Commission Staff 1-1:

Provide the following expense account data:

a. Schedules, in comparative form, showing the operating expense account balance for the base period 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.

Response:

a. Please see Excel file "PSC DR 1-01 – OPEX detail."

b. Since the last general rate case, Water Service Corporation of Kentucky ("WSCK") has continued to optimize its chemical dosing, which has reduced the need to backwash to 4-5 times per month. Each eliminated backwash cycle saves about 60,000-70,000 gallons of water. WSCK has also continued optimizing the frequency of chemical purchases, which provides savings of more than $1,200 annually. To ensure WSCK receives the best possible pricing, WSCK reviews vendor selection for routine materials and services, and this has saved more than $2,500. In addition to these measures, WSCK has also continued the following programs and activities that improve efficiency and reduce costs:

- Asset Management Program (Lucity)- Tracks useful life of assets as well as the replacement cost of all assets.

- GIS- Effectively maps all assets exact location throughout the system.
- Meter Test Program- Tests meters internally to assure all customers are being billed accurately.
- Valve Exercise Program- Annual exercise of all critical valves within the system to assure during a leak event WSCK can contain water loss quickly.
- Biannual Hydrant Exercise Program- Maintains water quality to all customers by flushing and assures fire protection to all structures throughout the service area.
- Constant Leak Monitoring and Repair- Assures costs and unaccounted for water levels remain low.
- Tank Coating Maintenance Repairs - Extends the useable life of all storage tanks to provide a safe environment to store water.
- Customer Education – The "My Utility Connect" and WSCK website provide information about water conservation and water quality.

Witness: Seth Whitney and Colby Wilson

Commission Staff 1-2:

Provide, in the format provided in Schedule A, schedules showing a comparison of the balance in the revenue accounts for each month of the base period 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.

Response:

Please see Excel file "PSC DR 1-02 – Schedule A – Revenue Info."

Witness:

James Kilbane

Commission Staff 1-3:

As the historical data becomes available, provide detailed monthly income statements for each forecasted month of the base period including the month in which the Commission hears this case.

Response:

Please see Excel file "PSC DR 1-03 – Monthly Income Statements." This includes monthly income statements through the period ending May 2022.

Witness:

James Kilbane

Commission Staff 1-4:

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.

Response:

Please see Excel file "PSC DR 1-04 – Cash Balances."

Witness:

James Kilbane

Commission Staff 1-5:

Provide the following monthly account balances and a calculation of the average (13-month) account balances for the 12 months preceding the base period:

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.

Response:

Please see Excel file "PSC DR 1-05 – Monthly Balances."

Witness:

James Kilbane

Commission Staff 1-6:

Provide a detailed analysis of expenses for professional services during the 12 months preceding the base period, 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.

Response:

Please see Excel file "PSC DR 1-06 – Pro Services."

Witness:

James Kilbane

Commission Staff 1-7:

Provide the following information:

a. A detailed analysis of charges booked for advertising expenditures during the 12 months preceding the base period. 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 12 months preceding the base period. 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 12 months preceding the base period. 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.

Response:

Please see Excel file "PSC DR 1-07 – Schedules C – Expense Details."

Witness:

James Kilbane

Commission Staff 1-8:

Provide an analysis of the utility's expenses for research and development activities for the base period 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.

Response:

This is not applicable to WSCK since it has not conducted such research and development activities.

Witness:

James Kilbane

Commission Staff 1-9:

Provide the following information for the most recent calendar year concerning the utility and any affiliated service corporation or corporate service division/unit:

a. A schedule detailing the costs charged, either directly or allocated, by the utility to the service corporation. Indicate the utility's accounts in which these costs were originally recorded. For costs that are allocated, include a description of the allocation factors utilized.

b. A schedule detailing the costs charged, either directly or allocated, by the service corporation to the utility. Identify the utility's accounts in which these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

Response:

a. This is not applicable because there is no cost charged from the utility to the service corporation.

b. Please see Shawn Elicegui's testimony and the attached Cost Allocation Manual ("CAM") for description of allocation factors. See Application Exhibit 26 for information regarding where allocated charges were coded to WSCK on the balance sheet. All Corporate and Regional Allocations were recorded in 2021 to accounts 691000 and 692000, respectively, as represented in Exhibit 29.18. Please see attached "PSC DR 1-09 – WSC Direct Charges by Account 2021," that contains notations regarding allocation methods that were used.

Witness:

James Kilbane

Commission Staff 1-10:

Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 11:

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.

Response:

a. Please refer to the CAM Manual, which is attached to the testimony of Shawn Elicegui.

b. This is not applicable because the utility does not provide services to other affiliates.

c. The affiliate agreement between WSCK and Water Service Corporation, along with the Corix Cost Allocation Manual, were attached to the testimony of Shawn Elicegui, which was filed in this matter on May 31, 2022. The affiliate agreement was included in Docket 2020-00160 as well as prior rate case dockets.

Witness:

James Kilbane

Commission Staff 1-11

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.

Response:

WSCK does not directly engage in any lobbying activities.

Witness:

James Kilbane

Commission Staff 1-12:

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 14.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 base period.

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 14(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 14.a. and 14.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.

Response:

Please see Excel file "PSC DR 1-12 – Rate Case Expenses;" please also see attached supporting documentation "PSC DR 1-12 – Rate Case expenses" below.

Witness:

James Kilbane

IceMiller
LEGAL COUNSEL

One American Square | Suite 2900 | Indianapolis, IN 46282-0200

April 19, 2022

WRITER'S DIRECT NUMBER: (317) 236-2208
DIRECT FAX: (317) 592-4676
EMAIL: KAY.PASHOS@ICEMILLER.COM

CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGED COMMUNICATION

Water Service Corporation of Kentucky
Attn: Seth A. Whitney, President
Corix Group
1921 Hamilton Avenue
Cleveland, OH 44114
SethAWhitney@clevelandthermal.com

RE: Letter of Engagement with Ice Miller LLP and Fee Estimate for 2022 Rate Case

Dear Seth:

As you know, we truly appreciate the opportunity to serve as legal counsel for Water Service Corporation of Kentucky (the "Company"). Please excuse the formality of this letter, but this letter confirms the Company's engagement of Ice Miller LLP. Please take a moment to review this letter (and the enclosed standard Ice Miller terms and conditions) and let us know if there is anything you do not understand or would like to discuss changing.

Client and Nature and Scope of the Relationship

We understand that we have been asked to represent the Company in various legal matters including but not limited to rate cases and regulatory strategy, or as further documented in various e-mails and other correspondence between us and you and/or representatives of the Company. Except to the extent otherwise agreed and confirmed by us and the Company in e-mails or other written correspondence, this engagement does not extend to advice or representation concerning or relating to compliance with federal or state securities laws, including appearing or practicing before the U.S. Securities and Exchange Commission (the "SEC") or your disclosure obligations under such laws, and we understand that you will not, without prior written consent, include documents we provide you in any filings with federal or state securities regulators, including the SEC. No other party is being represented by us or intended to be benefited by our representation. Please understand that while we cannot, and do not, guarantee the outcome or success of this or any other engagement or professional undertaking, we will earnestly strive to represent and serve the Company's interest in each engagement effectively, efficiently and responsibly while endeavoring to accomplish the Company's objectives.

Our engagement is for legal services, and it is understood that you are not relying on us for business, investment or accounting advice or decisions, nor to investigate the character or credit of any person with whom you may be dealing in connection with this matter.

I will be the primary contact as to this relationship with Ice Miller LLP. I can be reached at (317) 236-2208 (office), or kay.pashos@icemiller.com (email). Steven W. Krohne and Mark R. Alson will also provide services on the engagement, as may Mike Cracraft and associates Kelly Beyrer and Lauren Baldwin.

Compensation; Other Important Terms and Conditions

Unless otherwise specifically agreed, our fees are based primarily on our hourly billing rates for attorneys, paralegals, and other professionals as applied to the amount of time that we expend in providing services. Our base hourly rates for work performed by our attorneys, absent special engagements or circumstances, currently range from $305 for new associates to $975 for senior partners. Paralegal and legal assistant hourly rates currently range from $240 to $425 per hour. My standard 2022 hourly rate is $630, and the standard 2022 hourly rates for Steven W. Krohne and Mark R. Alson are $565 and $485, respectively. The standard hourly rate for Mike Cracraft is $715. The standard 2022 hourly rates for associates Lauren Baldwin and Kelly Beyrer are $350 and $305, respectively. We propose to use the following discounted hourly rates for the Company for the 2022 rate case, as follows:

Pashos - $500
Alson - $385
Krohne - $450
Cracraft - $570
Beyrer - $275
Baldwin - $300

Our fee estimate for the 2022 rate case is attached to this engagement letter.

When appropriate in our judgment, we will involve other attorneys and paralegals or other legal assistants on work that can be performed effectively at their rates. The hourly rates of our professionals are periodically reviewed and adjusted upward to reflect the current cost of delivering comparable legal services and other market conditions. Accordingly, in preparation of our statements for professional services, we will use those hourly rates in effect at the time the services are rendered.

In addition to the fees that we charge for our legal services, we also charge for ancillary services and expenses. Such charges and expenses may include photocopying, computer research, electronic data discovery services, mileage, travel expenses and other similar charges specifically applicable to the engagement. Our charges and expenses for such ancillary services are pursuant to a schedule of charges, as the same is revised from time to time. A copy of current charges and expenses is available to you upon request.

Ice Miller's standard Terms and Conditions of Engagements for Legal Services are enclosed. These terms and conditions, which cover various other aspects of this engagement, are important and are to be read as part of this letter, as they apply to this engagement to the same extent as if they were typed as part of this letter. Unless a different engagement letter is executed in the future, the basic terms of this engagement letter will also be applicable to, and govern our professional relationship on any subsequent matters, on or in which we may become involved or engaged on your behalf.

Acceptance

We hope that this letter and the enclosed Terms and Conditions are helpful and accurately state the scope of the representation agreed upon. We intend to provide legal services based on this letter, and will assume that this letter accurately reflects our mutual agreement (regardless of whether you sign and return this letter to us), unless you promptly notify us in writing to the contrary. If you have any questions or wish to discuss any portion of this letter, please call me.

Otherwise, please confirm for our records your acceptance of these terms and conditions by signing the copy of this letter in the space provided, and return the same to me.

Sincerely yours,

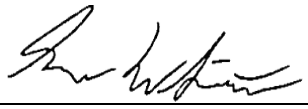
ICE MILLER LLP

Kay E. Pashos

Acknowledged and Agreed:

WATER SERVICE CORPORATION OF KENTUCKY

Date: 04/21/22

By: 

President
Printed Name and Title

Enclosures: Terms and Conditions of Engagements for Legal Services
Copy of Engagement Letter

cc: Accounting Department
NBI@icemiller.com

Ice Miller Fee Estimate for 2022 Kentucky Rate Case

You requested that we provide an estimate of attorneys' fees relating to representation of Water Service Corporation of Kentucky ("WSCK") in its upcoming water/wastewater rate case before the Kentucky Public Service Commission ("Commission").

Our fees for legal services are based on our stated hourly rates (which are discounted for WSCK), consequently the amount of the resulting fee for legal services in connection with representing WSCK in a general rate case will vary as a direct result of the amount of time we devote to the representation.

While we have not represented WSCK in its prior rate cases, we have represented multiple utilities in numerous rate and other cases before various state commissions and we reviewed the orders and testimony in WSCK's last base rate case. Based on a review of the filings in those proceedings, we derived our estimate assuming the performance of typical legal services in a fully-litigated case before the Commission (*i.e.*, preparing the case-in-chief and other procedural filings, reviewing and editing drafts of direct and rebuttal testimony, reviewing and drafting responses to discovery requests, preparing for and participating in hearings, communicating with representatives of WSCK and other parties, and preparing a proposed order and related briefs). We have also factored in the availability of and assistance from your local counsel. Our best estimate is that the fee for legal services would be approximately $200,000 in a fully-litigated proceeding, broken down as follows:

Prefiling strategy – $20,000
Preparation of case-in-chief – $50,000
Preparation of rebuttal case - $30,000
Discovery – $25,000
Settlement negotiations - $10,000
Hearing prep and hearings – $35,000
Post-hearing filings - $25,000
Misc. motions, pleadings - $5,000

This estimate does not include any expansion of the proceeding, nor services required to represent WSCK in any rehearing before the Commission, or in any appeal of the final order to Kentucky appellate courts.

ICE MILLER LLP

Terms and Conditions of Engagements for Legal Services

Ice Miller LLP has prepared this statement of the terms and conditions that are generally applicable to its legal services representations of its clients, in the absence of an express agreement specifically to the contrary. These terms and conditions, together with the letter or other document that references them, are the Terms and Conditions applicable to our engagement by you. When used in this document, "we" or "us" or "our" and similar terms refer to Ice Miller LLP, a limited liability partnership, and "you" or "your" and similar terms refer to the person or persons specifically identified in this statement as the client or clients of Ice Miller LLP.

Our Responsibilities

We are responsible to provide legal services to you in accordance with these Terms and Conditions and with our express understandings with you concerning the nature and scope of our representation.

Your Responsibilities

You are responsible for paying our statements for services and expenses. You also are responsible for being candid and cooperative with us and for keeping us informed with complete and accurate information, documents and other communications relevant to the subject matter of our representation or otherwise requested by us. Because it is important that we be able to contact our clients at all times in order to consult with them regarding our representation, we expect that you will inform us, in writing, of any changes in the name, address, telephone number, contact person, e-mail address, state of incorporation or other relevant changes regarding you and your business or affairs. If you affiliate with, acquire or your company is acquired by or merged with another company, you will provide us with sufficient notice to permit us to withdraw as your attorneys if we determine that such an affiliation, acquisition or merger creates a conflict of interest between any of our clients and the other party to such affiliation, acquisition or merger, or if we determine that it is not in the best interests of the Firm with respect to the resulting association with the new entity. Your failure to communicate and cooperate with us in these respects could have an adverse effect on our ability to effectively and efficiently represent your interests in this matter and may require that we suspend the rendition of further services in respect of or entirely withdraw from this engagement.

Client(s) Represented

The client or clients for this engagement are as specifically identified in the engagement letter. Our client(s) do not include natural persons or entities that are not identified as a client in the engagement letter. For clients that are companies, unless otherwise specified or agreed, this does not include individuals or persons who are shareholders, partners, members or owners of the company, or its officers, directors, managers or other representatives, or family members, nor does it include affiliates of the company. Our representation of you for the matter described in the engagement letter does not give rise to a lawyer-client relationship with any such other individual, person or affiliate. Accordingly our representation of you will not give rise to a conflict of interest in the event other clients of ours are or become adverse to any such other individual, person or affiliate. For clients that are trade associations or other group-type organizations, our clients would not include their members or other constituents.

How We Will Work For You

We provide services to you through our attorneys and other professionals. We will designate a mutually agreeable partner whom you may contact should you have any questions or concerns at any time about our representation of you or your interests. You will keep us advised of the name(s) and contact information of the person(s) who are authorized to instruct us as to the performance of our legal services for you.

Our engagement is for legal services. While from time to time we may share with you as part of our legal advice information and insights based on our experience with respect to certain market, industry or business practices, structures, or the like, it is understood that you will be solely responsible for determining the extent to which other professional services and advice are obtained and for making all decisions concerning business, investment and accounting matters. In addition, it is understood that we will not have any responsibility to investigate the character or credit of any person with whom you may be dealing in connection with any matter directly or indirectly related to our engagement.

How We May Communicate With You

Unless you instruct otherwise in writing, we may communicate with you using unencrypted e-mail, facsimile transmission and cellular telephone with the understanding that these methods carry an inherent risk of interception.

About Our Fees

We will charge you fees based upon the time expended and other factors applicable to legal fees that are specified by applicable professional rules and standards. Unless otherwise specifically agreed, our fees are based on our hourly rates as applied to the amount of time that we expend in providing services. Our base hourly rates for work

performed by our attorneys, absent special engagements or circumstances, are established effective January 1 of each calendar year. Hourly rates may change periodically without prior notice to clients, typically after the end of each calendar year, but a current schedule for anyone working on your engagement is available at any time upon request.

Payment of our fees and other charges is in no way contingent on the outcome of any matter, unless and to the extent that there is a mutual written agreement to the contrary.

Other Charges and Expenses

Our charges for ancillary services and expenses, such as photocopying, computer research, electronic data discovery services, mileage, travel expenses and other similar charges are pursuant to a schedule of charges and expenses, as the same is revised from time to time, a copy of which is available to you upon request.

Estimates

The total amount of fees and costs relating to this matter are difficult to predict. Accordingly, we have made no commitment to you concerning the maximum fees and costs that will be necessary to resolve or complete this matter. If requested to provide an estimate of our fees for a given matter, we will endeavor in good faith to provide our best estimate, but unless there is a mutual written agreement to a fixed fee, the actual fees incurred on any project will likely differ from the estimate.

Billing Procedures

Unless we agree to an alternative billing arrangement, you will receive a statement on a monthly basis for services rendered, and for costs and other charges posted to your account, in the prior month. Payment is due upon receipt of our billing statement or within 30 days thereafter. If your account becomes more than 30 days past due, our Billing and Collection Committee will decide whether additional legal work will be performed while the account remains past due, taking into account obligations we owe to you under applicable professional conduct rules. While we typically do not charge interest on past due amounts, we reserve the right to charge interest on any amount invoiced that remains unpaid after 30 days at the rate of 1% per month until paid in full, plus all costs of collection (including reasonable attorneys' fees). Any questions or disagreements should be brought to our attention in writing within 60 days of the billing date.

Retainers

As a matter of standard practice for new clients and/or new matters, we typically request a retainer deposit before we begin work, and we may request retainers or additional retainers from time to time with respect to existing clients and existing matters. Unless there is a mutual written agreement to the contrary, we will hold any such retainers in our firm's agency account until disbursed in accordance with these terms and conditions or other mutual written agreement. We may apply funds held as retainers to any past due account balance of your account. We will return any unapplied excess of your retainers to you within a reasonable period of time following the conclusion of the related engagement. Unless we determine in our discretion to apply all or a portion of the retainers sooner, we will apply the retainers to the final invoice for the related engagement. If we determine for any client or matter to initially waive the required retainer deposit, we nonetheless reserve the right at a later date to require a retainer deposit if conditions concerning either the extent or nature of the matter in our discretion so warrant, or should our statements not be timely paid as expected.

Your Consent to Future Conflicts of Interest

You are aware that the Firm has grown geographically and represents many other entities and individuals. Thus, during the time that we are representing you, some of our present or future clients may have disputes or transactions with you or other interests that may be adverse to yours. As part of this engagement, you agree that we may undertake in the future to represent existing or new clients in any matter that is not substantially related to any matter as to which we have represented or advised you, even if the interests of such clients in those other matters are directly or indirectly adverse to yours, and you agree not to disqualify our Firm for those conflicting representations. Of course, we agree that we will keep confidential any information of a nonpublic nature provided to us as a result of our representation of you. You acknowledge that we may obtain confidential information as a result of our representation of other clients that might be of interest to you but for the same reasons cannot be shared with you.

Document Retention

Unless you indicate otherwise to us in writing, we will assume that all papers and property that you provide to us are duplicates and that you retain all originals, so that we do not need to return them to you. When the representation concludes, we will (if you request) return any papers and property that you have provided to us (or that we have obtained for you and that belong to you) if we have them in our possession. Our drafts and work product that we create in relation to our work for you, however, belong to us. We reserve the right, subject to any applicable laws or rules of professional responsibility to the contrary, to apply records retention policies and procedures to these items and also to destroy within a reasonable time any items described in this paragraph that are retained by us.

Personal Data from the European Economic Area

If you will be providing the Firm with the personal data of individuals in the European Economic Area during the course of the engagement, then it is your responsibility to obtain all appropriate consents, make any necessary disclosures, and take all other required steps to comply with

any applicable data privacy and protection laws and regulations in connection with your use of the Firm's services. As used herein, "personal data" means any information relating to an identified or identifiable natural person, to the extent that such personal data are associated with individuals in the European Economic Area or are otherwise within the scope of the General Data Protection Regulation (EU) 2016/679.

Response to Audit Inquiries

If you ask that we do so, we will respond to your auditors concerning certain "loss contingencies" as defined by accounting standards by preparing a letter to your auditors. To assist us in responding timely to your auditors, please direct all audit inquiries to:

Audit Letter Coordinator
Ice Miller LLP
One American Square, Suite 2900
Indianapolis, Indiana 46282-0200.

If there are any questions presented by your audit inquiry letter, our Audit Letter Coordinator will contact you. Absent special circumstances, our current fee structure for the preparation of these letters is a minimum of $300 and a maximum of $700, depending on the extent and number of any matters reported. However, the fee may exceed $700 if there are many matters to be reported upon, or if the letter requires extensive substantive attention to disclosure or other related issues. This charge will appear on your statement as a line item for "Services rendered in connection with preparation of response to audit inquiry."

Termination or Withdrawal

Both you and we have the right to terminate any engagement at any time after providing reasonable advance written notice, and our withdrawal or termination is further subject to applicable rules of professional responsibility. In the event that we terminate the engagement, we will, subject to the terms hereof, take such steps as are reasonably practicable to protect your interests in the above matter and, if you so request, we will suggest to you possible successor counsel and provide that counsel with whatever papers you have provided to us. If permission for withdrawal is required by a court, we will promptly apply for such permission, and you agree to engage successor counsel to represent you. Otherwise, this representation will terminate (a) once the specific services covered within the scope of the representation have been completed and we have sent you our final statement for services rendered in this matter, or (b) if the engagement is open-ended without any specific services being described, when more than six months have elapsed from the last time you requested and we furnished legal services to you. We are not obligated to provide advice or other legal services concerning this representation to you after our representation of you is completed, or has terminated. After completion of a matter in which we have represented you, changes may occur in the applicable laws or regulations that could have an impact upon your future rights and liabilities. Even though we may send you newsletters or the like after the date of termination of our engagement, we will have no responsibility to provide you with updates or advice concerning any changes in the law or regulations or future legal developments on any matter, including those matters that may have been the subject of a prior representation, unless you and we have expressly agreed that we will provide this service.

Certain Limitations

Any opinions or views, formal or informal, that we may express to you or to third parties about the outcome of a legal matter are only our best professional estimates. Those opinions or views are necessarily limited by our knowledge of facts at the time that we express them and the law and regulations that are then in effect. You understand and agree that we cannot – and will not – promise to you, or guarantee to you, that any particular outcome will result from your legal matters.

Identification of Relationship

We are pleased that you have chosen Ice Miller LLP as your legal advisor and would like to have your permission to share this with others. By signing the acknowledgement, you hereby grant us the authority to use your name and logo in connection with Ice Miller LLP's marketing activities, including, without limitation, identification of you as a client of Ice Miller LLP on its website and other printed marketing materials and publications issued by Ice Miller LLP. You may revoke the consent granted in this paragraph at any time by contacting our marketing department at enews@icemiller.com.

Revised: August 2019

scottmadden
MANAGEMENT CONSULTANTS

Smart. Focused. Done Right.®

ScottMadden, Inc.
1900 West Park Drive
Suite 250
Westborough, MA 01581
508-202-7918
scottmadden.com

February 1, 2022

Privileged and Confidential

Mr. Steven M. Lubertozzi
Senior Vice President, North Region
Corix Company
500 W. Monroe Street, Suite 3600
Chicago, IL 60661-3779

RE: Water Service of Kentucky

Dear Mr. Lubertozzi:

ScottMadden, Inc. ("ScottMadden") is pleased to provide this engagement letter to Corix Company ("Corix" or the "Company") in response to your email regarding sponsoring a rate of return study and testimony for Corix's operating subsidiary, Water Service Kentucky ("WSK"). We understand Corix expects to file a rate case on behalf of WSK before the Kentucky Public Service Commission ("KY PSC") in Spring 2022. The remainder of this letter describes ScottMadden's proposed approach to this engagement and summarizes our proposed commercial terms.

SCOPE OF WORK

It is our expectation that the requested consulting services encompass the following:

- Provide a rate of return on common equity for WSK to be supported by a direct testimony and exhibit.

It is also our understanding that the following consulting services may be required:

- Responding to data requests from opposing parties;
- Reviewing and analyzing the direct, rebuttal, and surrebuttal testimonies of other parties to the case (if required);
- Preparing rebuttal and rejoinder testimony (if required);
- Testifying before the KY PSC on issues related to the rate of return on equity (if required);
- Assisting in the preparation of testimony in support of settlement, should the case be negotiated and settled by stipulation; and
- Assisting in the preparation of legal briefs (if required).

Methodology

ScottMadden will develop a recommended common equity cost rate based upon the results of the application of the Discounted Cash Flow Model ("DCF"), Risk Premium Model ("RPM"), and the Capital Asset Pricing Model ("CAPM") for a proxy group of water utilities, which is consistent with the opportunity

cost standards encapsulated in *Hope*[1] and *Bluefield*[2]. Both the use of proxy utilities and multiple common equity cost rate models adds reliability and accuracy to the informed expert judgment used in arriving at a recommended common equity cost rate. These methodologies are identical to those utilized in other rate of return cases in which we are involved.

All these common equity cost rate models will be used as primary tools in arriving at a recommended common equity cost rate because no single model is so inherently precise that it can be relied upon solely, to the exclusion of other theoretically sound models. The results of the application of these cost of equity models will be reviewed in light of the average total investment risk of the proxy companies compared with that of the Company to determine whether or not (and to what extent) any risk adjustment(s) to the indicated return on equity based upon the proxy utilities is (are) warranted.

Finally, our recommended return on equity will be evaluated for reasonableness in light of the current and expected capital market and economic conditions.

Data Requirements

An initial data request will be distributed upon acceptance of this proposal. Any additional data required to complete the study will be requested in a timely fashion so the direct testimony and exhibit will be completed before the filing date.

Work Product

The results of the recommended rate of return study will be summarized in Excel spreadsheet format and provided to the Company. All work product, i.e., draft testimonies and accompanying exhibits, draft data request responses, etc. will be provided in accordance with the schedule set by the Company.

PROJECT TEAM

Dylan W. D'Ascendis, Partner, will serve as the expert witness in this proceeding. Mr. D'Ascendis' detailed resume and testimony listing is included as Attachment A to this engagement letter. Mr. D'Ascendis will be supported by ScottMadden's team of highly qualified consultants and analysts, as needed.

PROPOSED COMMERCIAL TERMS

For the purpose of a rate of return analysis and ready-to-file direct testimony and accompanying exhibit supporting a return on equity recommendation, ScottMadden proposes a fixed fee of $22,500. With respect to the preparation of rebuttal testimony, responding to discovery, hearing preparation and attendance, and post-hearing assistance for the filing, we would bill for services on a time and materials basis at the rates provided in Table 1, below.

Please note that ScottMadden's normal practice is to invoice monthly for professional fees and travel expenses (with no mark-up), as well as for reasonable direct expenses, as incurred, with no additional mark-up.

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1 Federal Power Commission v. Hope Natural Gas Co., 320 U.S. 561 (1944).
2 Bluefield Water Works Improvement Co. v. Public Serv. Comm'n, 262 U.S. 679 (1922).

Privileged and Confidential

Table 1: Hourly Billing Rates

Position	Hourly Rate
Partner/ Executive Advisor	$325
Director	$295
Manager	$270
Senior Associate	$230
Associate	$200
Senior Analyst	$150
Analyst	$125
Administrative Assistant	$65

Should you have any questions or wish to discuss the terms of this engagement letter, please feel free to contact me directly at your convenience via phone at 609.680.8695, or email at ddascendis@scottmadden.com.

We thank you for contacting ScottMadden regarding this engagement and look forward to working with Corix on this 2022 proceeding.

Sincerely,

Dylan W. D'Ascendis
Partner

ACCEPTED AND AGREED BY:

Name: Seth Whitney

Signature:

Title: President

Date: 2/14/22

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MANAGEMENT CONSULTANTS

Attachment A – Resume & Testimony Listing of:
Dylan W. D'Ascendis, CRRA, CVA
Partner

Summary

Dylan is an experienced consultant and a Certified Rate of Return Analyst (CRRA) and Certified Valuation Analyst (CVA). Dylan joined ScottMadden in 2016 and has become a leading expert witness with respect to cost of capital and capital structure. He has served as a consultant for investor-owned and municipal utilities and authorities for 13 years. Dylan has testified as an expert witness on over 100 occasions regarding rate of return, cost of service, rate design, and valuation before more than 30 regulatory jurisdictions in the United States and Canada, an American Arbitration Association panel, and the Superior Court of Rhode Island. He also maintains the benchmark index against which the Hennessy Gas Utility Mutual Fund performance is measured. Dylan holds a B.A. in economic history from the University of Pennsylvania and an M.B.A. with concentrations in finance and international business from Rutgers University.

