will be limited to the condition(s) causing Total Disability. All terms and conditions of this Plan will continue to apply.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Health Plans of Kentucky, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Kentucky. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in

Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Health Plans of Kentucky, Inc. and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Group for any of Anthem's obligations to the Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives include making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, will determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have, to the fullest extent permitted under applicable law, discretion to determine administration of your benefits. Our determination shall be binding, subject to any rights of complaint and/or appeal provided under the Plan or under applicable law. This may include, without limitation, determinations of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowed Amount. However you may utilize all applicable complaint and/or appeals procedures specified in the Booklet or otherwise required by applicable law. This reservation of discretionary authority shall not be used in such a manner as to deny coverage clearly set forth in the Booklet or to arbitrarily construe or abuse the provision of benefits or rights of appeal under the Plan. This reservation of discretionary authority does not prohibit you from seeking judicial review of our determination after exhausting administrative remedies.

We, or anyone acting on our behalf, will have all the powers necessary or appropriate to enable it to carry out our duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Booklet. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered. Except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We reserve the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on Your ID card and we will work with you (and, if you wish, Your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please see the "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Medical Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Medical Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After the Group Contract Ends."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Please see the "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by us.

Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Health Plans of Kentucky, Inc., for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Health Plans of Kentucky, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by The Joint Commission.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan. The name of network for this Plan is listed on your ID card.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maintenance Medications

Please see the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90-day supply of Maintenance Medication.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury that is determined by us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Not Experimental / Investigational;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an Exclusion under this Plan.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition, other than autism or pervasive development disorders, that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the “What’s Covered” section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. Please see the ” Schedule of Benefits” for details.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem’s behalf. Anthem’s PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem’s PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group’s Contract with us.

Prescription Drug (Drug)

Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1) Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2) Insulin, diabetic supplies, and syringes.

Prescription Order

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Residential Treatment Center / Facility:

A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
2. A staff with one or more Doctors available at all times.
3. Residential treatment takes place in a structured facility-based setting.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Surprise Billing Claim

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Total Disability (or Totally Disabled)

A condition where you are not able to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. It includes conditions where you are confined to a Hospital or are completely incapacitated and unable to perform normal activities of daily living. We may require your Physician to send us proof of your condition.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section "Prescription Drugs Administered by a Medical Provider"), procedures, and/or facilities.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ bédé dyí-bèdèìn-dèò bé m̀ ké bɔ̃̀ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ bídí-wùdùŭn bó pídyi. Đá mébà jè gbo-gmɔ̀ Kpòè nɔ̀bà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ bé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။
(TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。
(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કૉલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ
ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເ
ພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd01zingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd01zingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf . Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 34

Responding Witness: Dewayne Lewis

Q-34. Provide a listing of all life insurance plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Include the associated employee contribution rates and employer contribution rates of the total premium cost for each plan category.

A-34. Wood Creek District does not provide life insurance coverage for the members of its Board of Commissioners.

Each full-time employee is provided with a life insurance policy with $40,000 coverage from Lincoln National Life Insurance Company and a life insurance policy with $10,000 coverage from Anthem Life Insurance Company. Wood Creek District pays the entire cost of these policies.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 35

Responding Witness: Dewayne Lewis

Q-35. Provide a listing of all retirement plans available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Include the associated employee contribution rates, if any, and employer contribution rates of the total cost for each plan category.

A-35. All full-time employees of Wood Creek District participate in the County Employees Retirement System, which is operated and managed by the Kentucky Public Pension Authority. The employee and employer contribution rates are shown in Attachment 35. Members of Wood Creek District's Board of Commissioners do not participate in any retirement plan.

CERS Nonhazardous Contribution Rates		
FISCAL YEAR	**EMPLOYEE**	**EMPLOYER**
1998-1999	**5% of creditable compensation**	8.22%
1999-2000		7.28%
2000-2001		7.17%
2001-2002		6.41%
2002-2003		6.34%
2003-2004		7.34%
2004-2005		8.48%
2005-2006		10.98%
2006-2007		13.19%
2007-2008		16.17%
2008-2009	**5% of creditable compensation. PLUS 1% Health Insurance Contribution for employees who began participating on or after 9/1/2008.**	13.50%
2009-2010		16.16%
2010-2011		16.93%
2011-2012		18.96%
2012-2013		19.55%
2013-2014		18.89%
2014-2015		17.67%
2015-2016		17.06%
2016-2017		18.68%
2017-2018		19.18%
2018-2019		21.48%
2019-2020		24.06%
2020-2021		24.06%
2021-2022		26.95%

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 36

Responding Witness: Dewayne Lewis

Q-36. Concerning employee fringe benefits:

a. Provide a detailed list of all fringe benefits available to the utility's employees. Indicate any fringe benefits that are limited to management employees.

b. Provide comparative cost information for the 12 months preceding the test year and the test year. Explain any changes in fringe benefits occurring over this 24-month period.

A-36. a. See the responses to Questions 30 through 35 for the detailed list of all fringe benefits available to Wood Creek District's employees. No fringe benefit is limited to management employees. All full-time employees receive the same benefits. The members of Wood Creek District's Board of Commissioners receive no fringe benefits.

b. See response to Question 30a. No changes in fringe benefits have occurred in the 24-month period beginning with the year preceding the Test Year and the Test Year.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 37

Responding Witness: Dewayne Lewis

Q-37. State whether the utility, through an outside consultant or otherwise, performed a study or survey to compare its wages, salaries, benefits, and other compensation to those of other utilities in the region, or to other local or regional enterprises.

a. If comparisons were performed, provide the results of the study or survey, including all workpapers and discuss the results of such comparisons. State whether any adjustments to wages, salaries, benefits, and other compensation in the rate application are consistent with the results of such comparisons.

b. If comparisons were not performed, explain why such comparisons were not performed.

A-37. Wood Creek District has not performed any wage studies or surveys. Likewise, it has not engaged any outside consultant to perform any wage studies or surveys.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 38

Responding Witness: Dewayne Lewis

Q-38. Regarding the utility's employee compensation policy:

a. Provide the utility's written compensation policy as approved by the board of directors.

b. Provide a narrative description of the compensation policy, including the reasons for establishing the policy and the utility's objectives for the policy.

c. Explain whether the compensation policy was developed with the assistance of an outside consultant. If the compensation policy was developed or reviewed by a consultant, provide any study or report provided by the consultant.

d. Explain when the utility's compensation policy was last reviewed or given consideration by the board of directors.

e. Explain whether the utility's expenses for wages, salaries, benefits, and other compensation included in the test year and any adjustments to the test year, are compliant with the board of director's compensation policy.

A-38. a. Wood Creek District does not have any written compensation policy.

b. See response to Question 38a.

c. See response to Question 38a.

d. See response to Question 38a.

e. See response to Question 38a.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 39

Responding Witness: Dewayne Lewis

Q-39. To the extent not provided in the responses above, provide all wage, compensation, or employee benefits studies, analyses, or surveys conducted since the utility's last rate case or that are currently utilized by the utility.

A-39. Wood Creek District has not conducted any wage, compensation, or employee benefit studies or surveys.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 40

Responding Witness: Dewayne Lewis

Q-40. Provide the average number of customers on the utility's system (actual and projected), by rate schedule, for the test year and the three most recent calendar years.

A-40. See table below. The number of customers indicated for each year represents the number of customers as of December 31 of that year.

	2019	**2020**	**2021**
Residential customers			
5/8 x 3/4-Inch Meter	4,949	5,070	5,079
1-Inch Meter	12	11	14
2-Inch Meter	11	11	12
Commercial Customers			
5/8 x 3/4-Inch Meter	312	317	312
1-Inch Meter	24	24	24
1.5-Inch Meter	1	1	1
2-Inch Meter	35	36	36
3-Inch Meter	2	2	2
6-Inch Meter	4	4	4
Total:	5,350	5,476	5,484

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 41

Responding Witness: Alan Vilines

Q-41. To the extent not already provided, provide a copy of each cost of service study, billing analysis, and all exhibits and schedules that were prepared in the utility's rate application in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

A-41. See Excel Workbook Q41_WoodCreekWorksheet.xlsx. A copy of this workbook is embedded in this Response and has also been filed separately with the Response.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 42

Responding Witness: Alan Vilines

Q-42. To the extent not already provided, provide all workpapers, calculations, and assumptions the utility used to develop its forecasted test period financial information in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

A-42. Wood Creek District's application uses a historical test period. No forecasted test period was developed. All workpapers, calculations and assumptions used to prepare the Application are set forth in Excel Workbook Q41_WoodCreekWorksheet.xlsx.

WOOD CREEK WATER DISTRICT

Response to Commission Staff's First Request for Information
Case No. 2022-00145

Question No. 43

Responding Witness: Dewayne Lewis

Q-43. Provide a detailed explanation of the method of allocation used to allocate and Revenues and Expenses associated with any and all other utilities operated by Wood Creek District.

A-43. Wood Creek District provides operation and maintenance services for East Laurel Water District ("East Laurel") and West Laurel Water Association ("West Laurel"). In addition, it operates the Wood Creek District Water Division and the Wood Creek District Sewer Division. All employees, except for the Board members of East Laurel and West Laurel, are employees of Wood Creek. All vehicles and equipment are owned by Wood Creek District.

Each employee, except for those noted below, keep accurate records of their time on a daily basis. Their time is allocated among the following four (4) "cost centers:"

1. Wood Creek District Water Division;
2. Wood Creek Sewer Division;
3. East Laurel
4. West Laurel

On Friday of each week a spreadsheet is completed using the timesheets submitted by each employee. The spreadsheet charges the time of each employee to each "cost center."

By using a detailed work order system, not only is the time of each employee allocated to each "cost center," but also the transportation expense, equipment expense, and use of spare parts from Wood Creek District's inventory are allocated to each "cost center."

Administrative & General Expenses. The time for Wood Creek District's Superintendent (General Manager) and its Assistant Superintendent is allocated as follows: 1/3 to Wood Creek District; 1/3 to East Laurel; and 1/3 to West Laurel. None of their time is allocated to Wood Creek District Sewer Division.

Customer Service Representatives. The time for each of the seven (7) Customer Service Representatives, the Assistant Office Manager, and the Office Manager is allocated by charging $3.10 per customer, per month to Wood Creek District, East Laurel, and West Laurel. There is no charge for Wood Creek's sewer customers. In his Cost-of-Service Study and Rate Analysis, Mr. Vilines adjusted Wood Creek's Salary and Wages by reducing it in the amount of $12,252 to account for the time that these workers spent working on Wood Creek District's Sewer Division. He derived this amount using the ratio of Wood Creek District's sewer customers and its water customers to the combined number of customers served. See Written Testimony of Alan Vilines, page 6 at lines 13-15 and page 9, line 7-18.