Areas of Specialization

- Regulation and Rates
- Rate of Return
- Valuation
- Mutual Fund Benchmarking
- Capital Market Risk
- Regulatory Strategy
- Cost of Service

Recent Expert Testimony Submission/Appearance

- Regulatory Commission of Alaska – Capital Structure
- Federal Energy Regulatory Commission – Rate of Return
- Public Utility Commission of Texas – Return on Equity
- Hawaii Public Utilities Commission – Cost of Service / Rate Design
- Pennsylvania Public Utility Commission - Valuation

Recent Assignments

- Provided expert testimony on the cost of capital for ratemaking purposes before numerous state utility regulatory agencies
- Sponsored valuation testimony for a large municipal water company in front of an American Arbitration Association Board to justify the reasonability of their lease payments to the City
- Co-authored a valuation report on behalf of a large investor-owned utility company in response to a new state regulation which allowed the appraised value of acquired assets into rate base

Recent Articles and Speeches

- Co-Author of: "Decoupling, Risk Impacts and the Cost of Capital", co-authored with Richard A. Michelfelder, Ph.D., Rutgers University and Pauline M. Ahern. The Electricity Journal, March, 2020
- Co-Author of: "Decoupling Impact and Public Utility Conservation Investment", co-authored with Richard A. Michelfelder, Ph.D., Rutgers University and Pauline M. Ahern. Energy Policy Journal, 130 (2019), 311-319
- "Establishing Alternative Proxy Groups", before the Society of Utility and Regulatory Financial Analysts: 51st Financial Forum, April 4, 2019, New Orleans, LA
- "Past is Prologue: Future Test Year", Presentation before the National Association of Water Companies 2017 Southeast Water Infrastructure Summit, May 2, 2017, Savannah, GA.
- Co-author of: "Comparative Evaluation of the Predictive Risk Premium Model™, the Discounted Cash Flow Model and the Capital Asset Pricing Model", co-authored with Richard A. Michelfelder, Ph.D., Rutgers University, Pauline M. Ahern, and Frank J. Hanley, The Electricity Journal, May, 2013
- "Decoupling: Impact on the Risk and Cost of Common Equity of Public Utility Stocks", before the Society of Utility and Regulatory Financial Analysts: 45th Financial Forum, April 17-18, 2013, Indianapolis, IN

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MANAGEMENT CONSULTANTS

Attachment A – Resume & Testimony Listing of:
Dylan W. D'Ascendis, CRRA, CVA
Partner

Sponsor	Date	Case/Applicant	Docket No.	Subject
Regulatory Commission of Alaska				
Cook Inlet Natural Gas Storage Alaska, LLC	07/21	Cook Inlet Natural Gas Storage Alaska, LLC	Docket No. TA45-733	Capital Structure
Alaska Power Company	09/20	Alaska Power Company; Goat Lake Hydro, Inc.; BBL Hydro, Inc.	Tariff Nos. TA886-2; TA6-521; TA4-573	Capital Structure
Alaska Power Company	07/16	Alaska Power Company	Docket No. TA857-2	Rate of Return
Alberta Utilities Commission				
AltaLink, L.P., and EPCOR Distribution & Transmission, Inc.	01/20	AltaLink, L.P., and EPCOR Distribution & Transmission, Inc.	2021 Generic Cost of Capital, Proceeding ID. 24110	Rate of Return
Arizona Corporation Commission				
EPCOR Water Arizona, Inc.	06/20	EPCOR Water Arizona, Inc.	Docket No. WS-01303A-20-0177	Rate of Return
Arizona Water Company	12/19	Arizona Water Company – Western Group	Docket No. W-01445A-19-0278	Rate of Return
Arizona Water Company	08/18	Arizona Water Company – Northern Group	Docket No. W-01445A-18-0164	Rate of Return
Arkansas Public Service Commission				
Southwestern Electric Power Co.	07/21	Southwestern Electric Power Co.	Docket No. 21-070-U	Return on Equity
CenterPoint Energy Resources Corp.	05/21	CenterPoint Arkansas Gas	Docket No. 21-004-U	Return on Equity
Colorado Public Utilities Commission				
Summit Utilities, Inc.	04/18	Colorado Natural Gas Company	Docket No. 18AL-0305G	Rate of Return
Atmos Energy Corporation	06/17	Atmos Energy Corporation	Docket No. 17AL-0429G	Rate of Return
Delaware Public Service Commission				
Delmarva Power & Light Co.	11/20	Delmarva Power & Light Co.	Docket No. 20-0149 (Electric)	Return on Equity
Delmarva Power & Light Co.	10/20	Delmarva Power & Light Co.	Docket No. 20-0150 (Gas)	Return on Equity
Tidewater Utilities, Inc.	11/13	Tidewater Utilities, Inc.	Docket No. 13-466	Capital Structure
Public Service Commission of the District of Columbia				
Washington Gas Light Company	09/20	Washington Gas Light Company	Formal Case No. 1162	Rate of Return
Federal Energy Regulatory Commission				
LS Power Grid California, LLC	10/20	LS Power Grid California, LLC	Docket No. ER21-195-000	Rate of Return
Florida Public Service Commission				
Tampa Electric Company	04/21	Tampa Electric Company	Docket No. 20210034-EI	Return on Equity
Peoples Gas System	09/20	Peoples Gas System	Docket No. 20200051-GU	Rate of Return
Utilities, Inc. of Florida	06/20	Utilities, Inc. of Florida	Docket No. 20200139-WS	Rate of Return
Hawaii Public Utilities Commission				
Launiupoko Irrigation Company, Inc.	12/20	Launiupoko Irrigation Company, Inc.	Docket No. 2020-0217 / Transferred to 2020-0089	Capital Structure
Lanai Water Company, Inc.	12/19	Lanai Water Company, Inc.	Docket No. 2019-0386	Cost of Service / Rate Design
Manele Water Resources, LLC	08/19	Manele Water Resources, LLC	Docket No. 2019-0311	Cost of Service / Rate Design
Kaupulehu Water Company	02/18	Kaupulehu Water Company	Docket No. 2016-0363	Rate of Return
Aqua Engineers, LLC	05/17	Puhi Sewer & Water Company	Docket No. 2017-0118	Cost of Service / Rate Design
Hawaii Resources, Inc.	09/16	Laie Water Company	Docket No. 2016-0229	Cost of Service / Rate Design

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MANAGEMENT CONSULTANTS

Attachment A – Resume & Testimony Listing of:
Dylan W. D'Ascendis, CRRA, CVA
Partner

Sponsor	Date	Case/Applicant	Docket No.	Subject
Illinois Commerce Commission				
Utility Services of Illinois, Inc.	02/21	Utility Services of Illinois, Inc.	Docket No. 21-0198	Rate of Return
Ameren Illinois Company d/b/a Ameren Illinois	07/20	Ameren Illinois Company d/b/a Ameren Illinois	Docket No. 20-0308	Return on Equity
Utility Services of Illinois, Inc.	11/17	Utility Services of Illinois, Inc.	Docket No. 17-1106	Cost of Service / Rate Design
Aqua Illinois, Inc.	04/17	Aqua Illinois, Inc.	Docket No. 17-0259	Rate of Return
Utility Services of Illinois, Inc.	04/15	Utility Services of Illinois, Inc.	Docket No. 14-0741	Rate of Return
Indiana Utility Regulatory Commission				
Aqua Indiana, Inc.	03/16	Aqua Indiana, Inc. Aboite Wastewater Division	Docket No. 44752	Rate of Return
Twin Lakes, Utilities, Inc.	08/13	Twin Lakes, Utilities, Inc.	Docket No. 44388	Rate of Return
Kansas Corporation Commission				
Atmos Energy	07/19	Atmos Energy	19-ATMG-525-RTS	Rate of Return
Kentucky Public Service Commission				
Atmos Energy Corporation	07/21	Atmos Energy Corporation	2021-00304	PRP Rider Rate
Atmos Energy Corporation	06/21	Atmos Energy Corporation	2021-00214	Rate of Return
Duke Energy Kentucky, Inc.	06/21	Duke Energy Kentucky, Inc.	2021-00190	Return on Equity
Bluegrass Water Utility Operating Company	10/20	Bluegrass Water Utility Operating Company	2020-00290	Return on Equity
Louisiana Public Service Commission				
Utilities, Inc. of Louisiana	05/21	Utilities, Inc. of Louisiana	Docket No. U-36003	Rate of Return
Southwestern Electric Power Company	12/20	Southwestern Electric Power Company	Docket No. U-35441	Return on Equity
Atmos Energy	04/20	Atmos Energy	Docket No. U-35535	Rate of Return
Louisiana Water Service, Inc.	06/13	Louisiana Water Service, Inc.	Docket No. U-32848	Rate of Return
Maine Public Utilities Commission				
The Maine Water Company	09/21	The Maine Water Company	Docket No. 2021-00053	Rate of Return
Maryland Public Service Commission				
Washington Gas Light Company	08/20	Washington Gas Light Company	Case No. 9651	Rate of Return
FirstEnergy, Inc.	08/18	Potomac Edison Company	Case No. 9490	Rate of Return
Massachusetts Department of Public Utilities				
Unitil Corporation	12/19	Fitchburg Gas & Electric Co. (Elec.)	D.P.U. 19-130	Rate of Return
Unitil Corporation	12/19	Fitchburg Gas & Electric Co. (Gas)	D.P.U. 19-131	Rate of Return
Liberty Utilities	07/15	Liberty Utilities d/b/a New England Natural Gas Company	Docket No. 15-75	Rate of Return
Minnesota Public Utilities Commission				
Northern States Power Company	11/01	Northern States Power Company	Docket No. G002/GR-21-678	Return on Equity
Northern States Power Company	10/21	Northern States Power Company	Docket No. E002/GR-21-630	Return on Equity
Northern States Power Company	11/20	Northern States Power Company	Docket No. E002/GR-20-723	Return on Equity
Mississippi Public Service Commission				
Atmos Energy	03/19	Atmos Energy	Docket No. 2015-UN-049	Capital Structure
Atmos Energy	07/18	Atmos Energy	Docket No. 2015-UN-049	Capital Structure
Missouri Public Service Commission				

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MANAGEMENT CONSULTANTS

Attachment A – Resume & Testimony Listing of:
Dylan W. D'Ascendis, CRRA, CVA
Partner

Sponsor	Date	Case/Applicant	Docket No.	Subject
Spire Missouri, Inc.	12/20	Spire Missouri, Inc.	Case No. GR-2021-0108	Return on Equity
Indian Hills Utility Operating Company, Inc.	10/17	Indian Hills Utility Operating Company, Inc.	Case No. SR-2017-0259	Rate of Return
Raccoon Creek Utility Operating Company, Inc.	09/16	Raccoon Creek Utility Operating Company, Inc.	Case No. SR-2016-0202	Rate of Return
Public Utilities Commission of Nevada				
Southwest Gas Corporation	09/21	Southwest Gas Corporation	Docket No. 21-09001	Return on Equity
Southwest Gas Corporation	08/20	Southwest Gas Corporation	Docket No. 20-02023	Return on Equity
New Hampshire Public Utilities Commission				
Aquarion Water Company of New Hampshire, Inc.	12/20	Aquarion Water Company of New Hampshire, Inc.	Docket No. DW 20-184	Rate of Return
New Jersey Board of Public Utilities				
Middlesex Water Company	05/21	Middlesex Water Company	Docket No. WR21050813	Rate of Return
Atlantic City Electric Company	12/20	Atlantic City Electric Company	Docket No. ER20120746	Return on Equity
FirstEnergy	02/20	Jersey Central Power & Light Co.	Docket No. ER20020146	Rate of Return
Aqua New Jersey, Inc.	12/18	Aqua New Jersey, Inc.	Docket No. WR18121351	Rate of Return
Middlesex Water Company	10/17	Middlesex Water Company	Docket No. WR17101049	Rate of Return
Middlesex Water Company	03/15	Middlesex Water Company	Docket No. WR15030391	Rate of Return
The Atlantic City Sewerage Company	10/14	The Atlantic City Sewerage Company	Docket No. WR14101263	Cost of Service / Rate Design
Middlesex Water Company	11/13	Middlesex Water Company	Docket No. WR1311059	Capital Structure
New Mexico Public Regulation Commission				
Southwestern Public Service Company	01/21	Southwestern Public Service Company	Case No. 20-00238-UT	Return on Equity
North Carolina Utilities Commission				
Carolina Water Service, Inc.	07/21	Carolina Water Service, Inc.	Docket No. W-354 Sub 384	Rate of Return
Piedmont Natural Gas Co., Inc.	03/21	Piedmont Natural Gas Co., Inc.	Docket No. G-9, Sub 781	Return on Equity
Duke Energy Carolinas, LLC	07/20	Duke Energy Carolinas, LLC	Docket No. E-7, Sub 1214	Return on Equity
Duke Energy Progress, LLC	07/20	Duke Energy Progress, LLC	Docket No. E-2, Sub 1219	Return on Equity
Aqua North Carolina, Inc.	12/19	Aqua North Carolina, Inc.	Docket No. W-218 Sub 526	Rate of Return
Carolina Water Service, Inc.	06/19	Carolina Water Service, Inc.	Docket No. W-354 Sub 364	Rate of Return
Carolina Water Service, Inc.	09/18	Carolina Water Service, Inc.	Docket No. W-354 Sub 360	Rate of Return
Aqua North Carolina, Inc.	07/18	Aqua North Carolina, Inc.	Docket No. W-218 Sub 497	Rate of Return
North Dakota Public Service Commission				
Northern States Power Company	09/21	Northern States Power Company	Case No. PU-21-381	Rate of Return
Northern States Power Company	11/20	Northern States Power Company	Case No. PU-20-441	Rate of Return
Public Utilities Commission of Ohio				
Duke Energy Ohio, Inc.	10/21	Duke Energy Ohio, Inc.	Case No. 21-887-EL-AIR	Return on Equity
Aqua Ohio, Inc.	07/21	Aqua Ohio, Inc.	Case No. 21-0595-WW-AIR	Rate of Return
Aqua Ohio, Inc.	05/16	Aqua Ohio, Inc.	Case No. 16-0907-WW-AIR	Rate of Return
Pennsylvania Public Utility Commission				
Community Utilities of Pennsylvania, Inc.	04/21	Community Utilities of Pennsylvania, Inc.	Docket No. R-2021-3025207	Rate of Return
Vicinity Energy Philadelphia, Inc.	04/21	Vicinity Energy Philadelphia, Inc.	Docket No. R-2021-3024060	Rate of Return
Delaware County Regional Water Control Authority	02/20	Delaware County Regional Water Control Authority	Docket No. A-2019-3015173	Valuation
Valley Energy, Inc.	07/19	C&T Enterprises	Docket No. R-2019-3008209	Rate of Return

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MANAGEMENT CONSULTANTS

Attachment A – Resume & Testimony Listing of:
Dylan W. D'Ascendis, CRRA, CVA
Partner

Sponsor	Date	Case/Applicant	Docket No.	Subject
Wellsboro Electric Company	07/19	C&T Enterprises	Docket No. R-2019-3008208	Rate of Return
Citizens' Electric Company of Lewisburg	07/19	C&T Enterprises	Docket No. R-2019-3008212	Rate of Return
Steelton Borough Authority	01/19	Steelton Borough Authority	Docket No. A-2019-3006880	Valuation
Mahoning Township, PA	08/18	Mahoning Township, PA	Docket No. A-2018-3003519	Valuation
SUEZ Water Pennsylvania Inc.	04/18	SUEZ Water Pennsylvania Inc.	Docket No. R-2018-000834	Rate of Return
Columbia Water Company	09/17	Columbia Water Company	Docket No. R-2017-2598203	Rate of Return
Veolia Energy Philadelphia, Inc.	06/17	Veolia Energy Philadelphia, Inc.	Docket No. R-2017-2593142	Rate of Return
Emporium Water Company	07/14	Emporium Water Company	Docket No. R-2014-2402324	Rate of Return
Columbia Water Company	07/13	Columbia Water Company	Docket No. R-2013-2360798	Rate of Return
Penn Estates Utilities, Inc.	12/11	Penn Estates, Utilities, Inc.	Docket No. R-2011-2255159	Capital Structure / Long-Term Debt Cost Rate
South Carolina Public Service Commission				
Blue Granite Water Co.	12/19	Blue Granite Water Company	Docket No. 2019-292-WS	Rate of Return
Carolina Water Service, Inc.	02/18	Carolina Water Service, Inc.	Docket No. 2017-292-WS	Rate of Return
Carolina Water Service, Inc.	06/15	Carolina Water Service, Inc.	Docket No. 2015-199-WS	Rate of Return
Carolina Water Service, Inc.	11/13	Carolina Water Service, Inc.	Docket No. 2013-275-WS	Rate of Return
United Utility Companies, Inc.	09/13	United Utility Companies, Inc.	Docket No. 2013-199-WS	Rate of Return
Utility Services of South Carolina, Inc.	09/13	Utility Services of South Carolina, Inc.	Docket No. 2013-201-WS	Rate of Return
Tega Cay Water Services, Inc.	11/12	Tega Cay Water Services, Inc.	Docket No. 2012-177-WS	Capital Structure
Tennessee Public Utility Commission				
Piedmont Natural Gas Company	07/20	Piedmont Natural Gas Company	Docket No. 20-00086	Return on Equity
Public Utility Commission of Texas				
Southwestern Public Service Company	02/21	Southwestern Public Service Company	Docket No. 51802	Return on Equity
Southwestern Electric Power Company	10/20	Southwestern Electric Power Company	Docket No. 51415	Rate of Return
Virginia State Corporation Commission				
Virginia Natural Gas, Inc.	04/21	Virginia Natural Gas, Inc.	PUR-2020-00095	Return on Equity
Massanutten Public Service Corporation	12/20	Massanutten Public Service Corporation	PUE-2020-00039	Return on Equity
Aqua Virginia, Inc.	07/20	Aqua Virginia, Inc.	PUR-2020-00106	Rate of Return
WGL Holdings, Inc.	07/18	Washington Gas Light Company	PUR-2018-00080	Rate of Return
Atmos Energy Corporation	05/18	Atmos Energy Corporation	PUR-2018-00014	Rate of Return
Aqua Virginia, Inc.	07/17	Aqua Virginia, Inc.	PUR-2017-00082	Rate of Return
Massanutten Public Service Corp.	08/14	Massanutten Public Service Corp.	PUE-2014-00035	Rate of Return / Rate Design

Baryenbruch & Company, LLC

Management Consultants

P91-2210-100175

INV #: 060322

June 3, 2022

Seth A. Whitney
President
Water Service Corporation of Kentucky, Inc.
1921 Hamilton Avenue
Cleveland, Ohio 44114

Water Service Corporation of Kentucky
Prepare Direct Testimony

	Hours	Rate	Amount
Fees			
Apr 2022	75.0		
May 2022	3.5		
Total Fees	78.5	$315	$24,728
Expenses			
Total Invoice			$24,728

terms: net 30

Not-to-Exceed Estimate: $28,350

2832 Claremont Road Raleigh, North Carolina 27608
patrickbaryenbruch.com Phone 919 832 3444 Fax 919 832 3444

Baryenbruch & Company, LLC

Client: Water Service Corporation, Kentucky

Month: Apr-May 2022

Prepare Direct Testimony

Date	Hours	Date	Hours
4/16	6.0	5/2	2.0
4/18	5.5	5/31	1.5
4/19	2.5		
4/20	6.0		
4/21	8.0		
4/22	8.0		
4/25	8.0		
4/26	6.5		
4/27	7.0		
4/28	6.0		
4/29	6.0		
4/30	5.5		
Total			78.5

IceMiller
LEGAL COUNSEL

One American Square | Suite 2900 | Indianapolis, IN 46282-0200

P91-2210-100175

P91-2210-100175

Invoice No. 01-2147119
May 20, 2022

James Kilbane
Water Service Corporation of Kentucky
1921 Hamilton Ave.
Cleveland, OH 44114

Re: 2022/2023 Rate Case, #2022213.
Our Matter No. 069810.10001

2022213

INVOICE SUMMARY

For Services rendered through April 30, 2022

Professional Services	$8,302.00
Total Current Invoice	**$8,302.00**

Thank you for giving Ice Miller the opportunity to serve you. We appreciate your business and the confidence you have placed in us. Please call if we can be of further assistance.

New payment option for you. You can now pay your invoice by **E-check**.

Find out more by contacting **PAYICE@icemiller.com**.

2022/2023 Rate Case, #2022213.
Our Matter No. 069810.10001

Invoice No. 01-2147119
May 20, 2022

2022213

PROFESSIONAL SERVICES

Date	Initials	Description	Hours
03/09/2022	PASH K	Drafted timeline and checklist for Kentucky rate case and circulated document to Todd Osterloh for his review and comments.	1.20
03/17/2022	PASH K	Circulated preliminary timeline and checklist for rate case.	0.20
03/30/2022	PASH K	Corix Kentucky rate case meeting — no charge	1.30
03/30/2022	ALSO M	Call with client and local counsel to discuss rate case preparation; follow up emails.	1.10
04/08/2022	PASH K	Meeting regarding Kentucky rate case.	0.50
04/13/2022	PASH K	Meeting on cost allocation and meeting on rate case testimony.	1.20
04/14/2022	BEYR K	Began researching and reviewing last rate case from the Kentucky Public Service Commission.	0.50
04/15/2022	ALSO M	Reviewed portions of prior rate case for use in developing testimony.	1.40
04/15/2022	ALSO M	Reviewed topics and shell of Wilson direct testimony, and communications with witness.	1.50
04/18/2022	PASH K	Revisions and edits to various draft rate case testimonies.	2.70
04/19/2022	ALSO M	Worked on direct testimony of Wilson; call with Wilson regarding the same; follow up.	2.50
04/21/2022	BEYR K	Read and reviewed last rate case from the Kentucky Public Service Commission.	2.20
04/22/2022	BEYR K	Continued reading and reviewing past rate case.	0.50
04/22/2022	PASH K	Meeting on rate case testimony.	1.00
04/22/2022	ALSO M	Review of relevant CPCN orders for use in preparation of case in chief; follow up regarding Wilson direct.	1.20
04/25/2022	BEYR K	Drafted summary of major issues in last rate case in preparation for upcoming filing.	1.30
04/27/2022	PASH K	Reviewed and edited draft testimony.	1.40
Total Professional Services			**$8,302.00**

2022/2023 Rate Case, #2022213.
Our Matter No. 069810.10001

Invoice No. 01-2147119
May 20, 2022

2022213

SUMMARY OF PROFESSIONAL SERVICES

Attorney	Hours	Rate	Amount
Mark Alson	7.70	$385.00	$2,964.50
Kay Pashos	8.20	$500.00	$4,100.00
Kelly Beyrer	4.50	$275.00	$1,237.50
Total Professional Services	**20.40**		**$8,302.00**

Total Invoice Balance Due **$8,302.00**

Payment Terms: Net 30. Interest charges may accrue on past due balance.

Questions or concerns, please email **payice@icemiller.com**.

IceMiller
LEGAL COUNSEL

One American Square | Suite 2900 | Indianapolis, IN 46282-0200

James Kilbane
Water Service Corporation of Kentucky
1921 Hamilton Ave.
Cleveland, OH 44114

Invoice No. 01-2147119
May 20, 2022

Re: 2022/2023 Rate Case, #2022213.
Our Matter No. 069810.10001

2022213

INVOICE SUMMARY

For Services rendered through April 30, 2022

Professional Services	$8,302.00
Total Current Invoice	**$8,302.00**

Payment Options

Online Payments:
Click the logo below or visit
www.clientpay.com/login.
ClientPay®

Wire/ACH Instructions:
Huntington Bank
ABA for ACH 074000078
ABA for Wire 044000024
Account No. 01401048453
Swift Code:HUNTUS33
Please Reference **Invoice No. 01-2147119**

Payment by check
Remit to: Ice Miller LLP
P.O. Box 68
Indianapolis, IN 46206-0068
Please include remittance or reference **Invoice No. 01-2147119**

Questions or concerns, please email **payice@icemiller.com**.

March 28, 2022 *Privileged and Confidential*

Mr. Steven M. Lubertozzi
Senior Vice President, North Region
Corix Company
500 W. Monroe Street, Suite 3600
Chicago, IL 60661-3779

RE: Water Service of Kentucky

Dear Mr. Lubertozzi:

ScottMadden, Inc. ("ScottMadden") is pleased to provide this engagement letter to Corix Company ("Corix" or the "Company") in response to your request for a proposal for a wage and benefit study and supporting testimony for Corix's operating subsidiary, Water Service Kentucky ("WSK"). We understand Corix expects to file a rate case on behalf of WSK before the Kentucky Public Service Commission ("KY PSC") in Spring 2022. The remainder of this letter describes ScottMadden's proposed approach to this engagement and summarizes our proposed commercial terms.

SCOPE OF WORK

It is our expectation that the requested consulting services encompass the following:

- Evaluate the pay range competitiveness for 19 benchmark positions, including 13 positions within WSK's organization and six positions within the Corix organization that are salaried. These positions are allocated, in part, to WSK;
- Determine the competitiveness of WSK's pay practices, health, and retirement benefit offerings; and
- Provide WSK with a wage and benefit report supported by a direct testimony and exhibit.

It is also our understanding that the following consulting services may be required:

- Responding to data requests from opposing parties;
- Reviewing and analyzing the direct, rebuttal, and surrebuttal testimonies of other parties to the case (if required);
- Preparing rebuttal and rejoinder testimony (if required);
- Testifying before the KY PSC on issues related to the wage and benefit study and associated filed testimonies (if required);
- Assisting in the preparation of testimony in support of settlement, should the case be negotiated and settled by stipulation; and
- Assisting in the preparation of legal briefs (if required).

Methodology

ScottMadden will conduct a wage and benefit analysis by comparing WSK's wages and benefits for the 19 positions detailed in the Scope of Work to study and compare to comparable positions from a combination of public and private data sets:

- Public data sets will include information from the Department of Labor and Bureau of Labor Statistics; salary information represents all payroll tax reporting entities located in the same or similar regional areas where WSK has operations.
- Private data sets will include salary and benefit information from Economic Research Institute's ("ERI") Salary Assessor tool, and Salary.com's CompAnalyst tool (formerly owned by IBM). ERI's Salary Assessor tool compiles pay data from hundreds of published data sources for thousands of job titles. Salary.com's CompAnalyst tool includes Human Resources-reported executive and general staff compensation data from more than 2,600 organizations across industries. CompAnalyst also includes detailed pay practices and benefits.

ScottMadden may also supplement these data sources with a custom survey of relevant local peer companies, particularly to supplement information about benefits not included in the public or private data source cited above. These data sources and methodologies are similar to those commonly utilized in other utility rate cases filed in Kentucky and many other jurisdictions across the U.S.

Once the in-scope positions have been mapped to comparable positions in each of the proposed data sets, WSK's salary and benefit information will be evaluated against the benchmarks to determine how they compare to market averages, minimums, midpoints, and maximums for each position at the local, state and national levels. Data adjustments may also be made to the benchmark data to account for changes in pay structures over time (*i.e.,* between the effective dates for the data sources and the date of WSK's rate case filing), cost-of-labor differentials among different regions, and other adjustments.

Finally, our findings will be summarized for each position by base pay, total compensation, supplemental pay, paid leave, health benefits, and retirement. Findings and conclusions will be provided for the organization as a whole for all in-scope positions.

Work Product

The results of the wage and benefit study will be summarized in a report format and provided to the Company. All associated work product related to the wage and benefit study, *i.e.,* draft testimonies and accompanying exhibits, draft data request responses, etc. will be provided in accordance with the schedule set by the Company.

Data Requirements and Schedule

An initial data request will be distributed upon acceptance of this proposal. Any additional data required to complete the study will be requested in a timely fashion so the wage and benefit report, accompanying direct testimony, and exhibit will be completed before the filing date.

PROJECT TEAM

Dylan W. D'Ascendis, Partner, will serve as engagement lead, and Quentin Watkins, Benchmarking Manager, will serve as the expert witness in this proceeding. Mr. Watkins will be supported by

ScottMadden's team of highly qualified consultants and analysts, as needed. Mr. D'Ascendis' and Mr. Watkins' detailed resumes are included as Attachment A to this engagement letter.

PROPOSED COMMERCIAL TERMS

For the purpose of a wage and benefit study and accompanying ready-to-file direct testimony and exhibit, ScottMadden proposes a fixed fee of $37,000. With respect to the preparation of rebuttal testimony, responding to discovery, hearing preparation and attendance, and post-hearing assistance for the filing, we would bill for services on a time and materials basis at the rates provided in Table 1, below.

Please note that ScottMadden's normal practice is to invoice monthly for professional fees and travel expenses (with no mark-up), as well as for reasonable direct expenses, as incurred, with no additional mark-up.

Table 1: Hourly Billing Rates

Position	Hourly Rate
Partner/ Executive Advisor	$325
Director	$295
Manager	$270
Senior Associate	$230
Associate	$200
Senior Analyst	$150
Analyst	$125
Administrative Assistant	$65

Should you have any questions or wish to discuss the terms of this engagement letter, please feel free to contact me directly at your convenience via phone at 609.680.8695, or email at ddascendis@scottmadden.com.

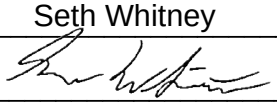
We thank you for contacting ScottMadden regarding this engagement and look forward to working with Corix on this 2022 proceeding.

Sincerely,

Dylan W. D'Ascendis
Partner

ACCEPTED AND AGREED BY:

Name: Seth Whitney

Signature: 

Title: President

Date: 04/05/2022

Summary

Dylan is an experienced consultant and a Certified Rate of Return Analyst (CRRA) and Certified Valuation Analyst (CVA). Dylan joined ScottMadden in 2016 and has become a leading expert witness with respect to cost of capital and capital structure. He has served as a consultant for investor-owned and municipal utilities and authorities for 13 years. Dylan has testified as an expert witness on over 100 occasions regarding rate of return, cost of service, rate design, and valuation before more than 30 regulatory jurisdictions in the United States and Canada, an American Arbitration Association panel, and the Superior Court of Rhode Island. He also maintains the benchmark index against which the Hennessy Gas Utility Mutual Fund performance is measured. Dylan holds a B.A. in economic history from the University of Pennsylvania and an M.B.A. with concentrations in finance and international business from Rutgers University.

Areas of Specialization

- Regulation and Rates
- Rate of Return
- Valuation
- Mutual Fund Benchmarking
- Capital Market Risk
- Regulatory Strategy
- Cost of Service

Recent Expert Testimony Submission/Appearance

- Regulatory Commission of Alaska – Capital Structure
- Federal Energy Regulatory Commission – Rate of Return
- Public Utility Commission of Texas – Return on Equity
- Hawaii Public Utilities Commission – Cost of Service / Rate Design
- Pennsylvania Public Utility Commission - Valuation

Recent Assignments

- Provided expert testimony on the cost of capital for ratemaking purposes before numerous state utility regulatory agencies
- Sponsored valuation testimony for a large municipal water company in front of an American Arbitration Association Board to justify the reasonability of their lease payments to the City
- Co-authored a valuation report on behalf of a large investor-owned utility company in response to a new state regulation which allowed the appraised value of acquired assets into rate base

Recent Articles and Speeches

- Co-Author of: “Decoupling, Risk Impacts and the Cost of Capital”, co-authored with Richard A. Michelfelder, Ph.D., Rutgers University and Pauline M. Ahern. The Electricity Journal, March, 2020
- Co-Author of: “Decoupling Impact and Public Utility Conservation Investment”, co-authored with Richard A. Michelfelder, Ph.D., Rutgers University and Pauline M. Ahern. Energy Policy Journal, 130 (2019), 311-319
- “Establishing Alternative Proxy Groups”, before the Society of Utility and Regulatory Financial Analysts: 51st Financial Forum, April 4, 2019, New Orleans, LA
- “Past is Prologue: Future Test Year”, Presentation before the National Association of Water Companies 2017 Southeast Water Infrastructure Summit, May 2, 2017, Savannah, GA.
- Co-author of: “Comparative Evaluation of the Predictive Risk Premium Model™, the Discounted Cash Flow Model and the Capital Asset Pricing Model”, co-authored with Richard A. Michelfelder, Ph.D., Rutgers University, Pauline M. Ahern, and Frank J. Hanley, The Electricity Journal, May, 2013
- “Decoupling: Impact on the Risk and Cost of Common Equity of Public Utility Stocks”, before the Society of Utility and Regulatory Financial Analysts: 45th Financial Forum, April 17-18, 2013, Indianapolis, IN

Sponsor	Date	Case/Applicant	Docket No.	Subject
Regulatory Commission of Alaska				
Cook Inlet Natural Gas Storage Alaska, LLC	07/21	Cook Inlet Natural Gas Storage Alaska, LLC	Docket No. TA45-733	Capital Structure
Alaska Power Company	09/20	Alaska Power Company; Goat Lake Hydro, Inc.; BBL Hydro, Inc.	Tariff Nos. TA886-2; TA6-521; TA4-573	Capital Structure
Alaska Power Company	07/16	Alaska Power Company	Docket No. TA857-2	Rate of Return
Alberta Utilities Commission				
AltaLink, L.P., and EPCOR Distribution & Transmission, Inc.	01/20	AltaLink, L.P., and EPCOR Distribution & Transmission, Inc.	2021 Generic Cost of Capital, Proceeding ID. 24110	Rate of Return
Arizona Corporation Commission				
EPCOR Water Arizona, Inc.	06/20	EPCOR Water Arizona, Inc.	Docket No. WS-01303A-20-0177	Rate of Return
Arizona Water Company	12/19	Arizona Water Company – Western Group	Docket No. W-01445A-19-0278	Rate of Return
Arizona Water Company	08/18	Arizona Water Company – Northern Group	Docket No. W-01445A-18-0164	Rate of Return
Arkansas Public Service Commission				
Southwestern Electric Power Co.	07/21	Southwestern Electric Power Co.	Docket No. 21-070-U	Return on Equity
CenterPoint Energy Resources Corp.	05/21	CenterPoint Arkansas Gas	Docket No. 21-004-U	Return on Equity
Colorado Public Utilities Commission				
Summit Utilities, Inc.	04/18	Colorado Natural Gas Company	Docket No. 18AL-0305G	Rate of Return
Atmos Energy Corporation	06/17	Atmos Energy Corporation	Docket No. 17AL-0429G	Rate of Return
Delaware Public Service Commission				
Delmarva Power & Light Co.	11/20	Delmarva Power & Light Co.	Docket No. 20-0149 (Electric)	Return on Equity
Delmarva Power & Light Co.	10/20	Delmarva Power & Light Co.	Docket No. 20-0150 (Gas)	Return on Equity
Tidewater Utilities, Inc.	11/13	Tidewater Utilities, Inc.	Docket No. 13-466	Capital Structure
Public Service Commission of the District of Columbia				
Washington Gas Light Company	09/20	Washington Gas Light Company	Formal Case No. 1162	Rate of Return
Federal Energy Regulatory Commission				
LS Power Grid California, LLC	10/20	LS Power Grid California, LLC	Docket No. ER21-195-000	Rate of Return
Florida Public Service Commission				
Tampa Electric Company	04/21	Tampa Electric Company	Docket No. 20210034-EI	Return on Equity
Peoples Gas System	09/20	Peoples Gas System	Docket No. 20200051-GU	Rate of Return
Utilities, Inc. of Florida	06/20	Utilities, Inc. of Florida	Docket No. 20200139-WS	Rate of Return
Hawaii Public Utilities Commission				
Launiupoko Irrigation Company, Inc.	12/20	Launiupoko Irrigation Company, Inc.	Docket No. 2020-0217 / Transferred to 2020-0089	Capital Structure
Lanai Water Company, Inc.	12/19	Lanai Water Company, Inc.	Docket No. 2019-0386	Cost of Service / Rate Design
Manele Water Resources, LLC	08/19	Manele Water Resources, LLC	Docket No. 2019-0311	Cost of Service / Rate Design
Kaupulehu Water Company	02/18	Kaupulehu Water Company	Docket No. 2016-0363	Rate of Return
Aqua Engineers, LLC	05/17	Puhi Sewer & Water Company	Docket No. 2017-0118	Cost of Service / Rate Design
Hawaii Resources, Inc.	09/16	Laie Water Company	Docket No. 2016-0229	Cost of Service / Rate Design

Sponsor	Date	Case/Applicant	Docket No.	Subject
Illinois Commerce Commission				
Utility Services of Illinois, Inc.	02/21	Utility Services of Illinois, Inc.	Docket No. 21-0198	Rate of Return
Ameren Illinois Company d/b/a Ameren Illinois	07/20	Ameren Illinois Company d/b/a Ameren Illinois	Docket No. 20-0308	Return on Equity
Utility Services of Illinois, Inc.	11/17	Utility Services of Illinois, Inc.	Docket No. 17-1106	Cost of Service / Rate Design
Aqua Illinois, Inc.	04/17	Aqua Illinois, Inc.	Docket No. 17-0259	Rate of Return
Utility Services of Illinois, Inc.	04/15	Utility Services of Illinois, Inc.	Docket No. 14-0741	Rate of Return
Indiana Utility Regulatory Commission				
Aqua Indiana, Inc.	03/16	Aqua Indiana, Inc. Aboite Wastewater Division	Docket No. 44752	Rate of Return
Twin Lakes, Utilities, Inc.	08/13	Twin Lakes, Utilities, Inc.	Docket No. 44388	Rate of Return
Kansas Corporation Commission				
Atmos Energy	07/19	Atmos Energy	19-ATMG-525-RTS	Rate of Return
Kentucky Public Service Commission				
Atmos Energy Corporation	07/21	Atmos Energy Corporation	2021-00304	PRP Rider Rate
Atmos Energy Corporation	06/21	Atmos Energy Corporation	2021-00214	Rate of Return
Duke Energy Kentucky, Inc.	06/21	Duke Energy Kentucky, Inc.	2021-00190	Return on Equity
Bluegrass Water Utility Operating Company	10/20	Bluegrass Water Utility Operating Company	2020-00290	Return on Equity
Louisiana Public Service Commission				
Utilities, Inc. of Louisiana	05/21	Utilities, Inc. of Louisiana	Docket No. U-36003	Rate of Return
Southwestern Electric Power Company	12/20	Southwestern Electric Power Company	Docket No. U-35441	Return on Equity
Atmos Energy	04/20	Atmos Energy	Docket No. U-35535	Rate of Return
Louisiana Water Service, Inc.	06/13	Louisiana Water Service, Inc.	Docket No. U-32848	Rate of Return
Maine Public Utilities Commission				
The Maine Water Company	09/21	The Maine Water Company	Docket No. 2021-00053	Rate of Return
Maryland Public Service Commission				
Washington Gas Light Company	08/20	Washington Gas Light Company	Case No. 9651	Rate of Return
FirstEnergy, Inc.	08/18	Potomac Edison Company	Case No. 9490	Rate of Return
Massachusetts Department of Public Utilities				
Unitil Corporation	12/19	Fitchburg Gas & Electric Co. (Elec.)	D.P.U. 19-130	Rate of Return
Unitil Corporation	12/19	Fitchburg Gas & Electric Co. (Gas)	D.P.U. 19-131	Rate of Return
Liberty Utilities	07/15	Liberty Utilities d/b/a New England Natural Gas Company	Docket No. 15-75	Rate of Return
Minnesota Public Utilities Commission				
Northern States Power Company	11/01	Northern States Power Company	Docket No. G002/GR-21-678	Return on Equity
Northern States Power Company	10/21	Northern States Power Company	Docket No. E002/GR-21-630	Return on Equity
Northern States Power Company	11/20	Northern States Power Company	Docket No. E002/GR-20-723	Return on Equity
Mississippi Public Service Commission				
Atmos Energy	03/19	Atmos Energy	Docket No. 2015-UN-049	Capital Structure
Atmos Energy	07/18	Atmos Energy	Docket No. 2015-UN-049	Capital Structure
Missouri Public Service Commission				

Sponsor	Date	Case/Applicant	Docket No.	Subject
Spire Missouri, Inc.	12/20	Spire Missouri, Inc.	Case No. GR-2021-0108	Return on Equity
Indian Hills Utility Operating Company, Inc.	10/17	Indian Hills Utility Operating Company, Inc.	Case No. SR-2017-0259	Rate of Return
Raccoon Creek Utility Operating Company, Inc.	09/16	Raccoon Creek Utility Operating Company, Inc.	Case No. SR-2016-0202	Rate of Return
Public Utilities Commission of Nevada				
Southwest Gas Corporation	09/21	Southwest Gas Corporation	Docket No. 21-09001	Return on Equity
Southwest Gas Corporation	08/20	Southwest Gas Corporation	Docket No. 20-02023	Return on Equity
New Hampshire Public Utilities Commission				
Aquarion Water Company of New Hampshire, Inc.	12/20	Aquarion Water Company of New Hampshire, Inc.	Docket No. DW 20-184	Rate of Return
New Jersey Board of Public Utilities				
Middlesex Water Company	05/21	Middlesex Water Company	Docket No. WR21050813	Rate of Return
Atlantic City Electric Company	12/20	Atlantic City Electric Company	Docket No. ER20120746	Return on Equity
FirstEnergy	02/20	Jersey Central Power & Light Co.	Docket No. ER20020146	Rate of Return
Aqua New Jersey, Inc.	12/18	Aqua New Jersey, Inc.	Docket No. WR18121351	Rate of Return
Middlesex Water Company	10/17	Middlesex Water Company	Docket No. WR17101049	Rate of Return
Middlesex Water Company	03/15	Middlesex Water Company	Docket No. WR15030391	Rate of Return
The Atlantic City Sewerage Company	10/14	The Atlantic City Sewerage Company	Docket No. WR14101263	Cost of Service / Rate Design
Middlesex Water Company	11/13	Middlesex Water Company	Docket No. WR1311059	Capital Structure
New Mexico Public Regulation Commission				
Southwestern Public Service Company	01/21	Southwestern Public Service Company	Case No. 20-00238-UT	Return on Equity
North Carolina Utilities Commission				
Carolina Water Service, Inc.	07/21	Carolina Water Service, Inc.	Docket No. W-354 Sub 384	Rate of Return
Piedmont Natural Gas Co., Inc.	03/21	Piedmont Natural Gas Co., Inc.	Docket No. G-9, Sub 781	Return on Equity
Duke Energy Carolinas, LLC	07/20	Duke Energy Carolinas, LLC	Docket No. E-7, Sub 1214	Return on Equity
Duke Energy Progress, LLC	07/20	Duke Energy Progress, LLC	Docket No. E-2, Sub 1219	Return on Equity
Aqua North Carolina, Inc.	12/19	Aqua North Carolina, Inc.	Docket No. W-218 Sub 526	Rate of Return
Carolina Water Service, Inc.	06/19	Carolina Water Service, Inc.	Docket No. W-354 Sub 364	Rate of Return
Carolina Water Service, Inc.	09/18	Carolina Water Service, Inc.	Docket No. W-354 Sub 360	Rate of Return
Aqua North Carolina, Inc.	07/18	Aqua North Carolina, Inc.	Docket No. W-218 Sub 497	Rate of Return
North Dakota Public Service Commission				
Northern States Power Company	09/21	Northern States Power Company	Case No. PU-21-381	Rate of Return
Northern States Power Company	11/20	Northern States Power Company	Case No. PU-20-441	Rate of Return
Public Utilities Commission of Ohio				
Duke Energy Ohio, Inc.	10/21	Duke Energy Ohio, Inc.	Case No. 21-887-EL-AIR	Return on Equity
Aqua Ohio, Inc.	07/21	Aqua Ohio, Inc.	Case No. 21-0595-WW-AIR	Rate of Return
Aqua Ohio, Inc.	05/16	Aqua Ohio, Inc.	Case No. 16-0907-WW-AIR	Rate of Return
Pennsylvania Public Utility Commission				
Community Utilities of Pennsylvania, Inc.	04/21	Community Utilities of Pennsylvania, Inc.	Docket No. R-2021-3025207	Rate of Return
Vicinity Energy Philadelphia, Inc.	04/21	Vicinity Energy Philadelphia, Inc.	Docket No. R-2021-3024060	Rate of Return
Delaware County Regional Water Control Authority	02/20	Delaware County Regional Water Control Authority	Docket No. A-2019-3015173	Valuation
Valley Energy, Inc.	07/19	C&T Enterprises	Docket No. R-2019-3008209	Rate of Return

Sponsor	Date	Case/Applicant	Docket No.	Subject
Wellsboro Electric Company	07/19	C&T Enterprises	Docket No. R-2019-3008208	Rate of Return
Citizens' Electric Company of Lewisburg	07/19	C&T Enterprises	Docket No. R-2019-3008212	Rate of Return
Steelton Borough Authority	01/19	Steelton Borough Authority	Docket No. A-2019-3006880	Valuation
Mahoning Township, PA	08/18	Mahoning Township, PA	Docket No. A-2018-3003519	Valuation
SUEZ Water Pennsylvania Inc.	04/18	SUEZ Water Pennsylvania Inc.	Docket No. R-2018-000834	Rate of Return
Columbia Water Company	09/17	Columbia Water Company	Docket No. R-2017-2598203	Rate of Return
Veolia Energy Philadelphia, Inc.	06/17	Veolia Energy Philadelphia, Inc.	Docket No. R-2017-2593142	Rate of Return
Emporium Water Company	07/14	Emporium Water Company	Docket No. R-2014-2402324	Rate of Return
Columbia Water Company	07/13	Columbia Water Company	Docket No. R-2013-2360798	Rate of Return
Penn Estates Utilities, Inc.	12/11	Penn Estates, Utilities, Inc.	Docket No. R-2011-2255159	Capital Structure / Long-Term Debt Cost Rate
South Carolina Public Service Commission				
Blue Granite Water Co.	12/19	Blue Granite Water Company	Docket No. 2019-292-WS	Rate of Return
Carolina Water Service, Inc.	02/18	Carolina Water Service, Inc.	Docket No. 2017-292-WS	Rate of Return
Carolina Water Service, Inc.	06/15	Carolina Water Service, Inc.	Docket No. 2015-199-WS	Rate of Return
Carolina Water Service, Inc.	11/13	Carolina Water Service, Inc.	Docket No. 2013-275-WS	Rate of Return
United Utility Companies, Inc.	09/13	United Utility Companies, Inc.	Docket No. 2013-199-WS	Rate of Return
Utility Services of South Carolina, Inc.	09/13	Utility Services of South Carolina, Inc.	Docket No. 2013-201-WS	Rate of Return
Tega Cay Water Services, Inc.	11/12	Tega Cay Water Services, Inc.	Docket No. 2012-177-WS	Capital Structure
Tennessee Public Utility Commission				
Piedmont Natural Gas Company	07/20	Piedmont Natural Gas Company	Docket No. 20-00086	Return on Equity
Public Utility Commission of Texas				
Southwestern Public Service Company	02/21	Southwestern Public Service Company	Docket No. 51802	Return on Equity
Southwestern Electric Power Company	10/20	Southwestern Electric Power Company	Docket No. 51415	Rate of Return
Virginia State Corporation Commission				
Virginia Natural Gas, Inc.	04/21	Virginia Natural Gas, Inc.	PUR-2020-00095	Return on Equity
Massanutten Public Service Corporation	12/20	Massanutten Public Service Corporation	PUE-2020-00039	Return on Equity
Aqua Virginia, Inc.	07/20	Aqua Virginia, Inc.	PUR-2020-00106	Rate of Return
WGL Holdings, Inc.	07/18	Washington Gas Light Company	PUR-2018-00080	Rate of Return
Atmos Energy Corporation	05/18	Atmos Energy Corporation	PUR-2018-00014	Rate of Return
Aqua Virginia, Inc.	07/17	Aqua Virginia, Inc.	PUR-2017-00082	Rate of Return
Massanutten Public Service Corp.	08/14	Massanutten Public Service Corp.	PUE-2014-00035	Rate of Return / Rate Design

Summary

Quentin Watkins joined ScottMadden in 2005 after graduating from Vanderbilt University's Owen Graduate School of Management with an M.B.A. in finance and strategy. As manager of energy benchmarking and leading practices, Quentin has managed a variety of client benchmarking projects. He also leads the development of ScottMadden's benchmarking and leading practices infrastructure. This includes a robust knowledgebase and proprietary tools and methodologies to help clients assess their performance, both quantitatively and qualitatively, and improve it. Quentin has extensive consulting experience in performance management, M&A integration, operations improvement, and financial planning. He has worked in a variety of industries, including electric utilities, financial services, engineering and construction, and information technology services. Prior to business school, Quentin worked in commercial banking, managing client relationships and administering a commercial loan portfolio of up to $100 million. Quentin earned an undergraduate degree in religion and economics from the University of the South in Sewanee, Tennessee.

Areas of Specialization

- Benchmarking and leading practices
- Financial analysis and modeling
- Operations improvement and process design
- Performance management
- Organization assessment and design
- Merger and acquisition integration
- Transmission
- Distribution
- Generation
- Gas LDCs

Recent Publications

- Co-author of "51st State Perspectives: Massachusetts: A Great Clean Energy Story – DERs and the Next Chapter." ScottMadden and SEPA
- "California's Combined Cycle Costs in the Age of the Duck Curve." The 69th Annual AREGC Conference. June 26, 2018
- Co-author of "The Smart City Opportunity for Utilities." ScottMadden
- Co-author of "G&T Organizational Benchmarking Study." co-authored with Todd Williams, ScottMadden; Barbara Hampton, GTC; Bob Kees, ODEC. G&T Accounting & Finance Association Annual Conference. June 22, 2016

Recent Assignments

Enterprise

- Developed a comprehensive organizational assessment of a large public power agency compared to a panel of investor-owned utility peers, combining financial and operational analyses with key industry trends and drivers, to support a strategic off-site retreat for executive leadership and the board of directors
- Completed an assessment of a vertically integrated utility's cost structure, benchmarking the costs for each business unit and support service against a panel of like-in-kind peers. Worked collaboratively with the client to identify which metrics, both internally monitored and externally benchmarked, should be used to manage the business—resulting in a dashboard of key performance indicators for senior management
- Developed and administered data collection and analysis processes to support two different iterations of the utility warehouse study conducted by the Utility Materials Management Benchmarking Consortium (UMMBC), serving as the point of contact for data collection and validation, and leading the development of reports
- Developed a proprietary tool to evaluate stand-alone utility service company performance down to the functional level. By enhancing and normalizing publicly available data, the model can be tailored to unique client needs to provide accurate comparisons of like-in-kind cost data
- Assisted a large investor-owned utility identify and screen potential acquisition candidates, leveraging a deep understanding of power supply markets, market and state regulatory environments, and contracting arrangements for power generation plant off-take
- Conducted market research on federal and state policies and financial incentives designed to encourage the development of new renewable and alternative energy and energy efficiency initiatives

Transmission

- Managed data collection and data analysis for a benchmarking consortium of transmission owners and designed enhanced modeling functionality to present data and results to participants in new ways which provide unique insights into performance measurement and management
- Designed, developed and administered a customized, recurring staffing study on behalf of a consortium of large electric G&T cooperatives that included all common utility corporate support functions
- Conducted industry research and analysis to support the development of a white paper on the potential for electric transmission development to serve as a solution for renewable integration in the United States
- Led the design, development, and construction of a backup operations center. Coordinated with client stakeholders, compliance personnel, and contractors to ensure that the implementation plan met all regulatory and company-defined requirements for the facility
- Conducted integration planning and project management for a client acquiring electric transmission facilities in four states. Coordinated management teams in engineering, operations, maintenance, field operations, human resources, planning, IT, and facilities to develop and track work plans, organize meetings, and report results to senior management
- Served as one of a two-person project management team responsible for the integration of the operations functions of two independent transmission companies. Developed and managed integration work plan for facilities, staffing, energy management system, training, document conversion, and procedures
- Worked as an integral member of the project management team responsible for building a transmission operations center to enable an independent transmission company to manage its transmission assets. Responsibilities included organizing recurring project meetings, assisting management with reporting requirements, and managing project documentation, calendars, task lists, meeting minutes, and work plans

Fossil/Hydro

- Conducted a comprehensive cost and staffing benchmarking study of a fossil and hydro generation fleet for a large public power company and provided an independent and objective assessment of cost and staffing performance of the client units compared to catered groups of like-in-kind peer units. Worked with accounting personnel to ensure that client plant costs were comparable to rate-regulated plants and conducted an assessment of the existing reliability performance benchmarking process based on leading industry practices
- Conducted a generation fleet cost and reliability benchmarking study for a large electric utility, including a deep-dive root cause analysis of all lost hours of production for each unit. Benchmarking results were used to support the development of organizational performance goals in the context of business planning, as well as specific improvement initiatives to bridge gaps to top-tier performance
- Conducted a comprehensive generation fleet benchmarking study for a large investor-owned utility, combining cost, reliability, and staffing assessments through the application of various data sources, to provide client management with actionable insights to improve fleet performance
  Conducted a comprehensive generation fleet benchmarking study for a large investor-owned utility, combining cost, reliability, and staffing assessments through the application of various data sources, to provide client management with actionable insights to improve fleet performance

Nuclear

- Developed and administered an industry survey of large nuclear operators examining project controls practices, including estimating and earned value management. Conducted interviews with executives in project management and project controls, analyzed the survey of the results, and developed key findings and recommendations for the client future state project controls organization
- Collected and analyzed the results of a data-intensive survey conducted by a consortium of nuclear operators to identify patterns and commonalities of spend on service and materials vendors and identified seven high-priority opportunities for savings through buyer aggregation, supplier aggregation, and improved competition
- Developed a framework for a management operating model for a nuclear power industry organization. Facilitated a series of workshops with a cross-functional client team and conducted interviews with the senior leadership team to determine current state gaps, priorities, and recommended focus areas for implementation
- Worked with a nuclear power operator to support the regulatory response and recovery plan for a site preparing for a rigorous inspection. Developed process improvement recommendations and created an automated work management tool for a group created to reduce the backlog for the site's corrective action program
- Worked with a multisite nuclear power operator to revise its contracting strategy for maintenance and construction services. Developed and administered an industry survey to identify leading practices, conducted

reference interviews with senior executive personnel from other utilities to validate contractors' past performance, and developed recommendations for improving results through future alliances with contractors

Gas LDC

- Completed a series of five different benchmarking studies for gas LDC companies in the United States, each including a unique examination of cost and operational performance compared to catered panels of peer companies, to support a variety of different management objectives, including due diligence in the context of M&A transactions, analysis to support strategic reviews, and assessment of target setting for strategic planning
- Developed an independent analysis of the gas LDC industry for a large contractor, examining historical capital and O&M expenditures among the universe of investor-owned gas utilities in the United States and conducted research on regulatory requirements, performance trends, technological developments, and other factors to develop an understanding of the drivers of historical and forecast spend by region and state

Other/Non-Benchmarking

- Managed an organizational assessment of the procurement function for a multinational engineering, procurement, and construction firm in the utility industry. Performed a leading practice assessment, comparing existing company practices to those of leading procurement organizations, to help management identify high-impact opportunities to improve operational efficiency and performance
- Performed market and competitor analysis, including on-site interviews and research in Shanghai, to develop a market-entry plan for a construction company considering expanding operations into China
- Developed a marketing plan for a $100 million IT consulting company, integrating a book on IT management authored by two principals of the company. Coordinated with internal stakeholders to investigate sales channels for the book through online retailers, universities, and trade organizations resulting in a ranking of #23 on the Amazon business best-seller list
- Completed current state assessment, defined the future state processes, and conducted gap analysis to support a strategic IT automation project for a top-10 financial services company. Worked with client management and subject matter experts to develop recommendations for business rules, new roles, and work unit process flows

Baryenbruch & Company, LLC

Management Consultants

April 15, 2022

Mr. Seth A. Whitney
President
Water Service Corporation of Kentucky, Inc.
1921 Hamilton Avenue
Cleveland, Ohio 44114
Dear Seth:

This is my proposal to provide direct testimony for Water Service Corporation of Kentucky's ("WSCK") upcoming rate. The projected test year for this case is 2023.

My testimony will incorporate the results of my 2021 evaluation of the necessity of services and reasonableness of charges from Corix Corporate Services to Corix Regulated Utilities (US), of which WSCK is a part. That study answered the following questions relative to necessity and reasonableness of those services:

Necessity of Corporate Support Services

1. Are Corporate Support Services provided to CRU US comparable to services provided by other utility service companies?

2. Are Corporate Support Services beneficial to CRU US utilities and their customers?

3. Are Corporate Support Services provided duplicative or overlapping with work performed by CRU US regulated utilities themselves?

4. Do governance structure and processes exist to ensure Corporate Support Services are necessary to CRU US regulated utilities?

Reasonableness of Corporate Support Services

5. Are charges for Corporate Support Services provided to CRU US in line with charges of other utility service companies to their regulated utility affiliates?

6. Are Corporate Support Services provided to CRU US priced at the lower of cost or market?

7. Are CRU US utilities' total customer accounts expenses, including charges directly from the Corporate Support Services organization, comparable to the costs of other utilities?

8. Are Corporate Support Services comparably priced to all CRU US regulated utilities?

Regarding question 5, for the WSCK case, I will calculate and present its cost per customer for Corporate Support Services in 2021 (actual), 2022 (budget) and 2023 (projected) and compare them to the projected 2023 cost per customer for the comparison group of utility service companies. The comparison group escalation will be based on expected inflation rates through 2023.

I will also develop a comparison of total administrative and general (A&G) and customer services expenses per customer for WSCK and other Kentucky water utilities. My cost comparison for the last WSCK case is show in the table below. Data for comparison group water will be from 2020 annual reports to the Kentucky Public Service Commission (2020 is the latest data available at the time of this study). I will present the cost for WSCK for 2020 (actual), 2021 (actual), 2022 (budget) and 2023 (projected). Also, I will present the projected 2023 cost for comparison group water companies based on expected inflation rates between 2020 and 2023.

Analysis of 2018 Customer Accounts and A&G Expenses per Customer
for Kentucky Class A Water Companies

Water Company	Cust Accts & A&G per Customer	Water Company	Cust Accts & A&G per Customer
Hardin County Water District 1	$ 324.50	Simpson County Water District	$ 107.66
Barkley Lake Water District	$ 218.95	Cumberland Falls Highway Water District	$ 103.45
Muhlenberg County Water District	$ 214.87	South Eastern Water Association Inc.	$ 103.09
Wood Creek Water District	$ 209.51	Magoffin County Water District	$ 101.20
Cannonsburg Water District	$ 205.76	Hyden-Leslie County Water District	$ 98.70
Harrison County Water Association Inc.	$ 204.75	North Mercer Water District	$ 92.47
Laurel County Water District 2	$ 181.98	Crittenden-Livingston County Water District	$ 91.87
North Shelby Water Company	$ 177.02	Marion County Water District	$ 91.68
Carroll County Water District 1	$ 171.30	Western Pulaski County Water District	$ 90.54
North Marshall Water District	$ 170.57	East Daviess County Water Association Inc.	$ 88.57
Green-Taylor Water District	$ 163.09	West Laurel Water Association Inc.	$ 86.22
Allen County Water District	$ 157.61	Madison County Utilities District	$ 84.14
Knox County Utility Commission	$ 154.83	Jessamine-South Elkhorn Water District	$ 81.02
Adair County Water District	$ 154.71	Meade County Water District	$ 79.82
Monroe County Water District	$ 150.45	Black Mountain Utility District	$ 78.31
Ohio County Water District	$ 147.31	Southern Madison Water District	$ 75.40
Bath County Water District	$ 146.29	Rowan Water Inc.	$ 74.65
Todd County Water District	$ 143.17	North Nelson Water District	$ 74.52
Southern Water and Sewer District	$ 140.80	Western Rockcastle Water Association Inc.	$ 72.44
Rattlesnake Ridge Water District	$ 140.68	**Water Service Corporation of Kentucky**	**$ 66.82**
South Hopkins Water District	$ 140.45	East Casey County Water District	$ 66.13
Oldham County Water District	$ 140.15	West Daviess County Water District	$ 65.61
McCreary County Water District	$ 136.31	Henry County Water District 2	$ 64.86
Grayson County Water District	$ 134.60	Edmonson County Water District	$ 62.94
Green River Valley Water District	$ 132.02	Big Sandy Water District	$ 60.35
Mountain Water District	$ 123.82	Garrard County Water Association Inc.	$ 59.63
Jackson County Water Association Inc.	$ 123.50	South Anderson Water District	$ 57.03
Christian County Water District	$ 119.36	East Logan Water District Inc.	$ 53.15
Bullock Pen Water District	$ 118.76	Larue County Water District 1	$ 53.10
Comparison Group Average	**$ 118.64**	Southeast Daviess County Water District	$ 50.43
Henderson County Water District	$ 117.40	East Laurel Water District	$ 39.06
Butler County Water System Inc.	$ 113.28	Graves County Water District	$ 24.98
Estill County Water District 1	$ 108.26	Fleming County Water Association Inc.	$ 3.47

Source: 2018 Annual Reports to the KPSC; Baryenbruch & Company, LLC, analysis

Completion Date and Cost Estimate

I will produce testimony in draft form by Monday, May 16, 2022.

I estimate it will take between 80 and 90 hours to perform the cost comparison and complete my direct testimony, as shown in the table below. I am willing to undertake this study on a not-to-exceed total of $28,350. If the study does not take as much time as estimated to complete, you will only be billed for the actual costs incurred. This estimate does not include the potential work associated with rebuttal testimony, answering rate case interrogatories or cross-examination. Should that be necessary, I will perform that work at an hourly rate of $315 for 2022 and $325 for 2023. If travel is required, that will be charged at actual cost.

	Estimate Range	
	Low	High
Hours		
Develop Cost Comparison	50	60
Prepare Direct Testimony	30	30
Total Hours	80	90
Fees		
Hourly Rate	$ 315	$ 315
Total Estimate	$ 25,200	$ 28,350

Patrick Baryenbruch Qualifications

Background

I am a Certified Public Accountant (CPA) with an active license from the state of Wisconsin (license number 5343-1). I am a Certified Information Technology Professional (CITP), an accreditation awarded by the American Institute of Certified Public Accountants to CPA professionals who can demonstrate expertise in Information technology management. I also hold a Global Information Assurance Certification (GIAC) in information security from the SANS Institute. I am a member of the American Institute of Certified Public Accountants and the North Carolina Association of Certified Public Accountants.

I began my career as an auditor with Arthur Andersen & Company and later worked for the management consulting firms of Theodore Barry & Associates and Scott Consulting Group, the predecessor firm to ScottMadden, Inc. I established my own management consulting firm, Baryenbruch & Company, LLC, in 1985. I hold a Bachelor of Arts degree in Accounting from the University of Wisconsin-Oshkosh and a Master in Business Administration degree from the University of Michigan.

Besides my rate case support work, much of my career has been spent as a management consultant for projects related to the utility industry. I have performed consulting assignments for more than 60 utilities and 10 public service commissions. I have participated as project manager, lead consultant or staff consultant for 24 commission-ordered management and prudence audits of public utilities. Of these, I have been responsible for evaluating the area of affiliate charges and allocation of corporate expenses in the Commission-ordered audits of Connecticut Light and Power, Connecticut Natural Gas, General Water Corporation (now United Water Company), Philadelphia Suburban Water Company (now Aqua America) and Pacific Gas & Electric Company. My firm performed the commission-ordered audit of Southern California Edison's 2002, 2003, 2004 and 2005 transactions with its non-regulated affiliate companies.

For 20 years of my career, I was heavily involved in information technology consulting for the utility industry. My assignments involved improvements in business management practices of utility IT organizations, covering processes such as business planning, risk management, performance measurement and reporting, cost recovery, budgeting, cost management and personnel development. I have acted as the project manager or member of the project management team for 20 large-scale IT implementation projects involving over 800,000 hours of work from hundreds of utility client employees and contractor personnel.

Utility-Affiliate Transactions Experience

In the course of my career, I have performed more than 130 evaluations of affiliate charges to 43 utility companies. I have acted as an expert witness on utility/affiliate charges in 90 rate case proceedings before regulators in 20 states. A list of these assignments is shown in Appendix 1.

I want to thank you for asking me to help on this important assignment. I can assure you I will give it my utmost attention. If you are in agreement with this proposal, please sign below and mail one copy to me.

Sincerely,

Patrick L. Baryenbruch

Client Agreement
I agree with the scope and terms of this proposal:

Seth Whitney _____ 4/19/22
Seth A. Whitney, President Date

Appendix 1
Page 1 of 2

Patrick Baryenbruch
Affiliate Transactions and Rate Case Experience

	Client	State	Year	Purpose	Rate Case Witness?
1	Connecticut American Water	Connecticut	1999	Rate Case	Yes
2	Illinois American Water	Illinois	2007	Rate Case	Yes
		Illinois	2021	Rate Case	Yes
3	Indiana American Water	Indiana	2017	Rate Case	Yes
4	Iowa American Water	Iowa	2020	Rate Case	Yes
5	Kentucky American Water	Kentucky	2003	Rate Case	Yes
		Kentucky	2006	Rate Case	Yes
		Kentucky	2008	Rate Case	Yes
		Kentucky	2009	Rate Case	Yes
		Kentucky	2018	Rate Case	Yes
6	Massachusetts American Water	Massachusetts	2000	Rate Case	Yes
7	Missouri American Water	Missouri	2002	Rate Case	Yes
		Missouri	2008	Rate Case	Yes
		Missouri	2014	Rate Case	Yes
		Missouri	2016	Rate Case	Yes
		Missouri	2019	Rate Case	Yes
8	New Jersey American Water	New Jersey	2005	Rate Case	Yes
		New Jersey	2007	Rate Case	Yes
		New Jersey	2009	Rate Case	Yes
		New Jersey	2010	Rate Case	Yes
		New Jersey	2014	Rate Case	Yes
		New Jersey	2017	Rate Case	Yes
		New Jersey	2019	Rate Case	Yes
9	New Mexico American Water	New Mexico	2007	Rate Case	Yes
10	New York American Water	New York	2006	Rate Case	Yes
		New York	2010	Rate Case	Yes
		New York	2013	Rate Case	Yes
		New York	2015	Rate Case	Yes
11	Ohio American Water	Ohio	2006	Rate Case	Yes
		Ohio	2010	Rate Case	Yes
12	Pennsylvania American Water	Pennsylvania	2008	Compliance	No
		Pennsylvania	2011	Compliance	No
		Pennsylvania	2014	Compliance	No
		Pennsylvania	2017	Compliance	No
		Pennsylvania	2020	Compliance	No
13	Tennessee American Water	Tennessee	2006	Rate Case	Yes
		Tennessee	2010	Rate Case	Yes
14	Virginia American Water	Virginia	1996	Rate Case	Yes
		Virginia	1999	Rate Case	Yes
		Virginia	2000	Rate Case	Yes
		Virginia	2001	Rate Case	Yes
		Virginia	2003	Rate Case	Yes
		Virginia	2007	Rate Case	Yes
		Virginia	2009	Rate Case	Yes
		Virginia	2011	Rate Case	Yes
		Virginia	2014	Rate Case	Yes
		Virginia	2018	Rate Case	Yes
		Virginia	2021	Rate Case	Yes
15	West Virginia American Water	West Virginia	2002	Rate Case	Yes
		West Virginia	2006	Rate Case	Yes
		West Virginia	2007	Rate Case	Yes
		West Virginia	2009	Rate Case	Yes
		West Virginia	2012	Rate Case	Yes
		West Virginia	2014	Rate Case	Yes
		West Virginia	2017	Rate Case	Yes
		West Virginia	2020	Rate Case	Yes
16	Atlanta Gas Light (Southern Co)	Georgia	2009	Rate Case	Yes
17	Atmos Energy Corporation	Virginia	2004	Compliance	No
18	Columbia Gas of Kentucky	Kentucky	2015	Rate Case	Yes
19	Columbia Gas of Maryland	Maryland	2015	Rate Case	Yes
20	Columbia Gas of Massachusetts	Massachusetts	2004	Rate Case	Yes
		Massachusetts	2006	Internal Info	No
		Massachusetts	2011	Internal Info	No
		Massachusetts	2012	Internal Info	No
		Massachusetts	2014	Internal Info	No
		Massachusetts	2017	Internal Info	No

Appendix 1
Page 2 of 2

Patrick Baryenbruch
Affiliate Transactions and Rate Case Experience

	Client	State	Year	Purpose	Rate Case Witness?
21	Columbia Gas of Pennsylvania	Pennsylvania	2015	Internal Info	No
		Pennsylvania	2020	Rate Case	Yes
22	Columbia Gas of Virginia	Virginia	2003	Compliance	No
		Virginia	2004	Compliance	No
		Virginia	2005	Rate Case	Yes
		Virginia	2006	Compliance	No
		Virginia	2007	Compliance	No
		Virginia	2008	Compliance	No
		Virginia	2009	Rate Case	Yes
		Virginia	2010	Compliance	No
		Virginia	2011	Compliance	No
		Virginia	2012	Compliance	No
		Virginia	2013	Rate Case	Yes
		Virginia	2014	Compliance	No
		Virginia	2015	Rate Case	Yes
		Virginia	2016	Compliance	No
		Virginia	2017	Rate Case	Yes
		Virginia	2018	Compliance	No
		Virginia	2019	Compliance	No
		Virginia	2020	Compliance	No
23	Northern Indiana Public Service	Indiana	2015	Internal Info	No
		Indiana	2016	Rate Case	Yes
		Indiana	2020	Rate Case	Yes
24	Dominion Energy, Inc.	Virginia	2008	Rate Case	Yes
		Virginia	2009	Compliance	No
		Virginia	2010	Compliance	No
		Virginia	2011	Compliance	No
		Virginia	2012	Compliance	No
		Virginia	2014	Compliance	No
		Virginia	2017	Compliance	No
		Virginia	2019	Compliance	No
25	Duke Energy	North Carolina	2006	Compliance	No
26	Elizabethtown Gas (Southern Co)	New Jersey	2008	Rate Case	Yes
27	Electric Transmission Texas	Texas	2016	Rate Case	Yes
28	General Water Works of Rio Rancho	New Mexico	1993	Rate Case	Yes
29	General Water Works of Virginia	Virginia	1992	Rate Case	Yes
30	Po River Water and Sewer	Virginia	1993	Rate Case	Yes
		Virginia	2007	Rate Case	Yes
		Virginia	2008	Rate Case	Yes
31	Progress Energy	North Carolina	2001	Internal Info	No
32	Roanoke Gas	Virginia	2006	Compliance	No
33	Southern California Edison	California	2002	Compliance	No
		California	2003	Compliance	No
		California	2004	Compliance	No
		California	2005	Compliance	No
34	AEP Texas	Texas	2018	Rate Case	Yes
35	Southwestern Electric Power	Texas	2016	Rate Case	Yes
		Texas	2020	Rate Case	Yes
36	Kentucky Utilities	Virginia	2020	Rate Case	Yes
37	Virginia Natural Gas (Southern Co)	Virginia	2004	Compliance	No
		Virginia	2005	Rate Case	Yes
		Virginia	2010	Rate Case	Yes
38	United Water of Pennsylvania	Pennsylvania	2004	Rate Case	Yes
39	Corix Infrastructure/Water Services Corp.	Enterprise	2018	Internal Info	No
		Enterprise	2019	Internal Info	No
		Enterprise	2021	Internal Info	No
40	Massanutten Public Service Company	Virginia	2006	Rate Case	Yes
		Virginia	2008	Rate Case	Yes
		Virginia	2013	Rate Case	Yes
		Virginia	2019	Rate Case	Yes
41	Water Service Corporation Kentucky	Kentucky	2010	Rate Case	Yes
		Kentucky	2012	Rate Case	Yes
		Kentucky	2019	Rate Case	Yes
42	Corix Utilities Oklahoma	Oklahoma	2019	Compliance	Yes
43	Great Basin Water Company	Nevada	2019	Rate Case	Yes
		Nevada	2021	Rate Case	Yes

Total Studies	132
Number of Rate Cases	90
Number of Utility Clients	43
Number of States	20

STURGILL TURNER

Sturgill, Turner, Barker & Moloney, PLLC
333 West Vine Street, Suite 1500
Lexington, KY 40507
p: 859.255.8581 f: 859.231.0851
www.sturgillturner.com

Employer I.D. No. 61-0576615

Allen Wilt
Utilities, Inc.
Allen Wilt
Water Service Corp of, KY

INVOICE OF SERVICES

Invoice Date: 03/07/2022
Invoice No: 156711
Account No: 64592.0012
PO# P91-2210-100171

2022 WSCK Rate Case

					Hours	
01/20/2022	MTO	C300	A109	WSCK Rate Case Appear for/attend meeting with S. Whitney and J. Kilbane on preparation for rate case.	1.50	
01/26/2022	MTO	L120	A104	Review and respond to email questions from J. Kilbane regarding minimum filing requirements for rate case	0.40	
	MTO	L120	A101	WSCK - Prepare information for J. Kilbane regading regulatory requirements for upcoming rate case	0.50	
02/03/2022	MTO	L120	A106	Communicate (with client) with J. Kilbane regarding treatment of rate base in Kentucky	0.20	
02/15/2022	MTO	C300	A106	Communicate (with client) - phone call with S. Whitney to discuss upcoming rate case	0.30	
02/28/2022	MTO	C300	A106	Communicate (with client) with S. Whitney, J. Kilbane, and K. Pashos	0.60	
				For Current Services Rendered	3.50	962.50

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	3.50	$275.00	$962.50

Total Current Work	962.50
Balance Due	$962.50

Task Code Summary

		Fees	Expenses
C300	Analysis and Advice	660.00	0.00
C300	Analysis and Advice	660.00	0.00
L120	Analysis/Strategy	302.50	0.00
L100	Do not Use-See L110-L190 Case Assessment,Development &Admin	302.50	0.00

Utilities, Inc.

03/07/2022
Account No. 64592-0012M
Invoice No. 156711

2022 WSCK Rate Case

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Lexington, KY 40507
p: 859.255.8581 f: 859.231.0851
www.sturgillturner.com

Employer I.D. No. 61-0576615

Allen Wilt
Allen Witt
500 W. Monroe
Suite 3600
Chicago, IL 60661-3779

INVOICE OF SERVICES

Invoice Date: 03/07/2022
Invoice No: 156711
Account No: 64592.0012

2022 WSCK Rate Case

Carbon Copy - Do Not Pay

					Hours	
01/20/2022	MTO	C300	A109	WSCK Rate Case Appear for/attend meeting with S. Whitney and J. Kilbane on preparation for rate case.	1.50	
01/26/2022	MTO	L120	A104	Review and respond to email questions from J. Kilbane regarding minimum filing requirements for rate case	0.40	
	MTO	L120	A101	WSCK - Prepare information for J. Kilbane regading regulatory requirements for upcoming rate case	0.50	
02/03/2022	MTO	L120	A106	Communicate (with client) with J. Kilbane regarding treatment of rate base in Kentucky	0.20	
02/15/2022	MTO	C300	A106	Communicate (with client) - phone call with S. Whitney to discuss upcoming rate case	0.30	
02/28/2022	MTO	C300	A106	Communicate (with client) with S. Whitney, J. Kilbane, and K. Pashos	0.60	
				For Current Services Rendered	3.50	962.50

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	3.50	$275.00	$962.50

Total Current Work	962.50
Balance Due	$962.50

Task Code Summary

		Fees	Expenses
C300	Analysis and Advice	660.00	0.00
C300	Analysis and Advice	660.00	0.00
L120	Analysis/Strategy	302.50	0.00

Allen Witt

03/07/2022

Account No. 64592-0012M

Invoice No. 156711

2022 WSCK Rate Case

		Fees	Expenses
L100	Do not Use-See L110-L190 Case Assessment,Development &Admin	302.50	0.00

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Employer I.D. No. 61-0576615

Allen Wilt
Utilities, Inc.
Allen Wilt
Water Service Corp of, KY

INVOICE OF SERVICES

Invoice Date: 04/06/2022
Invoice No: 157454
Account No: 64592.0012
PO# P91-2210-100171

2022 WSCK Rate Case

					Hours	
03/05/2022	MTO	L120	A104	Review prior WSCK rate cases and draft outline on issues to be addressed in upcoming rate case	1.50	
03/09/2022	MTO	L120	A104	Review email and respond to J. Kilbane regarding rate case questions	0.20	
03/11/2022	MTO	C300	A104	Review and respond to R. Guttormsen regarding rate case	0.20	
03/16/2022	MTO	C300	A104	Review and revise rate-case timeline for client	0.50	
03/30/2022	MTO	L120	A109	Appear for/attend meeting with WSCK team in preparation for rate case	1.30	
	MTO	L120	A104	Review - initial review of PSC cases on issue discussed during today's call.	0.80	
				For Current Services Rendered	4.50	1,237.50

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	4.50	$275.00	$1,237.50

Total Current Work	1,237.50
Previous Balance	$962.50
Balance Due	$2,200.00

Task Code Summary

		Fees	Expenses
C300	Analysis and Advice	192.50	0.00
C300	Analysis and Advice	192.50	0.00
L120	Analysis/Strategy	1045.00	0.00
L100	Do not Use-See L110-L190 Case Assessment,Development &Admin	1,045.00	0.00

Utilities, Inc.

04/06/2022
Account No. 64592-0012M
Invoice No. 157454

2022 WSCK Rate Case

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p: 859.255.8581 f: 859.231.0851
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Allen Wilt
Allen Witt
500 W. Monroe
Suite 3600
Chicago, IL 60661-3779

INVOICE OF SERVICES

Invoice Date: 04/06/2022
Invoice No: 157454
Account No: 64592.0012

2022 WSCK Rate Case

Carbon Copy - Do Not Pay

					Hours	
03/05/2022	MTO	L120	A104	Review prior WSCK rate cases and draft outline on issues to be addressed in upcoming rate case	1.50	
03/09/2022	MTO	L120	A104	Review email and respond to J. Kilbane regarding rate case questions	0.20	
03/11/2022	MTO	C300	A104	Review and respond to R. Guttormsen regarding rate case	0.20	
03/16/2022	MTO	C300	A104	Review and revise rate-case timeline for client	0.50	
03/30/2022	MTO	L120	A109	Appear for/attend meeting with WSCK team in preparation for rate case	1.30	
	MTO	L120	A104	Review - initial review of PSC cases on issue discussed during today's call.	0.80	
				For Current Services Rendered	4.50	1,237.50

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	4.50	$275.00	$1,237.50

Total Current Work	1,237.50
Previous Balance	$962.50
Balance Due	$2,200.00

Task Code Summary

		Fees	Expenses
C300	Analysis and Advice	192.50	0.00
C300	Analysis and Advice	192.50	0.00
L120	Analysis/Strategy	1045.00	0.00
L100	Do not Use-See L110-L190 Case Assessment,Development &Admin	1,045.00	0.00

Allen Witt

04/06/2022
Account No. 64592-0012M
Invoice No. 157454

2022 WSCK Rate Case

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Employer I.D. No. 61-0576615

Allen Wilt
Utilities, Inc.
Allen Wilt
Water Service Corp of, KY

INVOICE OF SERVICES

Invoice Date: 05/03/2022
Invoice No: 157877
Account No: 64592.0012

PO# P91-2210-100171

2022 WSCK Rate Case

					Hours	
04/11/2022	MTO	L120	A104	Review information related to rate case expense; draft letter to S. Whitney regarding same	0.40	
	MTO	L120	A104	Review - review of information regarding issues that may arise in rate case, as discussed in last meeting with WSCK; draft email to client regarding same.	1.80	
04/13/2022	MTO	L120	A106	Communicate (with client) - team meeting regarding upcoming rate case.	0.40	
04/22/2022	MTO	C300	A109	Appear for/attend conference call with WSCK rate case team regarding testimony	1.20	
	MTO	L250	A103	Review and draft comments on Whitney testimony	0.50	
				For Current Services Rendered	4.30	1,182.50

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	4.30	$275.00	$1,182.50

Total Current Work	1,182.50
Previous Balance	$2,200.00
Balance Due	$3,382.50

Task Code Summary

		Fees	Expenses
C300	Analysis and Advice	330.00	0.00
C300	Analysis and Advice	330.00	0.00
L120	Analysis/Strategy	715.00	0.00
L100	Do not Use-See L110-L190 Case Assessment,Development &Admin	715.00	0.00

Utilities, Inc.

05/03/2022
Account No. 64592-0012M
Invoice No. 157877

2022 WSCK Rate Case

		Fees	Expenses
L250	Other Written Motions and Submissions	137.50	0.00
L200	Do Not Use-See L210-L260 Pre-Trial Pleadings & Motions	137.50	0.00

PAYMENT DUE UPON RECEIPT
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Suite 3600
Chicago, IL 60661-3779

INVOICE OF SERVICES

Invoice Date: 05/03/2022
Invoice No: 157877
Account No: 64592.0012

2022 WSCK Rate Case

Carbon Copy - Do Not Pay

					Hours	
04/11/2022	MTO	L120	A104	Review information related to rate case expense; draft letter to S. Whitney regarding same	0.40	
	MTO	L120	A104	Review - review of information regarding issues that may arise in rate case, as discussed in last meeting with WSCK; draft email to client regarding same.	1.80	
04/13/2022	MTO	L120	A106	Communicate (with client) - team meeting regarding upcoming rate case.	0.40	
04/22/2022	MTO	C300	A109	Appear for/attend conference call with WSCK rate case team regarding testimony	1.20	
	MTO	L250	A103	Review and draft comments on Whitney testimony	0.50	
				For Current Services Rendered	4.30	1,182.50

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	4.30	$275.00	$1,182.50

Total Current Work	1,182.50
Previous Balance	$2,200.00
Balance Due	$3,382.50

Task Code Summary

		Fees	Expenses
C300	Analysis and Advice	330.00	0.00
C300	Analysis and Advice	330.00	0.00
L120	Analysis/Strategy	715.00	0.00
L100	Do not Use-See L110-L190 Case Assessment,Development &Admin	715.00	0.00

Allen Witt

05/03/2022

Account No. 64592-0012M

Invoice No. 157877

2022 WSCK Rate Case

		Fees	Expenses
L250	Other Written Motions and Submissions	137.50	0.00
L200	Do Not Use-See L210-L260 Pre-Trial Pleadings & Motions	137.50	0.00

PAYMENT DUE UPON RECEIPT
To ensure proper credit to your account
Please write Account 64592.0012 on your check
Thank you

STURGILL TURNER

Sturgill, Turner, Barker & Moloney, PLLC
333 West Vine Street, Suite 1500
Lexington, KY 40507
p: 859.255.8581 f: 859.231.0851
www.sturgillturner.com

Employer I.D. No. 61-0576615

Allen Wilt
Corix Regulated Utilities
Allen Wilt
Water Service Corp of, KY

INVOICE OF SERVICES

Invoice Date: 06/06/2022
Invoice No: 158689
Account No: 64592.0012

2022 WSCK Rate Case

PO# P91-2210-100171

			Hours
05/01/2022	MTO	Draft/revise - begin drafting application.	1.80
05/02/2022	MTO	Review and comment on draft testimony for S. Whitney	0.40
05/03/2022	MTO	Draft/revise - continued drafting of rate case application materials	3.50
05/04/2022	MHP	Prepare rate case minimum filing requirements chart for use in Application	1.30
05/05/2022	MHP	Prepare rate case minimum filing requirements chart for use in Application	0.50
05/06/2022	MTO	Appear for/ partially attend meeting with WSCK team regarding rate case	1.00
05/10/2022	MTO	Review and respond to email from S. Whitney regarding certain issues that may arise in rate case	0.40
05/11/2022	MTO	Appear for/attend conference call with WSCK team to discuss action items for rate case.	0.50
05/13/2022	MHP	Research - obtain copies of Certificate of Good Standing/Existence and Certificate of Assumed Name from the Kentucky Secretary of State	0.60
05/16/2022	MTO	Review certificate of good standing and certificate of assumed name	0.20
05/18/2022	MTO	Review and draft comments on testimony; provide information on MSFRs; participate in conference call with team to discuss rate case application.	1.30
05/19/2022	MTO	Draft/revise Notice for E-Filing to obtain docket number	0.20
	JWG	Review cases regarding recent PSC ROEs.	0.20
05/20/2022	MTO	Appear for/attend meeting with WSCK rate case team to discuss filing requirements and action items	0.70

Corix Regulated Utilities
06/06/2022
Account No. 64592-0012M
Invoice No. 158689

2022 WSCK Rate Case
PO# P91-2210-100171

			Hours	
	MTO	Review and draft materials for application	0.80	
05/24/2022	MTO	Review customer notice and make revisions; draft email to client regarding same.	0.50	
	MTO	Appear for/attend team meeting to discuss rate case application materials and action items	0.70	
05/25/2022	MTO	Communicate (with client) -emails with S. Lubertozzi regarding rate case	0.20	
05/26/2022	MTO	Appear for/attend team meeting to discuss application materials	0.60	
	MTO	Review proposed tariffs	0.30	
	MHP	Prepare exhibits for rate case filing with the Public Service Commission	1.80	
05/27/2022	MHP	Prepare exhibits for rate case filing with the Public Service Commission	1.60	
	MTO	Draft/revise - continued drafting of application; review materials; communicate with team regarding same.	3.50	
05/28/2022	MTO	Review - continued review of application materials; communicate with team by email regarding same.	2.30	
05/29/2022	MTO	Review and provide comments on testimony	2.30	
05/31/2022	MHP	Prepare exhibits for rate case filing with the Public Service Commission	1.80	
	MTO	Review and revising application materials; review of MSFR; communicate with WSCK team regarding same; revise Petition for Confidential Treatment	7.20	
	RCP	Draft/revise motion for confidential treatment of salary surveys	2.30	
		For Current Services Rendered	38.50	9,047.00

Recapitulation

Timekeeper	Title	Hours	Hourly Rate	Total
M. Todd Osterloh	Member	28.40	$275.00	$7,810.00
James W. Gardner	Of Counsel	0.20	275.00	55.00
Rebecca C. Price	Associate	2.30	200.00	460.00
Michael H. Peyton	Paralegal	7.60	95.00	722.00

Costs

05/31/2022	9 Document Reproduction	1.80

Corix Regulated Utilities

06/06/2022
Account No. 64592-0012M
Invoice No. 158689

2022 WSCK Rate Case
PO# P91-2210-100171

05/31/2022	50 Document Reproduction	10.00
05/31/2022	32 Document Reproduction	6.40
05/31/2022	63 Document Reproduction	12.60
05/31/2022	63 Document Reproduction	12.60
	E101 (653) Document Reproduction	43.40
	Total Costs Thru 05/31/2022	43.40
	Total Current Work	9,090.40
	Previous Balance	$3,382.50
05/17/2022	Thank you for your payment.	-2,200.00
05/31/2022	Thank you for your payment.	-1,182.50
	Total Payments	-3,382.50
	Balance Due	$9,090.40

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Thank you

Commission Staff 1-13:

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.

Response:

Please see Excel file "PSC DR 1-13 – Bad Debt Expenses."

Witness:

James Kilbane

Commission Staff 1-14:

Provide the amount of excess deferred federal income taxes resulting from the reductions in the corporate tax rate in 1986 and 2018, as of the end of the most recent calendar year. Show the amounts associated with each reduction separately.

Response:

This is not applicable because WSCKY recorded no excess deferred income taxes in 2021.

Witness:

James Kilbane

Commission Staff 1-15:

Provide the following tax data for the most recent calendar year:

a. Income taxes:

(1) Federal operating income taxes deferred – accelerated tax depreciation.

(2) Federal operating income taxes deferred – other (explain).

(3) Federal income taxes – operating.

(4) Income credits resulting from prior deferrals of federal income taxes.

(5) Investment tax credit net.

(a) Investment credit realized.

(b) Investment credit amortized – Revenue Act of 1971.

(6) The information in Item 17.a.(1–4) for state income taxes.

(7) A reconciliation of book to federal taxable income as shown in Schedule D1 and a calculation of the book federal income tax expense for the base period using book taxable income as the starting point.

(8) A reconciliation of book to state taxable income as shown in Schedule D2 and a calculation of the book state income tax expense for the base period using book taxable income as the starting point.

b. An analysis of Kentucky Other Operating Taxes as shown in Schedule D3.

Response:

Please see Excel file "PSC DR 1-15 – Tax Info" for responses to Items 1-4 and 6.

Item (5) is not applicable because WSCKY had no investment tax credit in 2021.

Please see Excel file "PSC DR 1-15 – Tax Info Schedules D" for responses to Items 7,8, and 8b.

Witness:

James Kilbane

Commission Staff 1-16:

Provide a copy of federal and state income tax returns for the most recent tax year, including supporting schedules.

Response:

Please see attached CONFIDENTIAL files labeled "PSC DR 1-16 – 2020 WSCKY Federal Proforma Tax Return" and "PSC DR 1-16 – 2020 WSCKY State Income Tax Return."

Witness:

James Kilbane

Commission Staff 1-17:

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

Response:

This is not applicable as WSCK does not pay franchise fees.

Witness:

James Kilbane

Commission Staff 1-18:

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 base period.

Response:

This is not applicable as WSCK did not acquire a utility plant in this manner.

Witness:

James Kilbane

Commission Staff 1-19:

Provide the utility's rate base, capital structure, and statement of income for the most recent 12 months preceding the base period and for the base period. Provide a reconciliation with detailed explanations.

Response:

Please see Excel file "PSC DR 1-19 – Financial Information."

Witness:

James Kilbane

Commission Staff 1-20:

Provide the capital structure at the end of the five most recent calendar years and each of the other periods shown in Schedule E1 and Schedule E2.

Response:

Please see Excel file "PSC DR 1-20 – Schedules E – Cap Structure." Please note the capital structure details shown are for CRU, WSCK's parent.

Witness:

James Kilbane

Commission Staff 1-21:

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 F1.

b. An analysis of short-term debt as shown in Schedule F2 as of the end of the latest calendar year.

Response:

Please see Excel file "PSC DR 1-21 – Schedules F – Debt Information."

Witness:

James Kilbane

Commission Staff 1-22:

Provide a reconciliation and detailed explanation of each difference, if any, in the utility's capitalization and net investment rate base for the base period and forecast period.

Response:

See Exhibit 8 of the Application for the forecast period. Please also see Excel file "PSC DR 1-22 – Rate Base to Capitalization Reconciliation."

Witness:

James Kilbane

Commission Staff 1-23:

Provide the information shown in Schedule G for each construction project in progress, or planned to be in progress, during the 12 months preceding the base period, the base period, and the forecasted test period.

Response:

Please see Excel file "PSC DR 1-23-25 – Schedules G H and I – Capital Project Info."

Witness:

James Kilbane

Commission Staff 1-24:

Provide, in the format provided in Schedule H, 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 G.

Response:

Please see Excel file "PSC DR 1-23-25 – Schedules G H and I – Capital Project Info

Witness:

James Kilbane

Commission Staff 1-25:

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 I1. 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 I1, calculate the annual "Slippage Factor" associated with those construction projects. The Slippage Factor should be calculated as shown in Schedule I2.

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

Response:

In response to items (a) and (b), please see Excel file "PSC DR 1-23-25 – Schedules G H and I – Capital Project Info." Regarding item (c), the utility did not use a slippage factor. The estimates WSCK used for the base period and forecasted period for capital are well defined.

Witness:

James Kilbane

Commission Staff 1-26:

Describe in detail how the base period 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.

Response:

There are two capitalization rates used: AFUDC and capitalized time. For forecast purposes, capitalized time uses a $41.65 per labor hour rate, which is the current blended rate for WSCK employees at the time of filing. For an explanation of capitalized time, please see the attached document referenced as "PSC DR 1-26 – Capitalized Time Guidelines." For AFUDC, please see Excel file "PSC DR 1-27 – 2021 AFUDC."

Witness:

James Kilbane

Capitalized Time Guidelines

Updated: May 2013

The purpose of these guidelines is to ensure that all employees are fully aware of the overall concept of capitalized time and to assist employees on the proper recording of capitalized time. Please contact Steve Lubertozzi, Jim Andrejko or Nicole Osbourne with any questions or for assistance with items not specifically covered in this guide.

Capitalized time refers to internal labor costs directly related to a capital expenditure or a capital project. The "cost" of your salary and benefits associated with the time you worked on a capital item is allocated to that item and becomes part of its overall cost basis.

For example, if an operator earns $40,000 in salary and benefits and records 50 hours of capitalized time related to a capital item, the amount of capitalized time would be $961 calculated as follows:

Annual salaries and benefits	$ 40,000
Total hours worked in one year	÷ 2,080
Hourly cap time rate	19.58
Capitalized time recorded	× 50
Capitalized time	$ 961

Using the above example, by capturing 50 hours of capitalized time the operator reduced our salary and benefits expense by $961 and increased our asset base by $961. These hours are typically project specific, charged to a specific capital project or asset and tracked for each employee.

Capital expenditures refer to costs incurred to acquire physical assets which have a useful life that extends beyond one year. All costs incurred to bring an asset to the condition and location necessary for its intended use are capitalized. Also, costs incurred to upgrade an existing asset which extends its original estimated useful life are capitalized. Costs include contracted labor, internal direct labor (in the form of capitalized time), materials and indirect costs.

Operating expenses refer to ongoing costs incurred in the day-to-day operations of the business. Typical operating expenses are for items such as chemicals, office supplies, permits and maintenance. In addition, costs incurred to keep a capital asset in its normal operating condition that do not extend the useful life of the asset or increase the assets future service potential or functionality are expensed as incurred.

Capitalized Time Guidelines

Updated: May 2013

Regulatory assets primarily consist of costs related to the rate filing process, including capitalized time, for which we have received or expect to receive prospective rate recovery. These costs are deferred and amortized over the period of rate recovery.

Deferred expenses primarily consist of repair and maintenance costs incurred in jurisdictions where these expenditures may be deferred and amortized over the period of rate recovery.

Following are Frequently Asked Questions and Answers Regarding Capitalized Time

Q: Can travel time be capitalized if you are working on a capital item (e.g.: to attend a new construction meeting)?

A: *Yes, but only if it is directly related to the project. Professional judgment must be used when recording travel time that may be considered excessive by a regulator.*

Q: Do I capitalize the time spent in transit to a meeting with someone to discuss a development in addition to the time in the meeting?

A: *If it is to discuss general development plans with no specific build out in mind (not yet considered to be a capital project), then no. However, if we a working with a developer who is preparing or currently working on a development or contiguous extension (considered to be a capital project) and you are working in connection with that development then, yes it should be capitalized.*

Q: If I replace a control panel or motor starter only, does that qualify as cap time?

A: *Yes.*

Q: Is changing out an existing meter or meter pit considered cap time?

A: *Yes.*

Q: Is the time spent designing automated answering trees and voicemail architecture for a new phone system considered cap time?

A: *No.*

Q: How many feet of replacement pipe are required before time can be capitalized?

A: *The cost of replacing pipe, regardless of length, is generally capitalized (including*

the cost of surface repair such as paving and landscaping) and therefore, time related to this effort can be capitalized. When pipe is replaced, it typically requires two clamps, one at each of end of the new pipe. A repair, on the other hand, would require only a single clamp. The costs of repairs are expensed as incurred and cap time would not be recorded.

Q: If you spend several hours doing paperwork (POs) for a cap (such as a major main break or where you replaced a section of main), is this time also capped?

A: *General paperwork would not qualify as cap time, unless you are engaged in construction related activities (i.e., engineering, supervision, or construction) then yes.*

Q: Spending an hour procuring a pump for a well (whether a replacement for one that burned out, or new) - is that time capped?

A: *Yes.*

Q: Time spent purchasing tools that are considered capital assets (which could be a specialty pump) - is that time capped?

A: *Yes.*

Q: Cross Connection personnel: If they spend time in the field inspecting facilities or to confirm proper equipment has been installed in order to protect our facilities from possible contamination or backflow, etc., is this time capped?

A: *Inspection of previously installed assets should not be capitalized.*

Q: Should time be capitalized when installing or replacing water meters at a service point?

A: *Yes.*

Q: Should time be capitalized when replacing a chemical feed mixer motor (from time purchasing, removing and replacing with a new one)?

A: *Yes.*

Q: Should time be capitalized when installing an elder valve?

A: *Yes.*

Q: Should time be capitalized when taking video of a sewer main to locate a tap in order to install an elder valve?

A: *Yes.*

Q: At a new house under construction it is necessary to video the line in order to locate the sewer tap. Can we cap this time spent, and the contractor's expense?

A: *Yes.*

Q: Taking video of a sewer line (as a follow-up from a previous sewer blockage):
A: *If no problems are found no time is capitalized. If we do find a problem and have it fixed then yes.*

Q: An operator exchanges a meter. Is the time to input the meter exchange data into CC&B capped?
A: *Yes, regardless of who inputs the data.*

Q: Should time related to rate cases be capitalized?
A: *Yes.*

Q: Can I capitalize time related to divestments and acquisitions?
A: No.

Q: Can I capitalize time spent associated while a vendor is on-site performing work related to a capital project?
A: *It depends. If you are supervising or inspecting the work, then yes. If the vendor is working independent, then no.*

Q: Should time be capitalized if I paint a tank?
A: Only if it is related to a capital project.

Q: Can I capitalize time related to developer agreements?
A: Yes because it would be related to a construction project.

Q: What if I work on a capital project but a project code hasn't been set up in JDE?
A: *Record this capitalized time in JDE using Pay Type 5 – Capital Suspense. Include the project name or other relevant information in the "Member Description" field.*

Q: What types of items are not capitalized?

A: *Services performed that are incidental to your work, such as general overhead costs that would have been incurred without the capital. Work not directly related to the development or construction of the project, and time related to non-capital repairs and maintenance.*

Examples of items that qualify for capitalization include the following, which is not an exhaustive list:

Installing or replacing:

1. Water supply / wells - Actual drilling of new well, testing new wells, install new or replace drop pipe, well casing, clearing land for new well, acidizing or shocking well, fracking well and capping an abandoned well.

2. Water electrical equipment - Well pumps; booster pumps; motors; well meters (turbo); piping within pumping station, recording, switching, measuring equipment, telemetry and generators.

3. Water storage - Water towers, storage tanks, pneumatic tanks, pressure control valves, quick tap on tanks, chemical tanks, check valves, anti- siphon valves and backflow preventer major maintenance on tanks.
4. Water mains/construction - Blow offs, valve boxes; section of main replaced, major main breaks.

5. Water hydrants - Hydrants, manholes, valves for hydrants and tees at main for hydrants.

6. Water buildings - Water treatment building: fences, building, well houses, locks, storage buildings, pole barns, driveways and reroofing or siding building.

7. Water treatment - Chlorinator, mixers, chemical pumps, air compressors, filter system, chemical scales and softeners.

8. Meters - original installations and replacements.

9. Sewer treatment plant/construction - Weir boxes, pumps, contact basin, piping within station, blowers, flow meter/box, clarifier, chlorinator, travel bridge, rewind/rebuild motor, surge tank impellor replacement is a rebuild to a

pump/motor, generator, electrical work building, fences, locks, storage buildings, driveways and reroofing or siding building.

10. Sewer mains/construction - Section of main replaced and major main breaks.

11. Sewer manholes/construction - Sealing of manhole covers and raising of manholes.

12. Sewer lift stations/construction - Pumping station, wet well and lift stations.

13. Sewer Refuse - Transmission, distribution, pump stations, storage.

14. Reuse - treatment, storage and transmission.

15. Road or landscape restoration as it relates to an above activity.

16. Master agreements.

17. Costs associated with the administration of water rights.

Commission Staff 1-27:

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).

Response:

Please see Excel file "PSC DR 1-27 – 2020 and 2019 AFUDC;" which is the same rate for both years. For 2021, please see Excel file "PSC DR 1-27 – 2021 AFUDC."

Witness:

James Kilbane

Commission Staff 1-28:

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.

Response:

Please see Excel file "PSC DR 1-27 – 2021 AFUDC" for AFUDC procedures that WSCK formalized in 2021.

Witness:

James Kilbane

ACCOUNTING POLICY – UPDATED 9/30/2021

Allowance for Funds Used During Construction (AFUDC)

Description:
The cost of debt and equity funds used to finance construction are capitalized as a cost element of property, with an offsetting credit to other income. Consistent with ASC 980-835, the inclusion of AFUDC in plant enables the fair return on, and the recovery of, capitalized costs by inclusion in rate base and depreciation, respectively.

Process:
AFUDC is calculated at the end of each reporting period (e.g. monthly) based on cumulative costs accrued on capital projects that are 1) active, and 2) where all project phases occur across more than 30 days. AFUDC will be recorded for the first active period where costs are accrued through the resulting asset's in-service date. If invoices are paid after the in-service date, AFUDC is charged until the period the last invoices are paid.

When a capital project is in-service and transferred to Utility Plant In-Service, the accumulated AFUDC is included in the asset's total depreciable base and depreciated with the other capitalized asset costs for the authorized depreciable life of the asset category.

Projects that are classified as regulatory assets or deferred debits will not accrue AFUDC.

If disallowance of capitalized plant by the regulator is probable, accumulated AFUDC should be written off.

AFUDC Rate:
The AFUDC rate used for a reporting period generally will reflect the authorized rate of return for the entity as set in its most recent base rate case proceeding. There are exceptions where:

1) The regulator does not allow the accrual of AFUDC. In these cases, a 0% rate is used.
2) The rate is not authorized in a base rate case for the entity but through a separate proceeding. In these cases, the rate authorized in the separate proceeding is used as of the effective date of the authorization by the regulator.
3) For unregulated jurisdictions, consistent with ASC 835, the AFUDC rate should only include a debt component and should not include an equity component. In these cases, the weighted cost of debt for Corix Regulated US ("CRU", formerly Utilities Inc.) as of the most recent June 30th financial

statements is used. The weighted cost of debt includes all long-term debt issuances and notes as well as revolving loans.

4) The regulator allows for AFUDC accrual but does not have an authorized rate of return identified in the entity's most recent base rate proceeding (e.g., black box settlements and operating margin-based returns). In these cases, the average of the regulated CRU affiliate entities that have established rates of return will be used. The affiliate average rate of return is calculated and updated every June 30th based on the most current effective affiliate rate orders.

Commission Staff 1-29:

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

Response:

WSCK's process for construction planning is embedded in its budgeting process. It has a five-year plan in which the first three years comprise the actual budget while years 4 and 5 are forecasted. The process starts by the operations team identifying the needs of the system. The focus of the planning is:

- Public & system safety
- System integrity & reliability
- Cost impact to rate payers
- Growth
- Technology advancements & best practices

After the operations team has identified projects, WSCK then begins preliminary planning and creates proposed budgets. This planning information is then built into the actual budget, and the budget review and approval process refines the planning goals and budget allocations. After the budget has been approved, the following steps occur:

- Develop engineering cost estimate and schedule
- Create business case and obtain approval from the internal capital project review team
- Obtain final engineering & design
- Project bidding phase

- Construction phase

These processes are ongoing so that WSCK can identify changing needs or priorities and incorporate them into the forecasting plan in a timely manner. This creates stability in the planning process, and WSCK can address projects quickly based upon their criticality and priority.

Witness:

Seth Whitney

Commission Staff 1-30:

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.

Response:

Please see Excel file "PSC DR 1-30 – Depreciation Schedule Report Output."

Witness:

James Kilbane

Commission Staff 1-31:

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

Response:

The utility does not offer any post-employment benefits to employees.

Witness:

James Kilbane

Commission Staff 1-32:

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

Response:

The utility does not have a pension plan. The utility offers and administers a 401(k) plan, "The Corix Affiliated Companies (US) 401(k) Plan". The utility's financial reporting for the 401(k) Plan follows Economic Retirement Income Security Act (ERISA) requirements, including the filing of an annual IRS 5500 tax return with audited plan financial statements. The utility also offers and administers a Registered Retirement Savings Plan (RRSP) for its Canadian Employees. The utility's financial reporting for the RRSP follows Canadian Regulatory Agency process requirements, conforms to all Capital Appreciation Plan (CAP) Guidelines, and is coordinated by plan advisors and record keeper. The ratemaking treatment of these plans include: a partial/allocated portion of retirement plan savings costs for support and/or corporate employees providing services to WSCK and a direct allocation of the retirement plan savings costs for direct employees of WSCK.

Witness:

James Kilbane

Commission Staff 1-33:

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 base period or the forecasted test period. Include all cost-benefit analyses associated with these programs.

Response:

WSCK does not have any early retirement or staff reduction programs.

Witness:

James Kilbane

Commission Staff 1-34:

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

Response:

WSCK does not have any current or recent labor contracts in place.

Witness:

James Kilbane

Commission Staff 1-35:

Provide the information requested in Schedule J 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, the base period, and the forecasted test period. Explain any variance exceeding 5 percent.

Response:

Please see Excel file "PSC DR 1-35 – Schedule J – Employee Info."

Witness:

James Kilbane

Commission Staff 1-36:

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 base period, and the forecasted test period.

Response:

Please see Excel file "PSC DR 1-36 – Merit Increase Information," a portion of which is being filed in conjunction with a Petition for Confidential Treatment.

Witness:

James Kilbane

Commission Staff 1-37:

For the base period 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.

Response:

Please see Excel file "PSC DR 1-37 – ELT Increases, Duties, and Direct Reports 2019 – 2022."

Witness:

James Kilbane

Commission Staff 1-38:

Provide, in the format provided in Schedule K, the following information for the utility's compensation and benefits, for the three most recent calendar years and the base period. 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).

Response:

Please see Excel File "PSC DR 1-38 – Schedule K – Payroll Info."

Witness:

James Kilbane

Commission Staff 1-39:

For each benefit listed in Item 41 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.

Response:

EE Cost for US Medical Plans – The total premiums (EE+ER) are a function of the Per Employee Per Month (PEPM) cost of the utility's medical plan. The PEPM is based on administrative costs and expected claims costs, which are BCBS forecasts based on weighted claims activity from recent plan years. Once the PEPM is set, the employee and employer portions are determined. The percentage of the employee's share of the total premium is a management decision made with consultation from the utility's broker and plan advisor. For recruiting and retention purposes, the utility has set the employee's percentage share of medical premiums at a rate that is competitive within the market. The employee's premium costs are also benchmarked annually against both employers in the utility industry and private sector employers within WSCK's geographic footprint to ensure that the utility's employee premiums remain competitive year over year.

EE Cost for Canadian Medical Plans – The amount of Flex Credits provided to employees in each tier level is a function of claims activity and administrative costs within the plan. While each employee is provided with flex credits based on their family (single, couple, or family), how they spend those credits will vary based on the medical plan they choose. The rates for each plan are established by SunLife. The employee portion of any premiums will vary based on each individual employee's elections. For example, an

employee with a spouse (couple) who enrolls in the Elite plan (Option 4) will have a higher premium cost than a similarly situated employee enrolling in the Cost Management plan (Option 2).

Witness:

James Kilbane

Commission Staff 1-40:

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.

Response:

Please reference the "PSC DR 1-40 – 2022 Benefits Guide."

Witness:

James Kilbane

2022 Employee Benefits Guide

CORIX®
Group of Companies

Table of Contents

Introduction

This benefits guide summarizes the benefit plans offered to eligible employees. Every effort has been made to ensure that the information is presented clearly and accurately. However, this is only a partial list of benefit information. Refer to the provider contracts, policies, descriptions and other materials that constitute the plan's summary plan description (SPD) for more detailed information about the benefits.

In the event of any conflict between the information in this document and the provider contracts or SPDs, such other documents will govern. The Corix Group of Companies reserves the right to change or discontinue these benefits, in whole or in part, at any time. You will be notified if a program is changed or discontinued. This document does not constitute an employment agreement between you and the Company.

DID YOU KNOW?

You have the power to help control benefit costs and save money by:

- Using generic Rx instead of brand name
- Utilizing in-network providers
- Taking advantage of your preventive care benefits
- Knowing where your closest urgent care facility is and only utilizing the emergency room for true emergencies

The benefits program provided to you by the Corix Group of Companies, is designed to offer eligible employees the flexibility to select benefits that best suit their needs. Significant costs are assumed by the Corix Group of Companies as our continuing commitment to provide a comprehensive benefits program for you. This guide provides a broad and brief overview of the various programs being offered to you and your eligible dependents. Eligibility in any given benefit plan is subject to the terms and conditions of that benefit plan. For a complete description of each benefit plan, see the applicable summary plan description (SPD) or certificate of coverage (COC).

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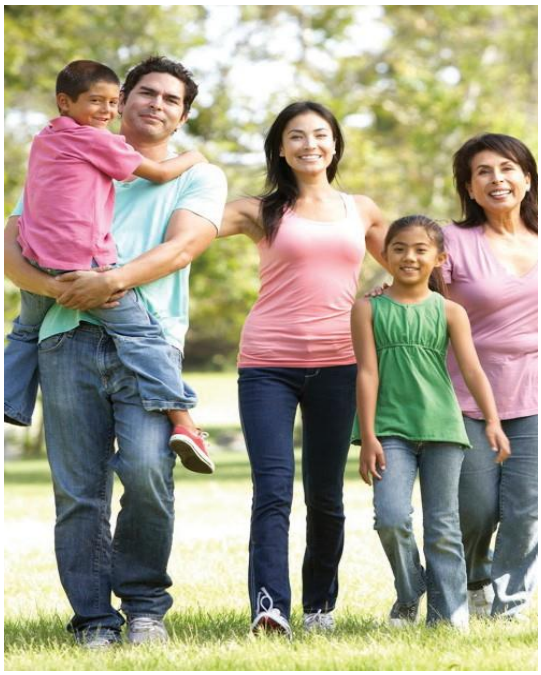
ELIGIBILITY



You are eligible to participate in the Corix Group of Companies Benefit Programs if you are a full-time employee scheduled to work a minimum of 30 hours per week. Temporary, seasonal and agency employees are *not* eligible to participate.

If you are eligible to participate in the Corix Group of Companies Benefit Programs, you may also enroll your legal spouse, domestic partner* (same and opposite sex) and dependent child(ren) for coverage. Please ensure you are making your elections carefully when enrolling dependents. A “dependent child” is the subscriber’s or spouse’s natural child, stepchild, foster child or legally adopted child. Children are generally considered dependents until:

- Age 26
- Any age, if they are mentally or physically disabled, chiefly dependent on the employee for support, and not capable of self-sustaining employment
- Age 30 if enlisted in the military

A summary of the benefits offered to you by the company are outlined in this guide. If you do not elect to enroll in coverage during the open enrollment period or when you are first eligible for benefits, you will not be allowed to enroll until the next open enrollment period unless you have a special enrollment event as defined by HIPPA (see “Qualifying Life Events” on the following page).

**If you are enrolling a domestic partner, please contact HR as there may be additional tax implications.*

When Coverage Begins:

If you are a new hire, you must enroll in benefits within 31 days of your initial eligibility date. Benefits begin on the first of the month following your hire date. If you fail to elect coverage under one or more of the optional plans within this time will be deemed to have voluntarily waived eligibility for coverage for the entire plan year. Once made, elections are irrevocable and remain in effect for the entire plan year unless a QLE change occurs. Enrollment in the employer paid benefits is automatic.

The 401(k) Retirement Plan is effective the first of the month following one month of employment.

ENROLLMENT

Qualifying Life Events:

Your initial new hire eligibility period allows you 30 days from your date of hire to submit enrollment forms for the benefits you wish to enroll in. You can change your enrollment during the plan year only when you have a qualifying life event that significantly affects your benefit needs. Life events can include:

- Marriage or Divorce
- Birth or adoption of a child or placement of a child for adoption
- Death of a child or spouse
- Loss of or obtainment of other coverage
- Exhausting the maximum period of COBRA coverage

An employee wanting to change elections due to a qualifying life event should contact Human Resources as soon as possible following the event, but no later than 30 days following the event. Appropriate documentation will be required to substantiate a change and must be received within 30 days of the event. Effective date for changes will be the actual date of the event. Any change reported or supporting documentation received after 30 days of the qualifying life event will not be accepted. In such an instance, the next opportunity to make a change will be during the next open enrollment period.

Pre-Tax vs. Post-Tax Benefit Contributions:

Generally, the cost to participate in the Company's Health plans and/or reimbursement accounts is taken from your paycheck on a **pre-tax** basis. This means, you do not pay Federal Income Tax, Social Security Tax, and in most cases state/local taxes on those contributions.

Preventive Incentive/Routine Physical & Blood Draw:

To promote a healthy lifestyle, we encourage you to receive a routine annual physical with blood draw at initial eligibility and every 3 years. Having a routine preventive physical is a step toward taking control of your health. If you choose to enroll in our medical plan and complete a routine annual physical, you will be incentivized with lower premium rates. Both medical plans cover your physical and blood draw at 100% with no copay, if you receive this service through an in-network provider.

To qualify for this incentive, you and your spouse (if you choose to cover), must have a routine physical with a blood draw documented with a date of service within 60 days of your insurance becoming effective. A Routine Physical Verification Form must be completed for both you and your spouse by the physician and returned to HR within the given time frame. If the form is not returned, your premiums will increase to the non-preventive rates on the 61st day from the effective date.

What is your requirement for the 2022 Plan year?

If enrolled in our coverage, you and your spouse (if you choose to cover), must have a routine physical with a blood draw documented within the first 180 days of your insurance becoming effective. A Routine Physical Verification Form must be completed for both you and your spouse by the physician and returned to HR within the given time frame. Beyond 2022, you'll be asked to complete this routine physical and blood draw every 3 years.

MEDICAL BENEFIT SUMMARY

The Corix Group of Companies offers you the option to choose between two medical plans, administered by BlueCross BlueShield of Illinois. The PPO plan provides you the freedom to seek services from the provider of your choice. Certain services may require satisfying a deductible. Once the deductible is met, the plan will begin paying based on a co-share amount known as coinsurance. The out-of-pocket maximum is the most you will spend in a given plan year. Please refer to page 34 for employee contribution amounts.

PPO Benefit Highlights:

BCBS PPO Plan	In-Network	Out-Of-Network
Deductible		
Individual	$400	$800
Family	$1,200	$2,400
Annual Out-of-Pocket Maximum (deductible embedded)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Covered Services		
Preventive Care	100%	60% after deductible
Primary Care Office Visit	$20 copay	60% after deductible
Specialist Office Visit	$20 copay	60% after deductible
Urgent Care	80% after deductible	60% after deductible
Diagnostic Tests	80% after deductible	60% after deductible
Emergency Room (copay waived if admitted)	80% after $200 copay	
Inpatient Hospital Services	80% after deductible	60% after deductible
Outpatient Hospital Services	80% after $20 copay/office visit	60% after deductible
Rehabilitation/Habilitation Services	80% after deductible	60% after deductible
Retail Prescription Drugs (34 days retail)		
Generic	$10 copay	$10 copay+25% coinsurance
Formulary brand name drugs	25% coinsurance Min: $25 copay Max: $75 copay	50% coinsurance Min: $25 copay Max: $75 copay
Non-formulary brand name drugs	50% coinsurance Min: $25 copay Max: $75 copay	75% coinsurance Min: $25 copay Max: $75 copay
Specialty	50% coinsurance Max: $250 copay	Not Covered
Mail Order Prescription Drugs (90 days mail order)		
Generic	$20 copay	$20 copay+25% coinsurance
Formulary brand name drugs	25% coinsurance Min: $50 copay Max: $150 copay	50% coinsurance Min: $50 copay Max: $150 copay
Non-formulary brand name drugs	50% coinsurance Min: $50 copay Max: $150 copay	75% coinsurance Min: $50 copay Max: $150 copay
Specialty	50% coinsurance Max: $500 copay	Not Covered

See appendix for a quick reference guide on how to access your benefits

MEDICAL BENEFIT SUMMARY

The Corix Group of Companies offers you the option to elect the BCBS HDHP Plan. This plan is a qualified High Deductible Health Plan, meaning you are eligible to contribute to a Health Savings Account (HSA) account with pre-tax dollars if you choose to do so. Refer to page 20 for additional information on HSAs. Please refer to page 34 for employee contribution amounts.

HDHP Benefit Highlights:

BlueCross BlueShield

BCBS HDHP	In-Network	Out-Of-Network
Deductible		
Individual	$1,500	$4,500
Family	$3,000	$13,500
Annual Out-of-Pocket Maximum (deductible embedded)		
Individual	$6,000	$12,000
Family	$12,000	$24,000
Covered Services		
Preventive Care	100%	70% after deductible
Primary Care Office Visit	90% after deductible	70% after deductible
Specialist Office Visit	90% after deductible	70% after deductible
Urgent Care	90% after deductible	70% after deductible
Diagnostic Tests	90% after deductible	70% after deductible
Emergency Room (copay waived if admitted)	90% after deductible	
Inpatient Hospital Services	90% after deductible	70% after deductible
Outpatient Hospital Services	90% after deductible	70% after deductible
Rehabilitation/Habilitation Services	90% after deductible	70% after deductible
Retail Prescription Drugs (34 days retail)		
Generic	90% after deductible	70% after deductible
Formulary brand name drugs	90% after deductible	70% after deductible
Non-formulary brand name drugs	90% after deductible	70% after deductible
Specialty	50% after deductible Max: $250 copay	Not Covered
Mail Order Prescription Drugs (90 days mail order)		
Generic	90% after deductible	70% after deductible
Formulary brand name drugs	90% after deductible	70% after deductible
Non-formulary brand name drugs	90% after deductible	70% after deductible
Specialty	50% after deductible Max: $500 copay	Not Covered

See appendix for a quick reference guide on how to access your benefits

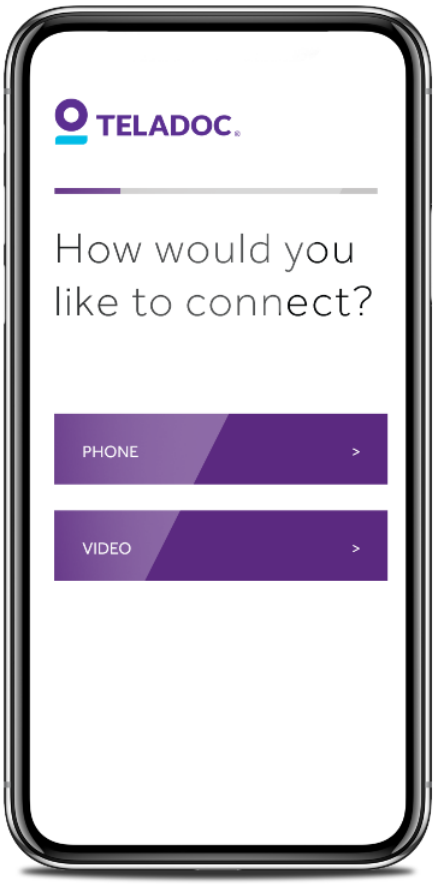
TELADOC TELEMEDICINE

TelaDoc Benefit Highlight:

The Corix Group of Companies offers you and your eligible dependents enrolled in a medical plan access to TelaDoc. TelaDoc allows you to talk to a doctor anytime and anywhere by phone or video consult. TelaDoc is **free (no copay)** to you and offers a convenient service that you and eligible dependents can access for consultations and treatment (including prescriptions) for a wide variety of medical conditions without leaving your home. If necessary, doctors can prescribe medication over the phone for you to pick up at a pharmacy most convenient to you. Visit TelaDoc's website at www.TelaDoc.com or call 1-800-Teladoc to request a consultation.

Speak with a physician with no copay!

- **Feel better faster** - TelaDoc provides you access to U.S. board certified physicians who can resolve most non-urgent medical issues via phone or online video
- **Available when you need care** - convenient alternative to urgent care or ER visits; access a physician anywhere, anytime, 24 hours a day, 7 days a week, 365 days a year
- **An alternative you can trust** - pay less to feel better quicker with a $0 copay and the convenience of not leaving your home



How to sign up?

- Visit the TelaDoc website at www.TelaDoc.com and click "Set Up Account" to begin the registration process. Remember to register in order to use this service when you are sick.
- Enter your first name, last name, date of birth, zip code, email and gender and click "continue"
- Follow the directions online to complete the account setup phase and provide your medical history

Request a Visit

- Visit the TelaDoc website and click "Request a Visit"
- Select the type of consult you would like to have
- Talk to a doctor within one hour of setting up your consultation

See appendix for a quick reference guide on how to access your benefits

RX ‘N GO PRESCRIPTION BENEFIT

Rx ‘n Go

The Corix Group of Companies allows you and your enrolled dependents the opportunity to receive **free** generic maintenance medication by utilizing the Rx ‘n Go mail order pharmacy service. Rx ‘n Go offers a comprehensive listing of nearly 1,200 available generic maintenance medications. By filling your generic maintenance medication through Rx ‘n Go, the Company will pay the entire cost of the medication. A ninety (90) day supply of medication will arrive directly at your home address or designated delivery location.

Please consult with your physician or health care provider if you are not currently taking a generic medication to determine if any of the prescriptions offered through the Rx ‘n Go pharmacy may be an option.

Interested plan members are required to have their health care provider submit a complete Rx ‘n Go prescription order form via email or fax (or the member may mail the original order form via regular mail).

Next Steps for You and Your Physician:

For Your Physician:

Have your physician/licensed health care practitioner E-Scribe, phone or fax your prescription(s) directly to Rx ‘n Go:

- E-Scribe: GoGoMeds
- Phone: 888-697-9646 (must be from your Physician’s office)
- Fax: 888-697-0646 (must be from your Physician’s office)

For You:

- Check to see if your medication is covered at https://rxngo.com/medications or by calling Customer Service at 888-697-9646
- Create an account at https://rxngo.com > Sign Up. Or, sign up by calling Customer Service at 888-697-9646 and provide your information

See appendix for a quick reference guide on how to access your benefits

LIVONGO – DIABETES MANAGEMENT

New!

Claim your Livongo Welcome Kit Today

Use registration code: **BCBSIL**

- Online: **join.livongo.com/BCBSIL/hi**
- Phone: **(800) 945-4355**

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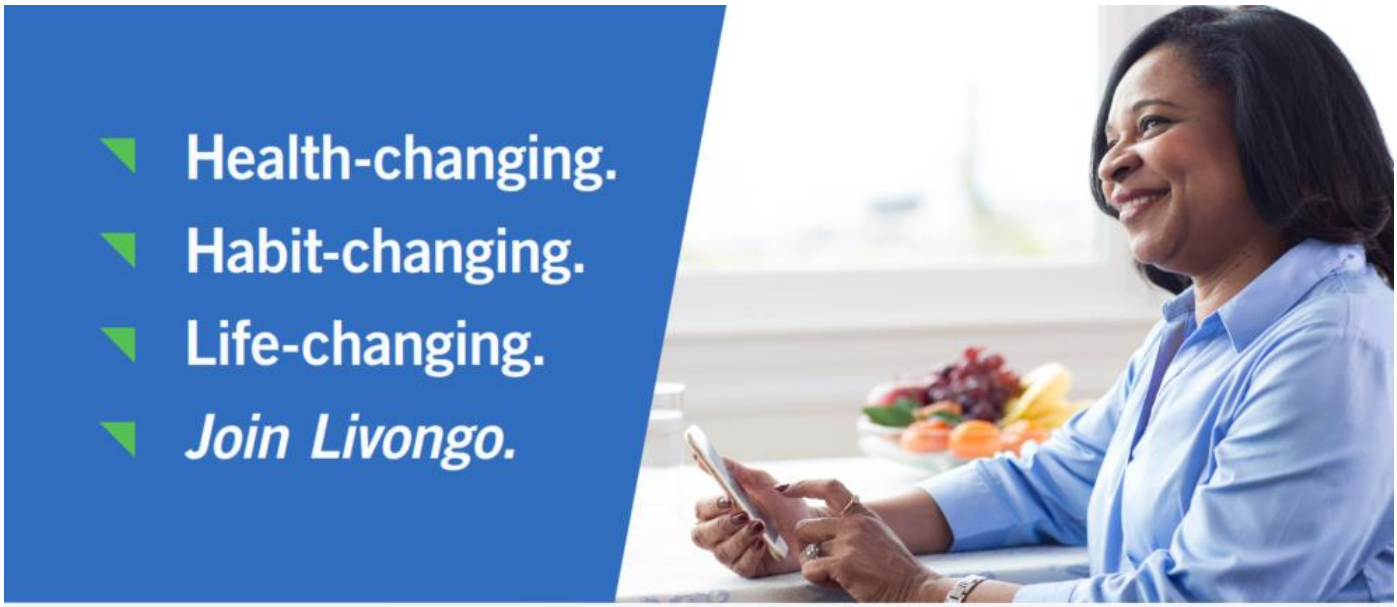
LIVONGO – HYPERTENSION MANAGEMENT

New!



Livongo gives you the technology, insights, and expert support to help you more easily manage high blood pressure. This free-to-you health benefit is paid for 100% by your employer. Join during open enrollment and start simplifying your health! The program is provided to you and your family members with high blood pressure and coverage through Blue Cross and Blue Shield of Illinois (BCBSIL).

Smart Tools for Better Health

- Monitor your numbers
- Get personalized tips after every check
- Make lifestyle changes with help from trained coaches
- Stay on track with reminders when to check
- Send data directly to your doctor
- Know how you're doing with customized reports

Use registration code: **ILHTN**

- Online: **ready.livongo.com/HTN**
- Phone: **(800) 945-4355**

Livongo®

DENTAL BENEFIT SUMMARY

The Corix Group of Companies offers you and your families a Dental PPO Plan administered by MetLife. You are eligible to participate in the dental plan within 31 days of eligibility. Benefits begin the 1st of the month following your hire date. The DPPO plan offers you the option to visit any licensed dentist or specialist without prior approval in or out-of-network for covered services. You do not have to designate a primary care dentist. You will generally save on the cost of covered dental care when you utilize an in-network dentist. Please refer to page 34 for employee contribution amounts. Below you will find a high level overview of the Dental Plan offered to you:

Dental PPO Benefit Highlights:

MetLife Dental PPO	In-Network	Out-Of-Network
Deductible (applies to Basic/Major)		
Individual	$50	
Family	$100	
Annual Benefit Maximum		
	$1,750	
Preventive Covered Services (Type A)		
Oral Examinations	100%	
Cleanings	100%	
Fluoride (children under 18)	100%	
Bitewing and Full Mouth X-rays	100%	
Sealants	100%	
Basic Covered Services (Type B)		
Amalgam (silver) Fillings	80% after deductible	
Composite Fillings	80% after deductible	
Space Maintainers (1 per lifetime to age 16)	80% after deductible	
Extractions (Non-surgical and Complex)	80% after deductible	
Periodontics (scaling, root planning, surgery)	80% after deductible	
Endodontics	80% after deductible	
General Anesthesia	80% after deductible	
Major Covered Services (Type C)		
Inlays/Onlays	50% after deductible	
Crowns	50% after deductible	
Full/Partial Dentures	50% after deductible	
Prosthetic Maintenance/Repairs	50% after deductible	
Bridges	50% after deductible	
Implants	50% after deductible	
Orthodontia Services (Type D) – Children 19 and Under		
Coinsurance	50%	
Lifetime Benefit Maximum	$1,500	

See appendix for a quick reference guide on how to access your benefits

VISION BENEFITS

The Corix Group of Companies offers you vision benefits administered by VSP at **no cost** to you. VSP offers you the option to see any licensed eye care professional. However, you will receive the highest level of benefits if you utilize an in-network provider. Vision coverage is effective on the 1st of the month following your date of hire. *Please note*: VSP does *not* provide ID cards.

Vision Benefit Highlights:

VSP Vision Plan	In-Network Copay	Out-Of-Network Reimbursement
Exams		
Optometrist	$10	Up to $25
Ophthalmologist	$10	Up to $25
Lenses		
Single Vision	$25	Up to $30
Bifocal	$25	Up to $35
Trifocal	$25	Up to $45
Frames		
Frames	$130 allowance, 20% off remaining balance	Up to $45
Contact Lenses		
Elective	$130 retail allowance	Up to $105
Medically Necessary	Covered	Up to $210
Frequency		
Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Frames (Children, excluding college students)	Once every 12 months	
Contact Lenses	Once every 12 months	

See appendix for a quick reference guide on how to access your benefits

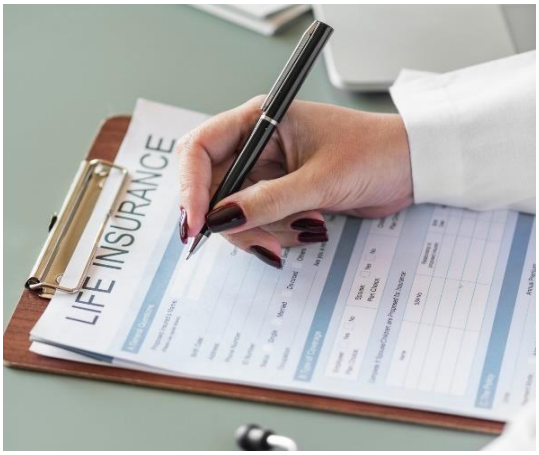
BASIC LIFE AND AD&D INSURANCE

The Corix Group of Companies provides all eligible employees Basic Life and Accidental Death and Dismemberment insurance effective the first of the month following your date of hire. While insured under this provision, your beneficiary will be paid a sum of two (2) times your base annual salary to a maximum of $750,000. Evidence of insurability is required on amounts greater than $650,000.

If, while covered under AD&D, you are accidentally injured and that injury is independent of illness and all other causes, then you will be paid a benefit based on the nature of the loss. The maximum benefit is an amount equal to two (2) times your base annual salary to a maximum of $750,000.

MetLife

When Basic Life/AD&D Insurance Applies:



The Corix Group of Companies provides employees a valuable Basic Term Life/AD&D plan, through MetLife. You must be actively at work on the date coverage is scheduled to become effective; otherwise, the effective date is delayed until you return to full-time active work.

Basic Life Insurance provides a benefit should you die of any cause. If employment terminates, employees may opt for conversion. The Basic Life benefit includes an accelerated benefit option. You may be eligible to receive the accelerated benefit if you have 24 months or less to live. In which case you may receive up to 80% of your coverage, to a maximum of $500,000.

Basic AD&D Insurance provides a benefit amount should you suffer the loss of life, sight, hand, or foot caused by an accidental bodily injury.

Things to think about:

- Life insurance and AD&D provides family members peace of mind by helping meet immediate financial needs arising from loss or injury of an employee.
- Employee's who have spouses electing similar coverage through their employer may wish to compare plans to determine the best coverage and most affordable rate.

Age Reductions Apply:

- Basic life insurance includes an age reduction benefit formula in accordance with the Age Discrimination and Employment Act (ADEA)
- At the age of 65 benefits will be reduced by 35% of the benefit amount. At the age of 70 basic benefits will be reduced by 50% of the benefit amount. All coverage terminates at retirement.

VOLUNTARY LIFE INSURANCE

The Corix Group of Companies offers you the option to purchase additional life/AD&D insurance to supplement your basic benefits. Voluntary Life/AD&D insurance is available for you, your spouse and/or your child(ren) at group rates on a post-tax basis, allowing the benefit to be tax-free. Employees must purchase coverage for themselves before they are able to purchase coverage for dependents. If you are a newly eligible employee, you may enroll yourself as well as eligible dependents without evidence of insurability up to the guarantee issue level listed below. Any amount above your guarantee issue level will require evidence of insurability. Both benefits are portable upon termination. Requests to port this benefit must be made to HR within 30 days of your termination.

The table below illustrates a summary of these benefits. Please note that MetLife requires the purchase of coverage in stated increments.

MetLife

Voluntary Life/AD&D Benefit Highlights:

	Voluntary Life Benefit Amounts
Employee	$10,000 increments up to a maximum of $500,000
Spouse	$5,000 increments up to a maximum of $150,000 not to exceed 50% of the employees elected amount
Child(ren)	15 days to 6 months old: $1,000 6 months and older: Options of $1,000, $2,000, $4,000, $5,000 or $10,000
Guarantee Issue*	*Employee*: $200,000 *Spouse*: $50,000

***Guarantee issue*:** the amount of coverage you are eligible to purchase during your initial enrollment period without providing evidence of “good health”. However, if you do not enroll when initially eligible, you will be required to provide evidence of “good health” for any amount elected.

DISABILITY INSURANCE

The Corix Group of Companies provides all eligible employees short term and long term disability insurance at **no cost** to you, administered by MetLife. Disability insurance is provided in the unfortunate event you become disabled and unable to work.

Short Term Disability Insurance (STD):

STD insurance provides paid leave for off-the-job illness or injury. To qualify for Short Term Disability, you must file a claim with MetLife and submit written proof of your disability from a treatment provider. You may also need to provide MetLife with additional medical records concerning the details of your disability. Once approved, STD claims are paid by the Company. An outline of the STD benefit offered to you is below:

Short Term Disability Benefit	
Weekly Benefit Amount	60% of your weekly earnings
Elimination Period	0 days accident / 8 days illness
Benefit Duration	26 weeks

Employees hired on or before 12/31/2016 may receive a short-term disability benefit in excess of 60%. These employees should reference page 46 of the Appendix for a complete chart potential benefit by years of service.

Long Term Disability Insurance (LTD):

In order to qualify for Long Term Disability insurance, you must satisfy all requirements set forth by MetLife during the application process. In the event of disability, it is suggested that you begin the application process to receive benefits no later than your twelfth week of continuous disability to ensure sufficient time for review. An outline of the LTD benefit offered to you is below:

Long Term Disability Benefit	
Monthly Benefit Amount	60% of pre-disability earnings
Maximum Monthly Benefit	$10,000/month
Elimination Period	180 days or until the end of the STD maximum benefit period
Own Occupation Period	24 months

PARENTAL LEAVE AND ADOPTION BENEFIT

The Corix Group of Companies provides full-time eligible employees who have completed one year of service, up to six weeks of parental leave paid at 100% following the birth of an employee's child or the placement of a child with an employee in connection with adoption or foster care. The purpose of paid parental leave is to enable the employee to care for and bond with a newborn or newly adopted or newly placed child. This policy will run concurrently with Family and Medical Leave Act (FMLA) leave, as applicable.

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Parental Leave Highlights:

- You will not receive more than six weeks of paid parental leave in a rolling 12-month period, regardless of whether more than one birth, adoption, or foster care placement event occurs within that 12-month time frame.
- Approved Parental Leave begins on the day the child is born* or adopted and must be taken within 90 calendar days of that event. Parental Leave can be taken in increments of no less than one hour (for hourly employees) or one half day (for salaried employees).
- Any leave beyond 6 weeks provided for Parental Leave will be covered as outlined under STD and will require completion of a Certification of Healthcare Provider Form.
- You must provide your manager or HR with notice of the request at least 30 days prior to the proposed date of leave or, if the leave was not foreseeable, as soon as possible. You will be required to complete all necessary HR forms to substantiate your request.
- The Company has the exclusive right to interpret this policy
- If you are on an unrelated STD leave when parental leave would begin, the guidelines for the STD benefit supersede those for parental leave.

*When complications or pre-mature birth occur and require extended hospitalization of a new born child, the 90-day parental leave eligibility period will begin on the date of discharge from the hospital. Documentation and HR approval required.

Adoption Benefit

Adoption benefits are available to full-time employees after one year of service. The adopted child must be 17 years of age or younger unless the child is physically or mentally incapable of caring for himself or herself. Eligible adoption related expenses* will be reimbursed as they are incurred during the adoption process up to a maximum of $5,000 per child.

*Adoption related expenses include lawyer fees, private and/or public agency fees, foreign adoption fees, temporary foster care charges, transportation costs, counseling fees associated with placement and costs related to pre-placement visitation.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Our Health Care Flexible Spending Account (FSA) and Dependent Care Account (DCA) administered by WEX, allows you the option to use pre-tax dollars to reimburse yourself for a wide variety of health and/or dependent care expenses that are not covered through your other benefit plans. You must re-enroll in the FSA each year if you would like to contribute for the next plan year. Your elections will not roll over.

Health Care Flexible Spending Account:

The Health Care FSA reimburses you for eligible healthcare FSA expenses incurred by yourself, your spouse and your dependents. This account can be used to pay for qualified medical, dental or vision expenses not covered by your insurance. Physician office visit and prescription copays are some examples of qualified expenses. Please note you may **not** contribute to the Health Care FSA account if you are contributing to an HSA account. You may contribute up to the 2022 federal maximum limit of $2,750.

Dependent Care Flexible Spending Account:

With the Dependent Care Flexible Spending Account, you may contribute up to the 2022 federal maximum limit of $5,000 each year on a pre-tax basis. The Dependent Care FSA can help you pay for work-related care of your eligible dependents, such as day care, after school care and elder care. This account is designed to help you pay for dependent care while you are at work or looking for work. This limit will be reduced to $2,500 if you are married and filing separate tax returns.

Limited Purpose FSA:

If you contribute to a HDHP and are contributing to a Health Savings Account, you are only eligible to contribute to a Limited Purpose FSA plan, up to the Federal IRS maximum. A Limited Purpose FSA allows you to set aside pre-tax dollars to cover out-of-pocket expenses **only** pertaining to dental, vision and preventive care. Your funds may be used for expenses incurred by you, your spouse or eligible dependents. Common eligible expenses are dental copays, vision copays and prescription glasses.

Eligible Health Care FSA Expenses:

- Laser eye surgery
- Prescription drugs
- Copays and coinsurance
- Deductibles
- Dental expenses
- Dermatology
- Eye exams, lenses, frames and contacts
- Hearing aids
- Cosmetic surgery to correct a medical condition
- Acupuncture
- Alcoholism and drug treatment center
- Artificial limbs and teeth
- Chiropractic care
- Insulin
- Smoking cessation Programs
- Wheelchairs

Deadline to Submit Claims:

Any dollar amount not reimbursed for expenses during the plan year will be forfeited. This is known as the “use it or lose it” rule. There is a grace period from January 1, 2023 through March 15, 2023 to incur expenses for the 2022 plan year. The deadline to submit all claims for the 2022 plan year is March 31, 2023.

Please note: Your election and contribution into an FSA plan is binding for the entire plan year and only a qualifying life event will allow you to change your election.

See appendix for a quick reference guide on how to access your benefits

HEALTH SAVINGS ACCOUNT (HSA)

FLEX
Leading the way

What is a Health Savings Account?

With an HSA, the unused dollars are yours to keep (even if you move out of the plan) to apply towards eligible medical, dental and vision expenses or to maintain as a retirement account. If you participate in a qualified High Deductible Health Plan, you are eligible to contribute to a Health Savings Account (HSA), administered by Flexible Benefits. The HSA plan is a consumer driven health plan that provides you the opportunity to build your retirement savings through unused contributed funds.

Who is Eligible for an HSA?

You are eligible to contribute to a Health Savings Account if:

- You are enrolled in a high-deductible health plan
- You are not covered under another medical plan that is not a high-deductible health plan
- You are not entitled to (eligible and enrolled) Medicare benefits

What are the Advantages to Participate?

Cost Savings:

- The Tax Benefits – money is set aside of a pre-tax basis
- HSA Contributions are excluded from federal income tax
- Interest earnings and withdrawals are tax-exempt
- Reduction in medical employee premium contributions.

Long-Term Financial Benefits:

- Save for future medical expenses. HSA funds can be used tax-free when withdrawn for qualified medical expenses. After age 65, HSA funds can be used for unqualified medical expenses without penalties, but those transactions will be subject to ordinary income taxes.
- Funds roll over year to year
- Fully-portable, meaning you can take the account with you if you leave the company

You may contribute up to the 2022 federal maximums listed below:

- **Single Coverage:** $3,650
- **Family Coverage:** $7,300
- **Catch-Up Contribution for 55+:** $1,000

For a full list of eligible medical expenses, refer to the IRS website at: **www.irs.gov**

See appendix for a quick reference guide on how to access your benefits

VOLUNTARY BENEFITS

Accident Advantage Plus Insurance:

Corix Group of Companies offers you the option to purchase Accident Advantage Plus Insurance, administered by Aflac. Accident insurance is designed to help covered employees meet their out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Aflac pays a lump sum benefit to you regardless of whether or not you are enrolled in any other insurance plans. Accident insurance pays a benefit to you if an accident occurs either on or off the job. Coverage of the plan is portable, meaning you may take the plan with you if you leave or retire from your job. You have the option to elect coverage for you and your family. Please refer to the table below for benefit amounts. Please refer to page 34 for employee contribution amounts.

Accident Advantage Plus - Benefit Amounts	
Paralysis (Quadriplegia/Paraplegia)	$10,000/$5,000
Torn/Severed Tendon or Ligament	$400 single/$600 multiple
Concussion	$200
Coma (lasting 30 days)	$10,000
Hospital Admission	$1,000
Hospital Confinement (per day)	$200
Hospital Intensive Care (per day)	$400
Emergency Room	$200
Ambulance (Ground/Air)	$200 / $1,000

Critical Illness Advantage Insurance:

Corix Group of Companies offers you the option to purchase Critical Illness Advantage insurance, administered by Aflac. Critical Illness insurance provides you extra money to help cover expenses incurred due to a critical illness. A few examples of qualified critical illnesses covered under the plan are: invasive cancer, heart attack, stroke and major organ transplant. The proceeds of your approved claim may be used towards whatever you wish. Coverage of the plan is portable, meaning you may take the plan with you if you leave or retire from your job. You may elect coverage for your spouse and dependent(s) not to exceed 50% of your own election. Please refer to the table below for benefit amounts and rate information.

Critical Illness Advantage - Benefit Amounts	
Benefit Amounts	*Employee:* $5,000 - $30,000 *Spouse:* $5,000 - $15,000; not to exceed 50% of employee's face amount *Child:* Up to 50% of the employee's face amount
Guaranteed Issue	*Employee:* $30,000 *Spouse:* $15,000
Health Screening Benefit	*Employee:* $50 *Spouse:* $50

VOLUNTARY BENEFITS

Hospital Indemnity Plan:

You have the option to enhance your medical plan with additional hospital benefits through Aflac. These benefits are designed to provide financial protection in the case of a hospital stay by paying you a cash benefit of up to $1,000 for hospital admission and $75-150 per day for inpatient days and days in the ICU. Plus, this plan also includes an additional wellness benefit. Aflac group hospital indemnity insurance plans are designed to provide you with cash benefits to help with the following:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit
- Intermediate Intensive Care Step-Down Unit
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more
- Hospital Indemnity also provides coverage for newborn children for 60 days from the date of birth

VOLUNTARY BENEFITS

Identity Theft Protection:

The Corix Group of Companies offers you the option to enroll in Identity Theft Protection for you and your family members in the unfortunate event you or a loved one's identity is stolen. Identity theft protection will actively monitor your banking/credit, loans, healthcare information, taxes, notify you if there is a breach in security and more. Please refer to page 34 under Identity Theft for employee contribution amounts.

Below are the Identity Theft plan options you may elect:

- **LifeLock Benefit Elite:** Only available as a deducted payroll benefit, LifeLock will scan its network to detect activity using your personal information, and will alert you to any potential threats, with their Restoration Team on standby if you become the victim of identity theft to work your case until you're restored, and their Million Dollar Protection Package to make you whole again. The benefit also scans millions of transactions per second every day for potential threats to your identity and financial assets, includes screening for misuse of your Social Security number, change of address and court records scanning if your identity was used to commit crimes.
- **LifeLock Ultimate Plus:** Services include all of the above features of Benefit Elite, plus bank account application and takeover alerts, credit monitoring, online credit reports credit scores, and monitoring of your property titles.
- **LifeLock Junior:** If dependents under age 18 are enrolled, protection helps safeguard your child's Social Security number with proactive identity theft protection designed for children.

Find out more by visiting LifeLock at www.lifelock.com or call 800-607-9174.

Pet Insurance:

The Corix Group of Companies offers employees Pet Insurance offered by MetLife Pet Insurance Solutions LLC. Pet insurance for cats and dogs is offered in the form of property and casualty insurance. Plan coverage options include lifetime accident and illness up to $25,000 per year. Choose which coverage best suits you and your pet's needs. For a quote with the employer discount visit: www.metlife.com/getpetquote to receive a 10% discount for enrolling through the Company. An overview of the benefits that are offered through MetLife Pet Insurance are outlined below:

Flexibility to select various levels of coverage, including optional preventive care, while also providing among the shortest wait periods for accident and illness coverage	
$500 - $25,000	Levels of coverage
$0 - $2,500	Deductible options
Eligible Ages	All ages
50% - 100%	Various reimbursement percentages

What does it cover?

- Accidental injuries
- illnesses
- exam fees
- surgeries
- medications
- ultrasounds
- hospital stays
- X-rays and diagnostic tests

And coverage also includes

- hip dysplasia
- hereditary conditions
- congenital conditions
- chronic conditions
- alternative therapies
- holistic care
- and much more!

SUPPORT AND GUIDANCE RESOURCES

Employee Assistance Program (EAP)

Problems are just a part of everyday life and Corix Group of Companies wants to provide you resources to deal with them. In addition to the benefits provided under your MetLife Insurance coverage, you and your household members have access to MetLife's completely confidential Employee Assistance Program (EAP), at no cost to you.

The EAP provides you and your dependents access to resources targeted to assist with work/life issues ranging from financial advice to grief counseling. Access to resources and advisors are available online as well as telephonically. The program can assist with identity theft recovery, relationship help, assistance with end-of-life matters, funeral arrangements, family support, addressing grief and financial issues.

How to get started:

- Log on to https://metlifeeap.lifeworks.com/ and enter the following username: **metlifeeap** and password: **eap**
- Speak with a clinician anytime or schedule an appointment by calling 1-888-319-7819

Support Services in a time of need:

- ❖ 24/7/365 telephone counseling and referral services
- ❖ Five face-to-face sessions with a licensed clinician per incident, per individual, per calendar year
- ❖ Call 1-888-319-7819 anytime to speak with a clinician or to schedule an appointment

Benefits Value Advisor (BVA)

Benefits Value Advisor (BVA) is a consumer advocacy program that guides members through the complex world of health care, at **no cost** to you. BVA helps prompt you to examine and weigh every aspect of your health care decisions. Call the customer service number on the back of your BCBSIL ID card to speak with a Benefits Value Advisor today!

According to BCBS, 90% of members who call BVA prior to having a procedure, resulted in lower cost options for their care. The price between an MRI at two different clinics in the same town can vary by several hundred, or even thousands of dollars. Let the experts do the research for you, saving you time and money.

What Can Blue Value Advisor do for you?

- ❖ Assist in helping you locate doctors and treatment centers and compare costs
- ❖ Connect you with clinical program staff and provide online educational tools to learn more about your condition
- ❖ Coordinate pre-certification procedures
- ❖ Understand claims, explain coverage guidelines, order ID cards and more!

Before your next procedure, call the customer service number on the back of your BCBS member ID card to speak with a Benefits Value Advisor!

PROFESSIONAL CERTIFICATION/LICENSES

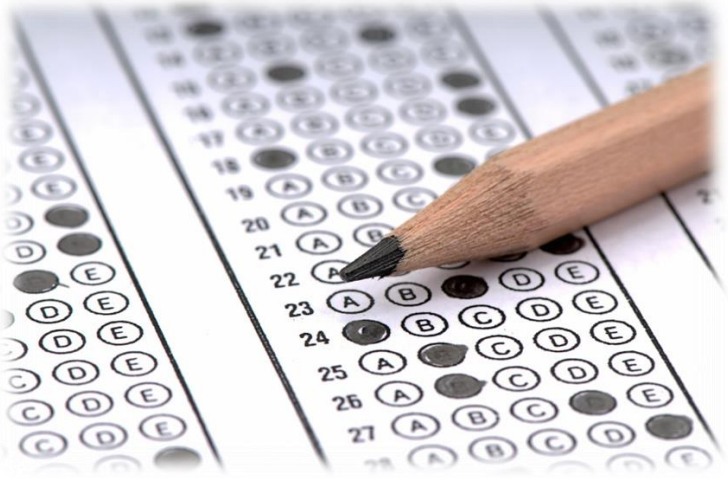
The Company requires certain positions to have the proper license and/or certifications for certain job titles. These requirements are listed on the job description for each position, which are on the WaterMain. Please contact a BU Executive about approval for any professional license or certification not identified below.

Coursework & Training:

The Corix Group of Companies will cover 100% of the costs associated with your first attempt at any job-required or job-related coursework related to obtaining a professional certification or license. This coursework must be approved by a BU Executive prior to any classes being scheduled and/or taken. Should the employee need to retake the course, the cost associated with additional attempts will be the responsibility of the employee.

Exams:

The Company will cover 100% of the costs associated with an employee's first attempt at completing an exam required to successfully obtain a professional certification or license. Should an employee not pass the exam on their first attempt, you will be responsible for the cost of the additional attempts.



Certification/Licensing Pay

Some certifications and/or licenses qualify for additional compensation or "Certification Pay" upon being obtained or re-certified. Certification pay is a one-time payment per qualifying event. Specific certification pay amounts are listed on the WaterMain. In order for an employee to be compensated for their achievement, a BU executive must submit approval via a certification pay check request.

CPA Review & Exam Reimbursement

The Company, at its sole discretion, may agree to reimburse an employee for CPA Review courses and/or CPA Exam fees that are deemed to be beneficial for the employee and the Company. This reimbursement would be subject to the stipulations outlined in the CPA Review & Reimbursement Agreement, found on the WaterMain.

Continuing Education Units or Credits (CEUs or CECs)

The Corix Group of Companies will cover 100% of the costs associated CEUs or CECs needed to maintain a professional license. CEUs or CECs must be approved by a BU Executive to ensure that the license meets a business need or is relevant to that employee's position.

EDUCATION ASSISTANCE

If you are a full-time employee, you may continue your education in a related field, and the Company may reimburse some of the tuition costs. All courses and costs must be pre-approved by the manager and a BU Executive and must be completed on your own time. Once the course is complete, a certified transcript of your grades and the receipts for your expenses must be submitted. You will be reimbursed for the portion of the tuition that was pre-approved on the following course by course basis:

Grade	Reimbursement
A	90% of the pre-approved reimbursement amount
B	75% of the pre-approved reimbursement amount
C	50% of the pre-approved reimbursement amount

In cases where classes are graded on a pass/fail basis, a passing grade will be reimbursed at 90%. To qualify for Education Assistance you must:

- Advise your manager prior to enrolling for approval of the course
- Ensure the course is job related and offered by an approved institution
- Have course and reimbursed approved by a BU Executive prior to the start of the course
- Receive a passing grade of a “C” or better
- Have at least one full year of prior service with the Company
- Sign an agreement stating that if you leave the Company within 12 months of completing the course, you must pay back the amount reimbursed

If you are eligible to receive educational benefits from another source, such as VeteransAdministration, the Company will consider some reimbursement of the remaining unpaid amount of your educational expenses.

401(k) Retirement Savings Account

J.P.Morgan

Plan Eligibility – You become eligible to make Elective Deferral Contributions, receive Safe Harbor Matching Contributions and Non-Elective Contributions as of the first of the month following the date you attain age 21 and you complete 1 month of service, measured from your date of hire, provided that you are an Eligible Employee as of that date.

Active Enrollment – If you are logging in for the first time, you will need your PIN which will be sent to you at your home address by mail a month prior to initial eligibility to your home address. To enroll, you must login to the JP Morgan website at **www.retirementlink.jpmorgan.com.** Additional information can be found on the Watermain in the HR/Payroll drop down under "Benefits", "Forms" then "401(k)."

Employee Contributions – You may elect to make a contribution to the Plan on a pre-tax basis and/or on an after-tax Roth basis. These pre-tax and/or after-tax Roth contributions are known as Elective Deferral Contributions. You may elect to defer up to 100% of your Compensation on a pre-tax basis and/or after-tax Roth basis.

Automatic Enrollment – New hires are automatically enrolled in the plan with a default deferral of 3%. A new employee may opt out or increase their deferral at the time of hire. These contributions will begin through a payroll deduction on the 1st of the month following the completion of one month of service.

Employer Matching - You are eligible to contribute 100% of your salary up to the IRS maximum through pre-tax payroll deductions to your 401(k) Plan. If you are 50 years of age or older, you are allowed an additional $6,500 in catch up contributions to the plan. If you elect to contribute to your 401(k) Plan, the company will make a matching to your account. Prior to the beginning of each year, the Company will announce the applicable matching level and cap for that year.

We will match your contributions 100%, dollar for dollar, on the first 3% you contribute to the 401(k) plan. The Company will make an additional matching contribution of $.50 on every $1.00 you contribute to the 401(k) Plan up to a maximum contribution on 5% (equal to 4%) of your base annual compensation. If you do not contribute to the 401(k) Plan you will not be eligible for a matching contribution.

Non-Elective Company Contribution - As of January 1, 2019, employees who meet the eligibility requirements of the 401(k) plan will receive a non-elective contribution (NEC) from the Company equal to 3% of their eligible wages which will be deposited into their 401(k) account on a per pay period basis regardless of whether they have made contributions of their own.

Vesting – All contributions made to the 401(k) plan are vested at 100%. This includes both the Employer Matching contributions & 401(k) Non-Elective Company contributions made by the Company.

Sound Consulting Services Retirement Plan Advisors (SCS):

SCS Retirement offers you free, one-on-one retirement plan consulting and wealth management services. SCS Retirement provides comprehensive investment fiduciary services and is experienced in creating efficient plans for participants. SCS works separately, but in conjunction with the retirement plan.

SCS Retirement Can Help:

- Understanding the investment choices available within your retirement plan
- Determining your Investment Objective and Risk Tolerance
- Deciding how much to contribute from your paycheck into your Retirement Plan
- Investment Allocation based on your needs and Risk Tolerance

SCS Retirement Provides:

- Comprehensive Investment Review
- Complete Retirement Planning
- College Financial Planning and Estate Planning
- Individual Retirement Accounts (IRAs)
- Consolidation of your Investment Account

SCS RETIREMENT

Contact SCS Retirement at: (425) 454-4015 or visit www.scsretirement.com.

Retirement and Other Financial Support Program

Transitions Benefit Group

Transitions Benefit Group (TBG) is a free consultative service available to all Corix employees and their family members, with a focus on planning for life after retirement.

Provided below are a few areas that Transitions Benefit Group can assist you with:

Are you ready for tomorrow?

Transitions team of advisors are here to help you understand what options are available now to help you be prepared for tomorrow. Financial protection, continuity of benefits, and understanding your needs. TBG will help with a variety of options to support your individual and family needs best.

Caregiver Support

Do you have a loved one that needs additional assistance in Medicare, VA Benefits, prescription drugs support, or more? Transitions services are offered to your friends and family!

Medicare Coordination

As TBG's clients become Medicare eligible regardless of just age, there are questions that need to be answered and coordination of benefits that need to be addressed. The TBG team is here to help you time your Medicare enrollment and assist with plan selections.

Social Security Planning

One of TBG's most asked questions, is when should I draw social security? TBG helps clients understand the timing, implications, and outcomes based on their individual needs.

Life Stage Planning

Each stage of life creates new demands on our families and finances. From Generation Z to Traditionalists, TBG has resources to assist with needs planning.

Educational Support

TBG's demand educational resources range from webinars to FAQ's. Through the TBG team, you will be able to find the answers, forms, resources, and more to help get you where you need to go!

COBRA Coordination & Opinions

This is more than just leaving the employer plan, this includes helping your college aged children who need to transition to their own insurance policy or even helping a divorcing spouse figure out their insurance options. This offers both a pre and post age 65 review of coverage options.

Contact Information
Carrier: Transitions
(800) 936-1404
www.transitionsrbg.com

ADDITIONAL BENEFITS

Paid Time Off (PTO):

Having enough time off to rest, relax and recharge is an important part of a work-life balance. We know employees who take most or all of their vacation time each year perform better, are more productive and more satisfied in their jobs than those who do not. We want to ensure you are well-rested and the most productive you can be. Refer to the accrual schedule below for annual PTO amounts:

Completed Years of Service	Hours Accrued Per Bi-Weekly Period	Hours Accrued Per Semi-Monthly Period	Annual PTO Hours (Days Available)
Up to 1 Year	5.54	6.00	144 hours (18 days)
2 to 5 Years	6.15	6.67	160 hours (20 days
6 to 8 Years	7.69	8.33	200 hours (25 days)
9 to 10 Years	8.31	9.00	216 hours (27 days)
11 o 14 Years	8.92	9.67	232 hours (29 days)
15 to 24 Years	9.23	10.00	240 hours (30 days)
25+ Years	9.85	10.67	256 hours (32 days)

* Contract Utilities Employees hired on or before 12/31/2019 will be grandfathered to receive 35 days of PTO after 30 completed years of service.

Unused PTO Time

If you have unused PTO time remaining at year-end, you may carry up to 5 days (40 hours full-time, 20 hours part time), when otherwise legally required by state or local law. Carry-over must be used the following year and unused roll-over PTO is not paid out upon termination

Terminated Employees

At time of termination, accrued PTO will be calculated by taking the number of full months worked during the current year times the amount of PTO time earned in one month. Any unused time will be prorated and paid upon termination. For employees voluntarily terminating, PTO cannot be used during the two-week notice period, as the employee is typically required to work during this time, train his/her replacement, or perform other duties as required.

Paid Company Holidays:

Corix Group of Companies offers full-time employees eleven (11) company paid holidays, including 2 Floating Holidays*. Please note that the designated holidays may change each year. The scheduled holidays include:

- **New Year's Day**
- **Martin Luther King, Jr. Day**
- **Memorial Day**
- **Independence Day**
- **Labor Day**
- **Thanksgiving Day**
- **Day after Thanksgiving**
- **Christmas Eve**
- **Christmas Day**
- **2 Floating Holidays**

*Two additional days (16 hours) are provided as a substitute for a public holiday to be taken on a date chosen by the employee and approved by her/his manager. Floating holidays must be used within the calendar year and do not carry over.

ADDITIONAL BENEFITS

Blue Access for Members (BAM):

If you are enrolled in a BCBSIL medical plan you have access to many of their online resources. Save time with self-service support tools and health and wellness resources on a convenient and secure online site. Below are just a few of the resources you have access to when you register online at bcbsil.com:

- Check claims and claims history
- Find an in-network provider
- Use the cost estimator tool for an expected cost range for your procedure
- View, save or print Explanation of Benefits (EOBs)
- Sign up for electronic EOBs, and turn off paper
- View benefits and covered dependents
- Check coverage details and Rx benefit information
- Manage mobile and texting preferences
- Request new ID cards or print temporary ID cards
- Access health and wellness information and guides
- Get details on wellness, discounts, 24/7 Nurseline

Go to **bcbsil.com** and log in to Blue Access for Members via web or mobile. Click **Register Now** for New Users

To register you will need your Identification number on the front your ID card OR you can call the Customer Service number on the back of the card

ILLINOIS

To download the app, go to Google Play, the App Store or text **BCBSILAPP** to **33633**

ADDITIONAL BENEFITS

Well onTarget

Employees and dependents (age 18 and older) who are covered on one of the medical plans offered through BCBSIL have access to the Well OnTarget Fitness program. Well OnTarget provides discounts on gym memberships at over 9,000 fitness centers nationwide.

Fitness that Works for you

Well onTarget is available exclusively to BCBSIL members and their covered dependents (age 18 and older). The fitness program provides flexible options to help you live a healthy lifestyle:

- **Flexible Gym Network –** A choice of gym networks to fit your budget and preferences.

Options	Base	Core	Power	Elite
Monthly Fee	$19	$29	$39	$99
Gym Facility Network Size†	3,000	7,500	12,000	12,400
$19 Initiation Fee				

- **Studio Class Network –** Boutique-style classes and specialty gyms with pay-as-you-go option and 30% off every 10th class.
- **Family Friendly** – Expands gym network access to your covered dependents at a bundled price discount.
- **Unlimited Access -** Nationwide network of more than 9,000 participating fitness centers
- **Convenient Payment** – Monthly fees are paid via automatic credit card or bank account withdrawals.
- **Complementary and Alternative Medicine (CAM) Discounts Through the Whole Health Living Choices Program–** Save money through a nationwide network of 40,000 health and well-being providers, such acupuncturists, massage therapists and personal trainers. To take advantage of these discounts, register at **whlchoices.com**.
- **Blue Points –** Get 2,500 points for joining the Fitness Program. Earn additional points for weekly visits. You can redeem points for apparel, books, electronics, health and personal care items, music and sporting goods.
- **Web Resources** – You can go online to find fitness locations and track your visits.

Enroll online today by:

- Logging on to Blue Access for Members (BAM) at bcbsil.com
- Calling 888-762-BLUE (2583) Monday-Friday 7am-7pm CT

ADDITIONAL BENEFITS

PerkSpot Discount Program

Corix offers you the option to save money on items that you may already be using! PerkSpot is a one-stop-shop discount program that provides you with exclusive discounts at hundreds of national and local merchants. Access your perks at hays.perkspot.com and browse dozens of categories that fit your lifestyle.

EMPLOYEE CONTRIBUTIONS

Medical:

PPO Plan	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$71.98	$77.98	$155.96
Employee + Spouse	$185.82	$201.31	$402.61
Employee + Child(ren)	$156.40	$169.43	$338.86
Family	$270.99	$293.58	$587.15
HDHP Plan	**Bi-Weekly**	**Semi-Monthly**	**Monthly**
Employee Only	$63.08	$68.34	$136.67
Employee + Spouse	$162.59	$176.14	$352.28
Employee + Child(ren)	$136.85	$148.26	$296.51
Family	$237.12	$256.88	$513.75

Dental:

Dental	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$3.96	$4.29	$8.57
Employee + Spouse	$8.20	$8.88	$17.76
Employee + Child(ren)	$9.63	$10.43	$20.86
Family	$14.91	$16.15	$32.30

Vision:

Vision	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$0	$0	$0
Employee + Spouse	$0	$0	$0
Employee + Child(ren)	$0	$0	$0
Family	$0	$0	$0

Accident Advantage Plus:

Accident	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$7.00	$7.59	$15.17
Employee + Spouse	$11.42	$12.37	$24.74
Employee + Child(ren)	$13.72	$14.87	$29.73
Family	$18.14	$19.65	$39.30

EMPLOYEE CONTRIBUTIONS

Hospital Indemnity:

Hospital Indemnity	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$10.38	$11.25	$22.49
Employee + Spouse	$19.80	$21.46	$42.91
Employee + Child(ren)	$15.99	$17.33	$34.65
Family	$25.42	$27.54	$55.07

Identity Theft:

Benefit Elite	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$3.92	$4.25	$8.49
Employee + Family	$7.84	$8.49	$16.98
Ultimate Plus	**Bi-Weekly**	**Semi-Monthly**	**Monthly**
Employee Only	$11.76	$12.75	$25.49
Employee + Family	$23.53	$25.50	$50.98

Voluntary Life/AD&D Rates

Employee & Spouse Age	Voluntary Life - Per $1,000
Under 30	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.11
45-49	$0.18
50-54	$0.28
55-59	$0.44
60-64	$0.67
65-69	$1.27
70+	$2.06
Dependent Child	$0.24

Voluntary AD&D - Per $1,000	
Employee & Spouse	$0.03
Dependent Child	$0.05

*Critical Illness, Pet Insurance, and Universal Life contributions differ by age and coverage level

IMPORTANT NOTICES

General Notice of COBRA Continuation Rights

This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. Please read it carefully.

Introduction

You are receiving this Notice because you have recently become covered (or may soon become covered) under a group health plan (the "Plan"). This Notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or,
You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

The parent/employee dies;
The parent/employee's hours of employment are reduced;
The parent/employee's employment ends for any reason other than his or her gross misconduct;
The parent/employee becomes entitled to Medicare benefits (under Part A, Part B or both;
The parents become divorced or legally separated; or,
The child is no longer eligible for coverage under the Plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualified event has occurred. When the qualifying event is the end of employment or reduction of hours, disability, death of an employee or the employee's becoming entitled to Medicare benefits, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events, such as divorce or legal separation or the dependent child losing eligibility under the Plan, you must notify the Plan Administrator within 60 days of the qualifying event occurring. You must provide this notice, along with any requested documentation to Human Resources

IMPORTANT NOTICES

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits, divorce or legal separation, or a dependent child losing eligibility under the Plan, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction in the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. *For example,* if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and any family members covered under the Plan may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of coverage. You must provide this notice of disability, along with any requested documentation to Corix Infrastructure.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, provided notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits, becomes divorced or legally separated or if the dependent child is no longer eligible as a dependent child under the Plan, but only if this second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Questions

Questions concerning your Plan or your COBRA coverage continuation rights should be addressed to the Plan contact. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and any other laws or regulations affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa.

Keep the Plan Informed of Any Address Changes

In order to protect your rights and the rights of your family, you should keep the Plan Administrator informed of any changes in the addresses of covered family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

IMPORTANT NOTICES

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify Corix Infrastructure within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Corix Infrastructure and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Corix Infrastructure has determined that the prescription drug coverage offered by the Corix Infrastructure Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Corix Infrastructure coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current Corix Infrastructure coverage, be aware that you and your dependents will not be able to get this coverage back (except during certain open enrollment periods).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Corix Infrastructure and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. Note that you will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Corix Infrastructure changes. You also may request a copy of this notice at any time.

IMPORTANT NOTICES

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31,2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31,2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under this Act. 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.

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Newborns' and Mothers' Health Protection Act of 1996

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

Genetic Information Non-Discrimination Act of 2008 (GINA)

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family members of the individual, except as specifically allowed by this law. To comply with this law, Corix Infrastructure will generally never require a benefits participant to provide any genetic information when responding to any request for medical information in connection with enrollment in any Corix Infrastructure benefits plan or accessing any of your Corix Infrastructure plan benefits. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. For more information about GINA, visit www.dol.gov/ebsa/faqs/faq-GINA.html

Uniformed Services Employment & Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted in 1994 following U.S. military action in the Persian Gulf. USERRA prohibits discrimination against individuals on the basis of membership in the uniformed services with regard to any aspect of employment. Since its enactment, USERRA h

as been modified and expanded by additional federal laws, such as the Veterans Benefits Improvement Act of 2008.

Maintenance of Benefits During Leave

A person who is reemployed upon returning from completion of uniformed service is entitled to the rights and benefits that he or she would have attained if he or she had remained continuously employed.

Health Benefits

An employer must allow individuals absent due to uniformed services to elect to continue health insurance coverage for themselves and their dependents. Health insurance coverage must be continued until the earlier of:

24 months beginning on the date when the absence began; or

The day after the date the employee fails to apply for return to work following completion of their service.

Individuals who are absent from work for less than 31 days may not be required to pay more for coverage than the employee share charged to employees that are actively at work. Employers may charge all other individuals no more than 102 percent of the full premium under the plan.

If benefits are cancelled because the employee did not elect to continue coverage or failed to pay premiums, the employer must restore to the employee benefits equivalent to those the employee would have had if leave had not been taken, including family or dependent coverage. The employee cannot be required to serve a new pre-existing condition waiting period, wait for open enrollment or pass a medical examination to obtain reinstatement of coverage.

IMPORTANT NOTICES

Exchange Notice
Beginning in 2014, there is a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.
The 2022 open enrollment period for health insurance coverage through the Marketplace begins on Nov. 1, 2021 and will end on Dec. 15, 2021. Individuals must have enrolled or changed plans prior to Dec. 15, 2021, for coverage starting as early as Jan. 1, 2022. After Dec. 15, 2021, you can get coverage through the Marketplace for 2022 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.
If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.61% of your household income for the year (9.83% for 2021), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact or contact your HR department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Patient Protection Notice and Selection

Corix Infrastructure allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. For children, you may designate a pediatrician as the primary care provider.

IMPORTANT NOTICES

The Mental Health Parity and Addiction Equity Act of 2008

The *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) requires group health plans to apply the same treatment limits on mental health or substance-related disorder benefits as they do for medical and surgical benefits. The MHPAEA also extends this parity requirement to inpatient and outpatient services, whether in-network or out-of-network, and to emergency care services and prescription drugs. MHPAEA revised the definition of "mental health benefits" to include substance use disorder benefits. The MHPAEA also requires group health plans to apply the same beneficiary financial requirements to mental health or substance use disorder benefits as they apply for medical and surgical benefits, including limits on deductibles, co-payments and out-of-pocket expenses. Plan administrators are also required to make the criteria for "medical necessity" determinations with respect to mental health and substance use disorder benefits available to plan participants, beneficiaries or providers upon request.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 31 days from the date of your marriage.

Health Insurance Portability and Accountability Act of 1996 - Privacy

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requires health plans to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice describes how the plan may use or disclose your health information, under what circumstances it may share your health information without your authorization (generally to carry out treatment, payment, or health care operations), and your rights with respect to your health information. As required by HIPAA, Corix Infrastructure maintains the confidentiality of your health information and has policies and procedures in place to help protect it from improper use and disclosure.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

CONTACT INFORMATION

Carrier	Group Number	Phone Number	Website/Email
BCBSIL Medical Plans			
PPO Plan HDHP Plan	PG2979 PG2984	800-828-3116	www.bcbsil.com
MetLife Dental			
Dental	5954815	800-942-0854	www.metlife.com
VSP Vision Plan			
Vision	12159678	800-877-7195	www.vsp.com
MetLife Life & Disability Plans			
Life & Disability STD/LTD	5954815	800-858-6506	www.metlife.com
Aflac Accident/Critical Illness Insurance			
Accident Critical Illness Hospital Indemnity	23188	800-992-3522	www.aflac.com
LifeLock Identity Theft			
Identity Theft	N/A	800-607-9174	www.lifelock.com
TelaDoc			
Teladoc	N/A	800-835-2362	www.teladoc.com
Rx 'n Go			
Rx 'n Go	N/A	888-697-9646	www.rxngo.com
PetFirst Pet Insurance			
Pet Insurance	9999206256	800-438-6388	www.metlifepetinsurance.com www.metlife.com/getpetquote
Flexible Spending Accounts (FSA)			
FSA	N/A	866-451-3399	www.wexinc.com
JP Morgan 401(k)			
401(k) Plan	N/A	855-576-7526	www.retirementlink.jpmorgan.com
MetLife Employee Assistance Program			
LifeWorks EAP	5954815	888-319-7819	www.metlifeeap.lifeworks.com
Flexible Benefits Health Savings Account (HSA)			
HSA	N/A	866-472-5352	www.flexiblebenefit.com
Benefits Value Advisor (BVA)			
Benefits Advisor	N/A	800-828-3116	www.bcbsil.com
Sound Consulting Services			
Sound Consulting Services	N/A	800-303-1856	www.scsretirement.com
Retirement and Financial Support			
Transitions	N/A	800-936-1404	www.transitionsrbg.com
Livongo			
Diabetes Management Hypertension Management	N/A	800-945-4355	join.livongo.com/BCBSIL/hi hello.livongo.com/HTN

GLOSSARY OF TERMS

Copayment

- The amount you pay to the provider each time you receive a service

Deductible

- The amount of eligible expenses you must pay each year before the plan begins to pay benefits

Coinsurance

- The portion of eligible medical expenses for which you have financial responsibility in excess of the plan's deductible.

Maximum Out-of-Pocket

- This term defines the maximum limit you pay for eligible services, out of your own pocket in a given calendar year

Participating Provider

- A health care provider (including doctors, hospitals, labs and urgent care facilities) that is a member of the Blue Cross Blue Shield network

Non-Participating Provider

- A health care provider that is a not a member of the Blue Cross Blue Shield network.

Summary Plan Description

- A detailed document that describes your medical, dental, vision, critical illness, life, accidental death and dismemberment, and disability benefits for covered participants.

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Group of Companies

APPENDIX

Corix Quick Guide: Accessing your US Benefits

BlueCross BlueShield Medical Insurance

- **Go to BCBSIL.com.** Click "Sign Up or Log In" and register as a New User.
- Follow the prompts to finish creating your account; use the Identification + Group Numbers on your ID card to continue.
- Log back in anytime to find an in-network doctor, review benefits, claim statuses & more!
- *Note: if prompted to enter in your employer name, choose Corix Infrastructure.*

VSP Vision Insurance

- **Go to VSP.com** and click on "Log In/Create an Account" at the top right of the page.
- Enter the last four digits of your social security number. Then, continue to enter in your info to create a username and password.

VSP does not provide ID cards. At your appointment, tell your doctor you have VSP. You can print a card from the Member Details section of the website.

Teladoc

- **Go to Teladoc.com.** Click "Log in/register"
- Begin the registration process: click on the link to "Get Started" as a new member. Enter your personal information and click "Continue"
- Follow the additional directions given to finish setting up your account and provide your medical history.
- If prompted to enter in your employer name, make sure to choose one of the following that applies to you: Corix Group of Companies, Gillem, Cleveland Thermal, Oklahoma University.

WEX

- Go to **benefitslogin.wexhealth.com,** click "Login." From the dropdown, select the "HSA, FSA, HRA/Wellness & Communter" login and identify yourself as a New User.
- Provide your information and click "Next."
- You will get an e-mail with a one-time login, type it in then click "Next."
- Follow the steps to complete account set up.

Rx 'N Go Prescription

- **Go to RxNGo.com.** Click "Register" at the top right of the homepage or call Customer Service at 888-697-9646 for account set-up
- Once your account is set up, your doctors can send prescriptions to the GoGoMeds pharmacy
- Go to the Rx 'n Go website for additional assistance at any time - just click on the "How it Works" link to walk through the program.

Flexible Benefits Health Savings Account (HSA)

- Once enrolled in the Health Savings Account through the Benefits Portal, you'll get an email from Flex Benefits Customer Service telling you to register your account online.
- Go to **flexiblebenefits.com/flexhsa** and choose "Get Started" under *My employer sent me here.*
- Click the "Register" button to complete Steps 1-4.
- Once registered, click "Enrollment" to start your online HSA enrollment process. Next, click "Online Enrollment" and then "Enroll". Uou will need to valudate your demographic info, complete the HSA application, and submit.

MetLife Dental Insurance

- **Go to MetLife.com.** Click "Log In/Register" at the top right of the page. Select "**Create a New Account.**" Choose the option to "**register MetLife benefits through an employer or association.**"
- Enter Corix Infrastructure (US) Inc. when asked who provides your group benefits.
- You'll get a notification stating you are eligible for the MetLife Dental PPO Plan. Click the "Log In" link to create your new account. Follow the prompts to continue creating a profile.

Note: You don't need to present an ID card to confirm that you're eligible. You should notify your dentist that you're enrolled in a MetLife dental plan and your group number is 5947521. Your dentist can easily verify information about your coverage.

APPENDIX

Employees hired on or before 12/31/2016 may receive a short-term disability benefit in excess of 60%. See below chart for potential benefit by years of service:

Employees Hired on or Before 12/31/2016:

Completed Years of Service	Short Term Disability Benefit
0-5 Years	60% of your weekly earnings up to 26 weeks
6 Years	65% of your weekly earnings up to 26 weeks
7 Years	70% of your weekly earnings up to 26 weeks
8 Years	75% of your weekly earnings up to 26 weeks
9 Years	80% of your weekly earnings up to 26 weeks
10 Years	85% of your weekly earnings up to 26 weeks
11 Years	90% of your weekly earnings up to 26 weeks
12+ Years	100% of your weekly earnings up to 26 weeks
Elimination Period	0 days accident / 8 days illness

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Commission Staff 1-41:

Provide each medical insurance policy that the utility currently maintains.

Response:

In the United States, the utility offers two medical plan options through Blue Cross Blue Shield of Illinois: 1) Low Deductible PPO and 2) High Deductible PPO with HSA Eligibility. **Note:** In Canada, employees enroll and participate in a government health plan within their province. The four health plan options offered through the benefits program are not full coverage options but rather are a supplement to cover services that a provincial health plan does not cover. Please see page 3 of the 2022 Core Flex Benefits eGuide for additional information.

Please see the following attachments for more information regarding medical insurance policies:

- "PSC DR 1-41 – PG2979 PPO SBC – Summary of Benefit Coverage for 2022 Low Deductible Medical Plan"
- "PSC DR 1-41 PG2984 HSA SBC – Summary of Benefit Coverage for 2022 High Deductible Medical Plan"
- "PSC DR 1-40 – 2022 Benefits Guide"
- "PSC DR 1-41 – 2022 Core Flex Benefit eGuide;" and "PSC DR 1-41 – SunLife e-Booklet"

Witness:

James Kilbane

Benefits eGuide

All Eligible Employees

Click to explore your benefit options . . . . ➤

CORIX®

Welcome

Your benefits are an important part of your overall compensation. In addition, we want to ensure your benefits meet your current needs and grow with you as those needs change over time. That is why we are proud to offer a flexible benefits plan. A flexible benefit plan allows you to choose from a comprehensive suite of benefits, creating a portfolio unique to you. This guide provides highlights of your benefits. Please read it carefully, along with any supplemental materials you may receive.

Eligibility

You are eligible for benefits if you work 20 or more hours per week. You must have provincial plan coverage (or special temporary replacement coverage) in place to be eligible for the benefit plan. You must also enroll your eligible family members under the plan.

Eligible family members include:

- Your legally married spouse
- Your common-law partner
- Your children who are your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply)
- Disabled children who reach the age limit and who meet certain criteria may continue on your health coverage

If you are enrolled in a spouse's plan and decide to waive health and dental benefits, you must still be enrolled in pooled benefits, including life and disability insurance.

When Coverage Begins

- **New Hires:** You must complete the enrollment process within 31 days of your date of eligibility. If you enroll on time, coverage is effective after the 3 month waiting period.

Making Changes

If you experience a qualified life event, please contact Human Resources within 31 days. Following are examples of the most common qualified life events:

- Marriage or divorce
- Reaching co-habitation period for common-law status
- Birth or adoption of a child
- Death of a spouse, common-law partner or child
- Spouse losing coverage under external benefits plan

Be prepared to show documentation of the event, such as a marriage license, birth certificate or divorce decree.

How the Flex Plan Works

You have the option to choose your Health, Dental, Life and Accident Insurance to custom design your benefits package. There are four options for Health and Dental coverage, and three options for Life and Accident insurance.

Annually, you are allocated a certain number of flex credits to purchase these benefits. You may allocate any remaining credits to either a Health Spending Account (HSA) or your Corix Group Registered Retirement Saving Plan (RRSP) with Canada Life.

Long Term Disability and EAP are considered core benefits and you will be automatically enrolled for this coverage. Voluntary Life Insurance, AD&D and Critical Illness is available for purchase via payroll deduction for yourself, your spouse and any dependent children.

Inside

Enrollment

Visit FUSION to enrol in your Corix flex benefits plan.

Health Care

We are proud to provide you health care through Sun Life. These plans cover what your provincial health plan does not, including prescription drugs outside of a hospital, paramedical practitioners, medical services and supplies and vision care.

Enrollment in a provincial health plan is a requirement to be eligible for reimbursement of supplemental medical expenses under this plan.

This chart provides an overview of the plan options available to you and your family.

Coordination of Benefits

If your spouse also has coverage, submit your own claims through your plan first and have your spouse submit claims through their plan first.

You can submit any leftover amounts to each other's plan to maximize your coverage. You must wait for the Explanation of Benefits (EOB) to be produced prior to coordinating your benefits. The EOB is a document that shows how much of a claim was actually paid along with any amounts that were not paid out.

For any children on the plan, submit their claims through the plan of the parent whose birth date comes first in the calendar year (for example, if you were born in March and your spouse in December, submit the children's claims through your plan first).

Key Benefits	Option 1 - Spousal Integration	Option 2 - Cost Management	Option 3 - Security	Option 4 - Elite[1]
Prescription Drugs	Plan pays 20%	Plan pays 80%	Plan pays 90%	Plan pays 100%
Paramedical Services Coverage	$750 for all services combined per practitioner	$1,000 for all services combined per practitioner	$1,250 for all services combined per practitioner	$1,750 for all services combined per practitioner
Paramedical Services Practitioners	Acupuncturist, Athletic Therapist, Audiologist, Chiropractor*, Dietician, Homeopath**, Kinesiologists** Massage Therapist, Naturopath, Occupational Therapist, Osteopath*, Physiotherapist, Podiatrist* or Chiropodist*, Psychologist or Social Worker, Psychotherapist**, Shiatsu Therapist**, Speech Therapist *1 x-ray each benefit year for Chiropractor, Osteopath, Podiatrist or Chiropodist **Practitioners must be active members of provincial association approved by Sun Life (Homeopath, Kinesiologist, Psychotherapist, Shiatsu Therapist)			
Hospital Coverage	100% semi private room			
Medical Services & Supplies Coverage	20% coverage; certain limits and maximums may apply (please see booklet for details)	80% coverage; certain limits and maximums may apply (please see booklet for details)	90% coverage; certain limits and maximums may apply (please see booklet for details)	100% coverage; certain limits and maximums may apply (please see booklet for details)
Private Duty Nursing Coverage	100% per 12 months per condition			
Emergency Out-of-Country Medical Coverage	100% coverage up to $1,000,000 lifetime maximum			
Vision Care				
Eye Exam Frequency	1 exam per benefit year			
Materials	100%, $200 per person for glasses, contact lenses and laser eye surgery	Not covered	100%, $350 per person for glasses, contact lenses and laser eye surgery	100%, $500 per person for glasses, contact lenses and laser eye surgery
Benefit Duration				
Termination Age	Age 75 or earlier retirement			
Survivor Benefit	24 months			

1. 2 year lock-in applies

Dental Care

Keeping those pearly whites healthy is easy with your Sun Life dental benefit.

A recall period is the amount of time between visits when the dentist meets with you to assess your oral health. If you go for checkups more frequently than the recall period below, you will not be covered.

Pre-Determination Limit

Before incurring any large dental expenses or beginning any orthodontic treatment, ask your dentist's office to complete a treatment plan and submit it to **Sun Life**. **Sun Life** will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

Key Benefits	Option 1 - Spousal Integration	Option 2 - Cost Management	Option 3 - Security	Option 4 - Elite[1]
Benefit Maximum (per calendar year)				
Per Individual	$1,500 Basic & Major combined	$1,500 Basic & Major combined	$2,000 Basic & Major Combined	$2,500 for Basic Services & $2,500 for Major Services
Covered Services				
Recall Period	Every 5 months			
Basic Services (exams, X-rays, cleanings, fillings and simple extractions)	20% coverage	100% coverage	80% coverage	100% coverage
Major Services (crowns, bridges and dentures)	50% coverage	0% coverage	50% coverage	70% coverage
Orthodontia	50%, $2,000 lifetime maximum (Dependent children only)	0% coverage	50%, $3,000 lifetime maximum (Dependent children only)	50%, $5,000 lifetime maximum (Children & Adults)
Benefit Duration				
Termination Age	Age 75 or earlier retirement			
Survivor Benefit	24 months			

1. 2 year lock-in applies

Spending Account

Giving you the ultimate flexibility, you may choose to allocate some of your excess Flex Credits to your Health Spending Account. You have a total of two benefit years to use your HSA funds. These accounts cover qualifying health and dental expenses incurred by you, your spouse and dependent children.

Health Spending Account (HSA)

Your HSA allows you to pay for health and dental expenses that are not covered under your group benefit or provincial health plan. Your HSA is a non-taxable benefit. Some eligible expenses include:

- Coinsurance
- Deductibles
- Prescription drugs
- Eye exams/eyeglasses
- LASIK eye surgery
- Massage therapy
- Dental work
- Orthodontia

For a complete list of approved expenses, visit the Canada Revenue Agency website.

Retirement Plan

Plan for retirement by contributing to a Registered Retirement Savings Plan (RRSP) administered through Canada Life, on a pre-tax basis. It offers a wide variety of investment funds so you can choose what works best for your needs.

Advantages of Contributing

The RRSP helps you meet your financial goals with the following advantages:

- Tax savings on pre-tax contributions
- Annual maximum: personal contribution limit (visit CRA's My Account website for details)
- Choice of investment funds
- Low investment management fees
- Convenient payroll deductions, lump sum payments or transfers from another registered plan are permitted at any time.

Please refer to your Canada Life plan member booklet for specifics on your Corix Group RRSP offering.

Voluntary TFSA

Corix also offers a voluntary Tax Free Savings Account (TSFA) administered through Canada Life, on an after-tax basis. You must be 18 years or older and have a valid Social Insurance Number (SIN) to participate.

Features of a TFSA

The TFSA helps you meet your financial goals with the following features:

- Tax savings on pre-tax contributions up to your TFSA contribution room
- Visit CRA's My Account Website to confirm your TFSA contribution limit for any given year
- Contributions to a TFSA are not deductible for income tax purposes
- Any amount contributed as well as any income earned in the account (for example, investment income and capital gains) is generally tax-free, even when it's withdrawn
- Administrative or other fees in relation to TFSA and any interest or money borrowed to contribute to a TFSA are not deductible
- Choice of investment types

Spending Account Rules

YOU MUST ENROLL EACH YEAR TO PARTICIPATE.

Health Spending Account: Unused funds from one year can carry over to the following year. Due to CRA regulations, these funds must be used within the second year. Unused funds after the second year will **NOT** be returned to you or carried over to the following year.

Life and AD&D Insurance

Life insurance provides your named beneficiary/ies with a benefit in the event of your death.

Accidental death and dismemberment (AD&D) insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Remember to make sure your beneficiary information is accurate. If you do not have a designated beneficiary, your life insurance and AD&D benefit will be paid to your estate.

Basic Life/AD&D

Coverage	Option 1 - Default	Option 2 - Security	Option 3 - Elite
Employee	1 x annual earnings to a maximum $350,000 (proof of good health not required)	2 x annual earnings to a maximum $500,000 (proof of good health not required)	3 x annual earnings to a maximum $1,000,000 (proof of good health required for Life Insurance amounts in excess of $680,000)
Termination Age	Age 75 or earlier retirement	Age 75 or earlier retirement	Age 75 or earlier retirement

Optional Benefits

Accidental Death & Dismemberment (AD&D)

Similar to Optional Life Insurance, Optional AD&D is available over and above the coverage you have selected.

Coverage	
Employee	Units of $10,000 up to a maximum of $500,000. Proof of good health is not required.
Spouse	Units of $10,000 up to a maximum of $200,000. Proof of good health is not required.
Child(ren)	Units of $5,000 up to a maximum of $20,000. Proof of good health is not required.

Life Insurance

Optional Life Insurance is available over and above the coverage you have selected.

Coverage	
Employee	Units of $10,000 up to a maximum of $500,000. Proof of good health is required.
Spouse	Units of $10,000 up to a maximum of $200,000. Proof of good health is required.
Child(ren)	Units of $5,000 up to a maximum of $20,000. Proof of good health is not required.

Critical Illness

Critical Illness provides a benefit if you or a covered dependent have a diagnosis of a covered condition (e.g., life threatening cancer, heart attack, stroke, etc.)

Coverage	
Employee	Units of $10,000 up to a maximum of $200,000 (minimum $20,000). Proof of good health is required for amounts over $30,000.[1]
Spouse	Units of $10,000 up to a maximum of $200,000 (minimum $20,000). Proof of good health is required for amounts over $30,000.[1]
Child(ren)	Units of $5,000 up to a maximum of $20,000. Proof of good health is not required.

1. This is only if they apply within the first 31 days of being eligible for benefits.

Disability Insurance

Disability insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury or illness. Disability insurance is provided through Sun Life.

Short-Term	
Benefit	70% of regular weekly earnings. You can use your sick pay to top up your weekly earnings to 100% of your salary (if available)
Plan Paid By	Salary Continuance paid by Corix
Tax Status	Benefits paid to you are taxable
Benefit Duration	17 weeks

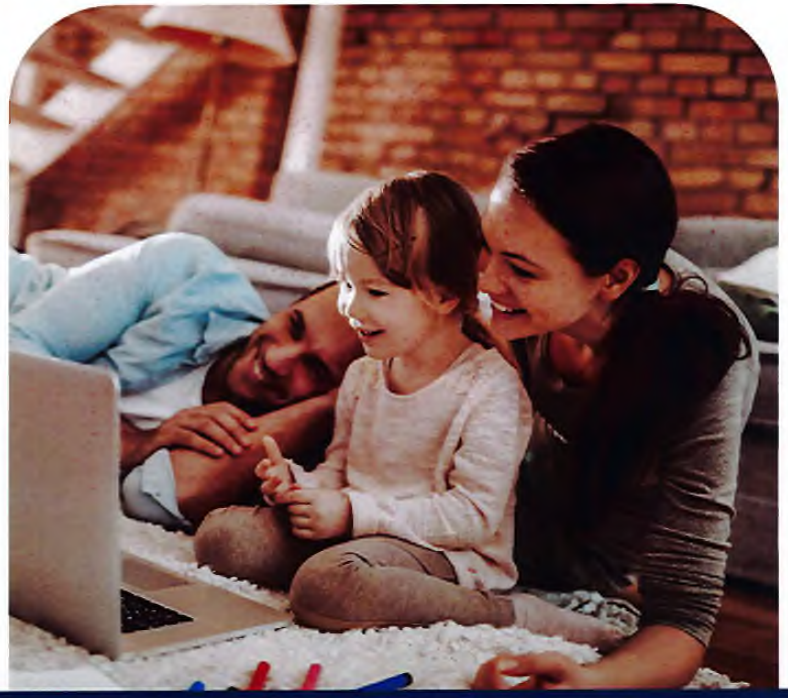
Long-Term	
Benefit	66.67% of the first $6,000 of monthly earnings, plus 50% of the balance to a maximum of $8,500 per month
Plan Paid By	Employee-Paid
Tax Status	Non taxable
Benefit Duration	Begins After 119 days of disability
Termination Age	Age 65 or earlier retirement

Employee Assistance Program (EAP)

Life is full of challenges, and sometimes balancing it is difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The EAP is provided at **NO COST** to you through Homewood Health.

The EAP can help with the following issues, among others:

- Mental health
- Relationship or marital conflicts
- Child and eldercare
- Substance abuse
- Grief and loss
- Legal and financial issues



Cost of Benefits

Each calendar year, Corix provides you with flex credits to purchase your customized employee benefit package.

As of January 1, 2022, your flex credits are as follows:

Coverage	Amount
Single	$2,160
Couple	$3,650
Family	$5,460

Employees are responsible for the Long Term Disability premiums along with any optional benefit coverage. Depending on the benefits package you select, you may also be responsible for contributing to your monthly premium for Health, Dental, Life and Accidental Death and Dismemberment Insurance.

Contact Information

Coverage	Carrier	Policy #	Phone #	Website/Email
Health, Dental and Spending Accounts	Sun Life	100125	1-800-361-6212	https://www.sunlife.ca/en/support/sign-in-help/my-sun-life/
Life, AD&D and Long Term Disability	Sun Life	101525	1-800-361-6212	https://www.sunlife.ca/en/support/sign-in-help/my-sun-life/
EAP	Homewood Health	–	1-800-663-1142	www.HomeWeb.ca
Retirement Plan	Canada Life	63987	1-888-222-0775	https://my.canadalife.com/sign-in

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Corix Infrastructure (US) Inc.: PPO Plan

Coverage Period: 01/01/2022 – 12/31/2022
Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-828-3116 or at www.bcbsil.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $400 Individual/$1,200 Family For Out-of-Network: $800 Individual/$2,400 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, services that charge a copay and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: $5,000 Individual/$10,000 Family For Out-of-Network: $10,000 Individual/$20,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or Call 1-800-828-3116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$20 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$10 copay/prescription (retail) $20 copay/prescription (mail order); deductible does not apply	$10 copay/prescription (retail) plus 25% coinsurance; deductible does not apply	34-day supply at Retail 90-day supply at Mail Order Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	25% coinsurance on retail and mail order prescriptions; deductible does not apply	50% coinsurance; deductible does not apply	Retail 34 day supply $25 minimum/$75 maximum. Mail 90 day supply $50 minimum/ $150 maximum. See above (refer to Generic)
	Non-preferred brand drugs	50% coinsurance on retail and mail order prescriptions; deductible does not apply	75% coinsurance; deductible does not apply	Retail 34 day supply $25 minimum/$75 maximum. Mail 90 day supply $50 minimum/ $150 maximum. See above (refer to Generic)
	Specialty drugs	50% coinsurance up to a $250 max (retail); deductible does not apply	Not Covered	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay/visit plus 20% coinsurance; deductible does not apply	$200 copay/visit plus 20% coinsurance; deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit; deductible does not apply; 20% coinsurance for other outpatient services	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details. PCP copay applies to psychotherapy office visit only.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	$20 copay/visit; deductible does not apply	40% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of those with diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids
- Infertility Treatment
- Most coverage provided outside the United States. See www.bcbsil.com.
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing (excluding inpatient care services) (Unlimited visits maximum per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-828-3116, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-828-3116 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-828-3116.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-828-3116.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-828-3116.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-828-3116.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$400**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$30
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,890**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$400**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$400**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Corix Infrastructure (US) Inc.: HSA Plan

Coverage Period: 01/01/2022 – 12/31/2022
Coverage for: Individual/Family | Plan Type: HSA

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-828-3116 or at www.bcbsil.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $1,500 Individual/$3,000 Family For Out-of-Network: $4,500 Individual/$12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: $6,000 Individual/$12,000 Family For Out-of-Network: $12,000 Individual/$24,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or Call 1-800-828-3116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	10% coinsurance	Not Covered	34-day supply at Retail 90-day supply at Mail Order Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	10% coinsurance	Not Covered	
	Non-preferred brand drugs	10% coinsurance	Not Covered	
	Specialty drugs	50% coinsurance up to a $250 max (retail)	Not Covered	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Rehabilitation services	10% coinsurance	30% coinsurance	
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization may be required
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization may be required. Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of those with diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids
- Infertility Treatment
- Most coverage provided outside the United States. See www.bcbsil.com.
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing (excluding inpatient care services) (Unlimited visit maximum per calendar year)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-828-3116, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-828-3116 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit http://insurance.illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-828-3116.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-828-3116.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-828-3116.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-828-3116.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

Sun Life Financial

your group benefits

CORIX Group of Companies

All regular employees

Contract Number 101525 and 100125
Effective January 1, 2021

Table of Contents

Benefit Details

In this section, you will find the options which are available to you under each benefit. For more information on each benefit, please refer to the appropriate section in this booklet.

Your Extended Health Care options

	Option 1 **Spousal Integration**	**Option 2** **Cost Management**	**Option 3** **Security**	**Option 4** **Elite**
Benefit year	January 1 to December 31			
Deductible	None	None	None	None
Prescription drugs	20% Drug card – Plan 84 Drug substitution limit to apply	80% Drug card – Plan 84 Drug substitution limit to apply	90% Drug card – Plan 84 Drug substitution limit to apply	100% Drug card – Plan 84 No drug substitution limit
Hospital expenses in your province	100% semi-private room	100% semi-private room	100% semi-private room	100% semi-private room
Convalescent hospital Maximum	100% $20 per day up to 180 days	100% $20 per day up to 180 days	100% $20 per day up to 180 days	100% $20 per day up to 180 days
Expenses out of your province	Emergency – 100% Referral – 80%	Emergency – 100% Referral – 80%	Emergency – 100% Referral – 80%	Emergency – 100% Referral – 80%
Medi-Passport	Covered	Covered	Covered	Covered

Your Extended Health Care options continued

	Option 1 Spousal Integration	Option 2 Cost Management	Option 3 Security	Option 4 Elite
Private duty nursing	100%	100%	100%	100%
Medical services and equipment	20%	80%	90%	100%
Paramedical services *per person per benefit year*	20% $750 for all services combined	80% $1,000 for all services combined	90% $1,250 for all services combined	100% $1,750 for all services combined
Vision care *Maximum per benefit year*	100% $200 per person	Not Covered	100% $350 per person	100% $500 per person
Overall maximum	Out-of-Canada emergency services – lifetime maximum of $1,000,000 per person All other expenses – none			
Lock-in period	1 year	1 year	1 year	2 years
Changes in options	Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. You can move up or down to any option. Proof of good health is not required.			
Coverage ends	When you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.			

Your Dental Care options

	Option 1 Spousal Integration	Option 2 Cost Management	Option 3 Security	Option 4 Elite
Benefit year	January 1 to December 31			
Deductible	None	None	None	None
Preventive	20%	100%	80%	100%
Basic	20%	100%	80%	100%
Major	50%	Not Covered	50%	70%
Orthodontics	50% Only children under 19 are covered for these procedures	Not Covered	50% Only children under 19 are covered for these procedures	50% All employees and dependents are covered
Benefit year maximum	$1,500	$1,500	$2,000	$2,500 for Preventive and Basic combined $2,500 for Major
Lifetime maximum	$2,000 for Orthodontics	N/A	$3,000 for Orthodontics	$5,000 for Orthodontics
Lock-in period	1 year	1 year	1 year	2 years
Changes in options	Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. You can move up or down to any option. Proof of good health is not required.			
Coverage ends	When you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.			

Your Health Spending Account

Benefit year	January 1 to December 31
Credits	Remaining Flex credits on the commencement of each benefit year
	If your coverage starts after the commencement of the benefit year, your plan credits are adjusted based on the number of months remaining in that benefit year.
Coverage ends	When you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Long-Term Disability coverage

Coverage	66.67% of the first $6,000 of your monthly basic earnings, add 50% of the balance of your monthly earnings
Maximum	$8,500 per month
Coverage ends	When you reach age 65, less the elimination period of 119 days or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Optional Critical Illness coverage

Coverage	As elected by the employee, units of $10,000
Maximum	$200,000
Minimum	$20,000
Proof of good health	Required when you request optional coverage and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.
Changes in options	You can change your selection at any time. Proof of good health of is required for any increase in coverage.
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.

Optional Critical Illness coverage for your spouse

Coverage	As elected by the employee, units of $10,000
Maximum	$200,000
Minimum	$20,000
Proof of good health	Required when you request optional coverage for your spouse and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.
Changes in options	You can change your selection at any time. Proof of good health of your spouse is required for any increase in coverage.
Coverage ends	When you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. In addition, your spouse's coverage will end on the date a Critical Illness benefit is paid for a covered condition which your spouse sustains.

Optional Critical Illness coverage for your children

Coverage	As elected by the employee, units of $5,000
Maximum	$20,000
Proof of good health	Proof of good health of your child is not required.
Changes in options	You can change your selection at any time. Proof of good health is not required.
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. In addition, coverage for any child will end on the date a Critical Illness benefit is paid for a covered condition which that child sustains.

Your Basic Life options

	Option 1 Default	Option 2 Security	Option 3 Elite
Coverage	1 times your annual basic earnings rounded to the next higher $1,000	2 times your annual basic earnings rounded to the next higher $1,000	3 times your annual basic earnings rounded to the next higher $1,000
Maximum	$350,000	$500,000	$1,000,000
Proof of good health	Not required	Not required	Required for coverage in excess of $680,000, and any increase in that coverage of 25% or more or $25,000, whichever is greater. Coverage will not take effect before Sun Life approves the proof of good health.
Coverage reduces	To 50% of the above amount at age 65. Coverage is reduced by another 50% of the amount in force when you reach age 70. The maximum benefit at age 70 will be $50,000.		
Lock-in period	1 year	1 year	1 year
Changes in options	Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. You can move up or down to any option. Proof of good health is only required as indicated for Option 3 - Elite.		
Coverage ends	When you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.		

Your Optional Life coverage

Coverage	As elected by the employee, units of $10,000
Maximum	$500,000
Proof of good health	Required on all optional amounts
Changes in options	You can change your selection at any time. Proof of good health is required for any increase in coverage.
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Coverage	As elected by the employee, units of $10,000
Maximum	$200,000
Proof of good health	Required when you request Optional Life coverage for your spouse and any increase in that coverage.
Changes in options	You can change your selection at any time. Proof of good health of your spouse is required for any increase in coverage.
Coverage ends	When you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your children

Coverage	As elected by the employee, units of $5,000
Maximum	$20,000
Proof of good health	Not required
Changes in options	You can change your selection at any time. Proof of good health is not required.
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Basic Accidental Death and Dismemberment options

	Option 1 Default	**Option 2 Security**	**Option 3 Elite**
Coverage	1 times your annual basic earnings rounded to the next higher $1,000	2 times your annual basic earnings rounded to the next higher $1,000	3 times your annual basic earnings rounded to the next higher $1,000
Maximum	$350,000	$500,000	$1,000,000
Proof of good health	Not required	Not required	Not required
Coverage reduces	To 50% of the above amount at age 65. Coverage is reduced by another 50% of the amount in force when you reach age 70. The maximum benefit at age 70 will be $50,000.		
Lock-in period	1 year	1 year	1 year
Changes in options	Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. You can move up or down to any option. Proof of good health is not required.		
Coverage ends	When you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.		

Your Optional Accidental Death and Dismemberment coverage

Coverage	As elected by the employee, units of $10,000
Maximum	$500,000
Proof of good health	Not required
Changes in options	You can change your selection at any time. Proof of good health is not required.
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Accidental Death and Dismemberment coverage for your spouse

Coverage	As elected by the employee, units of $10,000
Maximum	$200,000
Proof of good health	Proof of good health of your spouse is not required.
Changes in options	You can change your selection at any time. Proof of good health is not required.
Coverage ends	When you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Accidental Death and Dismemberment coverage for your children

Coverage	As elected by the employee, units of $5,000
Maximum	$20,000
Proof of good health	Proof of good health of your child is not required.
Changes in options	You can change your selection at any time. Proof of good health is not required.
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

General Information

About this booklet

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

Your group benefits may be modified after the effective date of this booklet. You will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

For administrative purposes, number 105015 will be used for the Critical Illness benefit under this contract.

If you have any questions about the information in this employee benefits booklet, or you need additional information about your group benefits, please contact your employer.

The contract holder, Corix Infrastructure Inc., self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Health Spending Account

This means Corix Infrastructure Inc., has the sole legal and financial liability for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a permanent employee.
- you are actively working for your employer at least 20 hours a week.
- you have completed the waiting period.

The waiting period for your group plan is 3 months of continuous employment.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an

eligible dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, we will continue coverage as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

In these cases, you must notify Sun Life within 31 days of the date the child attains the limiting age. Your employer can give you more information about this.

Enrolment

To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer within 31 days after the date you become eligible. If your enrolment request is not received by your employer within the 31 day period, you will be covered for the following ***Default*** coverage:

- Employee Life – Option 1 - Default
- Accidental Death and Dismemberment – Option 1 - Default
- Extended Health Care – Option 3 - Security
- Dental Care – Option 3 - Security

For a dependent to receive coverage, you must request dependent coverage. For a dependent to be covered for Optional Critical Illness, you must be covered for Optional Critical Illness.

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you cannot refuse this coverage under this plan.

For Optional Life coverage, proof of good health will be required as specified in the *Benefit Details* section. Coverage will not take effect before Sun Life approves the proof of good health.

For Optional Critical Illness coverage, proof of good health will be required as specified in the *Benefit Details* section. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.

When coverage begins

Your coverage begins on the date you become eligible for coverage.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

For Dependent Life, Extended Health Care and Dental Care benefits, once you have dependent coverage, any subsequent dependents will be covered automatically. Once a child is covered for Child Optional Critical Illness, any subsequent children are automatically covered for this benefit.

If you are not actively working on the date Optional Life or Optional Critical Illness coverage for your spouse or children would normally begin, then that coverage will not begin until you return to active work with your employer.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage. For example, your employment status may change, or your employer may change the group contract.

Any change in coverage resulting from a change in salary will take effect on the date of the change in circumstances.

For changes requested due to a *life event change*, subject to the exceptions below, the change in coverage is effective on the date the request is received but not before the actual date of the *life event change*.

The following exceptions apply if the result of the change is an increase in coverage:

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

For Critical Illness coverage, to understand the impact on coverage when new covered conditions are added to this plan, refer to the Critical Illness benefit provision.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- change of dependents.
- change of name.
- change of beneficiary.

Accessing your records

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.

- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

As an employee, your coverage will end on the earlier of the following dates:

- the date your employment ends or you retire.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

A dependent's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the Benefit Details section of this employee benefits booklet.

However, if you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following dates:

- 24 months after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

The continuation of coverage does not apply to the spouse and child coverage under Optional Life, Optional Accidental Death and Dismemberment, and Critical Illness.

Replacement coverage

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

With respect to Critical Illness, for coverage for any covered condition which was not included in the previous group plan, refer to the Critical Illness benefit provision.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. For Critical Illness claims, you should contact Sun Life to get the proper form to make a claim. For all other claims, you should contact your employer to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to

abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions for insured benefits

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Coordination of benefits

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, our benefits will be coordinated with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

The plan that does not contain a coordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a coordination of benefits clause.

For dental accidents, health plans with dental accident coverage pay benefits before dental plans.

The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

Where both plans contain a coordination of benefits clause, claims must be submitted in the order described below.

Claims for you and your spouse should be submitted in the following order:

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order applies:
  - the plan where the person is covered as an active full-time employee.
  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

Claims for a child should be submitted in the following order:

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.

- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

The above order applies in all situations except when parents are separated/divorced and there is no joint custody of the child, in which case the following order applies:

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.
- the plan of the parent not having custody of the child.
- the plan of the spouse of the parent not having custody of the child.

When you submit a claim, you have an obligation to disclose to Sun Life all other equivalent coverage that you or your dependents have.

Your employer can help you determine which plan you should claim from first.

Medical examination

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.

Recovering overpayments

We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

Definitions

Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.

Accident

An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.

Appropriate treatment

Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the

condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Basic earnings Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.

Doctor A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

Enrolment period The annual enrolment period is every year, as communicated by your employer.

Illness An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Life event change Life event changes include:

- marriage or any other formal union recognized by law, or common-law,
- birth or adoption of a child,
- divorce or legal separation,
- loss of spouse's benefit coverage, or
- death of a dependent.

Lock-in period The minimum time that you must remain with your chosen option. Normally, this is one plan year, unless you experience a *life event change*. For some options, the lock in period is two years.

Regular employees Regular employees are all employees other than executives, contract employees and US employees.

Retirement date If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

We, our and us We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care
(Medicare Supplement)

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the employee and all dependents covered for Extended Health Care benefits.

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

Benefit year

The benefit year is indicated in the Benefit Details section.

Deductible

The deductible is indicated in the Benefit Details section.

Prescription drugs for Option 1 - Spousal Integration and Option 4 - Elite

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation.*

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.

- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $500 for each person.
- over-the-counter muscle relaxants and antihistamines.
- vaccines.
- anti-obesity drugs and appetite suppressants.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

We will cover the cost of the above drugs and supplies, up to the reimbursement level indicated under each option in the Benefit Details section.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.

We will not pay for the following, even when prescribed:

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- proteins and food or dietary supplements.

- hair growth stimulants.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug evaluation

The following drugs will be evaluated and must be approved by us to be eligible for coverage:

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

Drug substitution limit

For Option 1- Spousal Integration – Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

Prior authorization program

The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.

In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

- our website at www.mysunlife.ca/priorauthorization
- our Customer Care centre by calling toll-free 1-800-361-6212

Reference Drug Program

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category.*

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.
- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

Other health professionals allowed to prescribe drugs

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Prescription drugs for Option 2 - Cost Management and Option 3 - Security

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation.*

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $500 for each person.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.
- anti-obesity drugs and appetite suppressants.

We will cover the cost of the above drugs and supplies, up to the reimbursement level indicated under each option in the Benefit Details section.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.

We will not pay for the following, even when prescribed:

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- proteins and food or dietary supplements.
- hair growth stimulants.
- vaccines.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug evaluation

The following drugs will be evaluated and must be approved by us to be eligible for coverage:

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

Drug substitution limit

Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

Prior authorization program

The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.

In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

- our website at www.mysunlife.ca/priorauthorization
- our Customer Care centre by calling toll-free 1-800-361-6212

Reference Drug Program

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category*.

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.
- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous

claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

Other health professionals allowed to prescribe drugs

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Hospital expenses in your province

We will cover costs for hospital care in the province where you live. The reimbursement level is indicated under each option in the Benefit Details section.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and the hospital room indicated under each option in the Benefit Details section.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Convalescent hospital

We will cover the cost of room and board in a convalescent hospital in the province where you live, if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

The reimbursement levels for treatment of an illness due to the same or related causes are indicated under each option in the Benefit Details section.

For purposes of this plan, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Expenses out of your province

We will cover emergency services while you are outside the province where you live. We will also cover referred services. The reimbursement levels and the maximum amounts are indicated under each option in the Benefit Details section.

For both emergency services and referred services, we will cover the cost of:

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you live, subject to the reimbursement level and all conditions applicable to those expenses.

Emergency services

We will only cover emergency services obtained within 183 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

Emergency means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when you are medically stable to return to the province where you live.

Emergency services excluded from coverage

Any expenses related to the following emergency services are not covered:

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Allianz Global Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any

complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.

- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Emergency services outside Canada

The maximum amount we will pay for expenses incurred for emergency services outside Canada is indicated under each option in the Benefit Details section.

Private duty nursing

We will cover out-of-hospital private duty nurse services when medically necessary. Services must be ordered by a doctor and must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. There is a limit of $10,000 per condition per person every 12 months. The reimbursement level is indicated under each option in the Benefit Details section.

Medical services and equipment

We will cover the cost for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order). The reimbursement level is indicated under each option in the Benefit Details section.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of $1,000 per person per benefit year.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.

- services of an ophthalmologist or licensed optometrist, up to a maximum of once per person per benefit year.
- wigs following chemotherapy, up to a maximum of $300 per person in a benefit year. Wigs do not require a doctor’s order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of one prostheses per person every 12 months.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 4 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, and custom-made orthopaedic shoes or modifications to orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a combined maximum of $300 per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.

- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a maximum of one glucometer per person over a period of 4 benefit years.
- Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, up to a combined maximum of $4,000 per person per benefit year. You must provide us with a doctor's note confirming the diagnosis.
- insulin pumps.
- wheelchair ramp, up to a lifetime maximum of $2,000 per person.

Paramedical services

We will cover the costs for paramedical specialists listed below. The reimbursement level and the maximum amount we will pay per person per specialty in a benefit year are indicated under each option in the Benefit Details section.

- licensed psychologists or social workers.
- licensed massage therapists.
- licensed speech therapists.
- licensed physiotherapists.
- licensed naturopaths.
- licensed acupuncturists.
- licensed audiologists.
- licensed dieticians.
- licensed occupational therapists.
- licensed athletic therapists, or athletic therapists who are active members of the Canadian Athletic Therapists Association (CATA) or of a provincial association approved by Sun Life.

- licensed osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year.
- licensed chiropractors, including a maximum of one x-ray examination each benefit year.
- licensed podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year.
- licensed homeopaths, or homeopaths who are active members of a provincial association approved by Sun Life.
- licensed kinesiologists or kinotherapists, or practitioners who are active members of a provincial kinesiology association approved by Sun Life.
- licensed psychotherapists, or psychotherapists who are active members of a provincial association approved by Sun Life.
- licensed Shiatsu therapists, or Shiatsu therapists who are active members of a provincial association approved by Sun Life.

Vision care

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery. Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

The reimbursement level and the maximum amount payable per benefit year are indicated under each option in the Benefit Details section.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.

Payments after coverage ends

If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,

- within 90 days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

- services or supplies for which no charge would have been made in the absence of this coverage.

We will not pay benefits when the claim is for an illness resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

Integration with government programs

This plan will integrate with benefits payable or available under the government-sponsored plan or program (the *government program*).

The covered expense under this plan is that portion of the expense that is not payable or available under the government program, regardless of:

- whether you have made an application to the government program,
- whether coverage under this plan affects your eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer.

In order for you to receive benefits, we must receive the claim no later than:

- 12 months after the date you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage, whichever is earlier.

Emergency Travel Assistance

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the employee and all dependents covered for Emergency Travel Assistance benefits.

If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (*Allianz Global Assistance*) can help.

Emergency means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 183 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

The Medi-Passport coverage is subject to any maximum applicable to the emergency portion of the Extended Health Care benefit. The emergency services excluded from coverage, and all other conditions, limitations and exclusions applicable to your Extended Health Care coverage also apply to Medi-Passport.

We recommend that you bring your Travel card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.

Getting help

At the time of an emergency, you or someone with you must contact Allianz Global Assistance. If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are

provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card.

Allianz Global Assistance may arrange for:

On the spot medical assistance

Allianz Global Assistance will provide referrals to physicians, pharmacists and medical facilities.

As soon as Allianz Global Assistance is notified that you have a medical emergency, its staff, or a physician designated by Allianz Global Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Allianz Global Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Allianz Global Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel.

Allianz Global Assistance will transmit an urgent message from you to your home, business or other location. Allianz Global Assistance will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Allianz Global Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Allianz Global Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Allianz Global Assistance, based on available medical evidence, will make the final decision whether you should be moved,

when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.

Meals and accommodations expenses

If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Allianz Global Assistance will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days.

Allianz Global Assistance will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Allianz Global Assistance, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.

Travel expenses home if stranded

Allianz Global Assistance will arrange and, if necessary, advance funds for transportation to the province where you live:

- for you, if due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated; or
- for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

If necessary, in the case of such a child, Allianz Global Assistance will also make arrangements and advance funds for a qualified attendant to accompany them home. The attendant is subject to the approval of you or a member of your family.

We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.

Travel expenses of family members

Allianz Global Assistance will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the place where you are hospitalized if you are hospitalized for more than 7 consecutive days, and:

- you are travelling alone, or
- you are travelling only with a child who is under the age of 16 or mentally or physically handicapped.

We will pay a maximum of $150 a day for the family member's meals and accommodations at a commercial establishment up to a maximum of 7 days.

Repatriation

If you die while out of the province where you live, Allianz Global Assistance will arrange for all necessary government authorizations and for the return of your remains, in a container approved for transportation, to the province where you live. We will pay a maximum of $5,000 per return.

Vehicle return

Allianz Global Assistance will arrange and, if necessary, advance funds up to $500 for the return of a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from returning the vehicle.

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Allianz Global Assistance will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and Allianz Global Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Allianz Global Assistance will ask you to sign a form authorizing them to act on your behalf.

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association.

The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Limits on advances

Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.

The maximum amount advanced will not exceed $10,000 per person per trip unless this limit will compromise your medical care.

Reimbursement of expenses

If, after obtaining confirmation from Allianz Global Assistance that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.

To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Allianz Global Assistance:

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.
- amounts paid for services or supplies not covered by this plan.
- amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a

6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

Limits on Emergency Travel Assistance coverage

There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure.

Allianz Global Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- the refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Allianz Global Assistance

Neither Sun Life nor Allianz Global Assistance will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Care

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the employee and all dependents covered for Dental Care benefits.

Dental Care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

Benefit year

The benefit year is indicated in the Benefit Details section.

Deductible

The deductible is indicated in the Benefit Details section.

Benefit year maximum

The maximum amount we will pay per person per benefit year is indicated under each option in the Benefit Details section.

Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person’s lifetime is indicated under each option in the Benefit Details section.

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Preventive dental procedures

Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

The reimbursement level is indicated under each option in the Benefit Details section.

Oral examinations

1 complete examination every 24 months.

1 recall examination every 5 months, up to a maximum of 2 examinations per benefit year.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 24 months.

1 set of bitewing x-rays every 5 months, up to a maximum of 2 sets per benefit year.

X-rays to diagnose a symptom or examine progress of a particular course of treatment.

Other services

Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 5 months, up to a maximum of 2 per benefit year.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 5 months, up to a maximum of 2 sessions per benefit year.

Basic dental procedures

Your dental benefits include the following procedures used to treat basic dental problems.

The reimbursement level is indicated under each option in the Benefit Details section.

Fillings

Amalgam, composite, acrylic or equivalent.

Extraction of teeth Removal of teeth, except removal of impacted teeth (*Preventive dental procedures*).

Basic restorations Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.

Endodontics Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

Periodontics Treatment of disease of the gum and other supporting tissue.

Oral surgery Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).

Major dental procedures

Your dental benefits include the following procedures used to treat major dental problems.

The reimbursement level is indicated under each option in the Benefit Details section.

Major restorations Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).

Repair Repair of bridges or dentures.

Rebase or reline Rebase or reline of an existing partial or complete denture.

Prosthodontics Construction and insertion of bridges or standard dentures. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

- it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.
- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Orthodontic procedures

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

The reimbursement level and maximum are indicated under each option in the Benefit Details section.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

Payments after coverage ends

If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

We will not pay for services or supplies that are not usually provided to treat a dental problem.

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.

- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.
- participation in a criminal offence.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive the claim no later than:

- 12 months after the date you incur the expenses, or
- 90 days after the end of your Dental Care coverage, whichever is earlier.

We can require that you give us the dentist’s statement of the treatment received, pre-treatment x-rays and any additional information that we consider necessary.

Health Spending Account

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

Your Health Spending Account coverage pays for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependent is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

Benefit year

The benefit year is indicated in the Benefit Details section.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one benefit year cannot be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year following the benefit year in which they have been allocated to your

account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Continuation of coverage for dependents

No plan credits will be allocated to the Health Spending Account after the employee's death. However, the remaining credits in the account on the date of the employee's death can be used to pay for expenses incurred by the dependents during the 12 months following the employee's death.

Credits

Your credits are indicated in the Benefit Details section.

Eligible expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act (Canada) **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act (Canada) is changed, this plan is automatically updated to reflect the changes.

Drugs

- drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses

- eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances

- deductible and coinsurance amounts under medical or dental plans.

Licensed practitioners (fee for services)

- acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapeutists.

Dental care

- preventative, diagnostic, restorative, orthodontic and therapeutic care.

Attendant care

- remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.

- remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.

Facilities

- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.

- payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.

Hospitals

- payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.

- artificial limbs.

- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of $1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.

- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.

- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
- costs of medical services and supplies outside of the province of residence.
- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.

- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
  - equivalent medical services are not available locally.
  - the route is reasonably direct.
  - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

If you or your eligible dependents have coverage under another plan, you should submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer.

In order for you to receive benefits, we must receive the claim no later than:

- 12 months after the date you incur the expenses, or
- 90 days after the end of your Health Spending Account coverage, whichever is earlier.

Long-Term Disability

General description of the coverage

Long-Term Disability coverage provides a benefit to you if you are totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since its onset.

For your Long-Term Disability coverage,

- during the elimination period and the following 24 months (this period is known as the **own occupation period**), you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

If you must hold a government permit or licence to perform your own occupation and your permit or licence is withdrawn or not renewed solely for medical reasons, we will consider you totally disabled for up to 12 months after the end of the elimination period. You cannot be working other than in a Sun Life approved partial disability or rehabilitation program.

Benefits are paid at the end of each month and are based on your coverage on the date you became totally disabled.

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 119 days or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 119 days and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

Here is how we calculate your Long-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take the percentage of your monthly basic earnings as indicated in the Benefit Details section. The maximum is also indicated in the Benefit Details section.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.

- under a group plan, including any coverage resulting from your membership in an association of any kind.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under the Québec Parental Insurance Plan.

The result from Step 2 is the amount you will normally receive.

If this amount plus the above sources of income and all the additional sources of income listed below exceeds 85% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 85% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

- under any Workers' Compensation Act or similar law for another disability, excluding any automatic cost-of-living increases that occur after benefits begin.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.

We will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

We have the right to adjust your benefit payments when necessary.

Maternity / parental leave of absence

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 119 days, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

Partial disability program

You may be required to participate in a partial disability program approved by Sun Life in writing.

After you are eligible for Long-Term Disability payments, you may be considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

During your partial disability program, you can receive a salary from your employer for the hours worked. However, your Long-Term

Disability payments will be reduced by the percentage of your normal work week that you are now working for your employer.

During your partial disability program your total income from all sources cannot exceed 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable). If this is the case, your Long-Term Disability payments will be further reduced by the excess.

Your participation in a partial disability program will be limited to the own occupation period.

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

It may include the involvement of our rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long-Term Disability payments plus income from other sources. However, if during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long-Term Disability payments will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled. If you enter a rehabilitation program during the elimination period, it will not be considered an interruption of the elimination period.

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and all of the following conditions are met:

- the initial period of total disability lasts for at least 30 days without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the elimination period.

If the Long-Term Disability benefit terminates, any balance of the elimination period must subsequently be completed by uninterrupted total disability.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability. You must be covered when total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

We have the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

Your responsibilities

During your total disability, you must make reasonable efforts to:

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

When payments end

Your Long-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the last day of the month in which you reach age 65.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

Payments after coverage ends

If the Long-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence* or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if:

- you have been covered for Long-Term Disability with your employer for at least 13 weeks during which you have been actively working continuously (up to 3 days of absence does not count) and you have not been treated by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- you became totally disabled more than 12 months after your coverage began.

If your coverage ends but you are covered again under this plan, we will use the latest date your coverage began when applying the above limitation.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.

- intentionally self-inflicted injuries.
- participation in a criminal offence.

When and how to make a claim

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

We must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins.
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give us as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, we must receive these forms no later than 90 days after the end of the elimination period.

We will assess the claim and send you or your employer a letter outlining our decision.

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

Critical Illness

General description of the coverage

Critical Illness coverage provides a benefit if, after the effective date of coverage, and while coverage is in force, you or your dependent (spouse or child) have a diagnosis of a covered condition, or you or your dependent have surgery for a covered condition, as indicated below under *What we will pay*.

To qualify for this coverage, the person must be a resident of Canada.

The amounts of coverage are indicated in the Benefit Details section.

What we will pay

We will pay the Critical Illness benefit if, after the effective date of coverage, and while coverage is in force, you or your dependent (spouse or child) have a diagnosis of a covered condition, or you or your dependent have surgery for a covered condition, subject to the survival period. Claims will be assessed based on the Critical Illness provisions in effect on the date of diagnosis or surgery.

The Critical Illness benefit is payable only on the first covered condition for which a diagnosis is effective, or surgery is performed, and the person's coverage then terminates. Such person may not become covered again under this benefit.

We reserve the right to require examination of the covered person and confirmation of any diagnosis of or surgery for any covered condition, by a medical practitioner appointed by us in order for any Critical Illness benefit to become payable.

Diagnosis

Diagnosis means a written diagnosis by a physician or specialist physician, licensed and practicing in Canada, of the covered condition. Any diagnosis must be made while coverage is in force and will be effective as of the date it is established by the physician or specialist physician, as supported by the covered person's medical records. Any diagnosis of a covered condition that was made prior to the effective date of coverage will not be covered.

Life support Life support means the covered person is under the regular care of a licensed physician or specialist physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Physician Physician means a legally and professionally qualified medical practitioner practicing in Canada. The physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Specialist physician Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a speciality examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Surgery Surgery means a medical operation performed on the covered person and recommended by a physician or specialist physician, licensed and practicing in Canada.

Survival period Survival period means the period starting on the date of diagnosis of the critical condition and ending 30 days following the date of diagnosis of the critical condition, unless a covered condition described below expressly modifies this definition. The survival period does not include the number of days on life support. The covered person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.

Who we will pay The Critical Illness benefit is payable to you or, in the event of your death, to your estate.

Changes in coverage Changes in the amount of coverage or covered conditions may occur as the result of an employment status change or a change in plan design.

Changes in the amount of coverage

If you are not actively working or a dependent is hospitalized (other than a newborn child) on the date a change occurs, refer to *Changes affecting your coverage* in the *General Information* section to understand the effective date of any change to the amount of Critical Illness coverage.

The *Pre-existing conditions* provision under *What is not covered* will apply to increased amounts of coverage as described in that provision.

Other changes

If new Critical Illness conditions are added to this plan, the new Critical Illness conditions will only apply to:

- employees who are actively working;
- dependents who are not hospitalized (other than newborn children); and
- persons already having Critical Illness coverage

on the date that the change occurs. The effective date of coverage for the new covered conditions is the date of the change to the plan.

If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions. If a dependent is hospitalized when the change occurs (other than a newborn child), the change will take effect when the dependent is discharged and resumes normal activities and such date will be the dependent’s effective date of coverage for the new covered conditions.

In all instances, we will:

- apply the effective date of coverage to determine a person's eligibility for a Critical Illness benefit payment; and
- apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where:

- proof of good health was previously required for a person's coverage; or
- the *Child moratorium period exclusion* previously applied or the child was born or adopted later than 10 months after the date the employee became covered for Child Critical Illness.

If the definition of a Critical Illness condition is changed, we will adjudicate any claim for a Critical Illness benefit based on the definition of that Critical Illness condition in effect on the date of the diagnosis or surgery, regardless of whether you were actively working or your dependent was hospitalized on the date of the change.

In the event of a change of carrier, the following rules apply to any person who was covered under the previous group contract on the date immediately preceding the effective date of coverage under this plan:

- the new plan, including coverage for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all employees and dependents on the effective date of this plan, regardless of whether the employee is actively working or the dependent is hospitalized on such date;
- for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of coverage is the effective date of this plan; and
- for Critical Illness conditions under this plan which were also covered under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of coverage is the date the person most recently became covered under the previous carrier's plan.

If a person received a Critical Illness benefit payment under the previous carrier's plan, then such person will not be covered under this plan for that Critical Illness condition for which a benefit payment was already made.

Sun Life is not responsible for any claim where the date of diagnosis or surgery, as applicable, is before the effective date of this plan.

Covered conditions for employees, spouses and children

We provide coverage for any illness, disorder or surgery that is defined below:

Aortic Surgery

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia

Aplastic Anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Bacterial Meningitis

Bacterial Meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial

meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

Exclusion:

No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour

Benign Brain Tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

The diagnosis of benign brain tumour must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this coverage), regardless of when the diagnosis is made; or

- a diagnosis of benign brain tumour (covered or excluded under this coverage),

no benefit will be payable for benign brain tumour for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for benign brain tumour for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

Blindness

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Cancer (Life-threatening)

Cancer (Life-threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of cancer must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

No benefit will be payable under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; or

- a diagnosis of cancer (covered or excluded under this coverage),

no benefit will be payable for cancer for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for cancer for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

For the purposes of this benefit, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For the purposes of this benefit, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Coma Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

The diagnosis of coma must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

- a medically induced coma;

- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

Coronary Artery Bypass Surgery

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of deafness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Dementia, including Alzheimer's Disease

Dementia, including Alzheimer's Disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour), which is affecting daily life.

The covered person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and

- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusion:

No benefit will be payable under this condition for affective or schizophrenic disorders or delirium.

For purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack Heart Attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;

- new electrocardiogram (ECG) changes consistent with a heart attack; or

- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart Valve Replacement or Repair

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure

Kidney Failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The diagnosis of kidney failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Independent Existence

Loss of Independent Existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;

- Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs Loss of Limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The diagnosis of loss of limbs must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Speech Loss of Speech means a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

The diagnosis of loss of speech must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Exclusion:

No benefit will be payable under this condition for any psychiatric related causes.

Major Organ Failure on Waiting List

Major Organ Failure on Waiting List means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the covered person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

For the purposes of the survival period, the date of diagnosis is the date of the covered person's enrolment in the transplant centre.

The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Major Organ Transplant

Major Organ Transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the covered person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The diagnosis of major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of their transplant.

Motor Neuron Disease

Motor Neuron Disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Multiple Sclerosis

Multiple Sclerosis means a definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of multiple sclerosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Occupational HIV Infection

Occupational HIV Infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the covered person's normal occupation, which exposed the person to HIV contaminated body fluids.

For any amount of coverage, the accidental injury leading to the infection must have occurred after the later of:

- the date the employer receives enrolment information for such amount of coverage; or
- the effective date of such amount of coverage.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying this requirement.

Payment under this condition requires satisfaction of all of the following:

- the accidental injury must be reported to Sun Life within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist physician. The covered person must survive for 30 days following the date of the second serum HIV test described above.

Exclusions:

No benefit will be payable under this condition if:

- the covered person has elected not to take any available licensed vaccine offering protection against HIV;
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of paralysis must be made by a specialist physician. The covered person must survive for 90 days following the precipitating event.

Parkinson's Disease Parkinson's Disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular

rigidity or rest tremor. The covered person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist or a specialist physician. The covered person must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage),

no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for those additional amounts. All other coverage remains in force.

No benefit will be payable under Parkinson's disease and specified atypical parkinsonian disorders for any other type of parkinsonism.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

Severe Burns

Severe Burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

The diagnosis of severe burns must be made by a specialist physician. The covered person must survive for 30 days following the date the severe burn occurred.

Stroke (Cerebrovascular Accident)

Stroke (Cerebrovascular Accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Covered conditions for children only

We provide coverage for any illness, disorder or surgery that is defined below.

You cannot apply for Critical Illness coverage for children until you have children who are living.

Children may be subject to either the *Child moratorium period exclusion* or the *Pre-existing conditions* provision as described below. When applicable, the *Child moratorium period exclusion* and the *Pre-existing conditions* provision apply to all covered conditions for which the child is covered.

For children:

- who are the children of you or your spouse and are born during the period beginning 90 days prior to the date you become covered for Child Critical Illness and ending 10 months after such date, the *Child moratorium period exclusion* applies.
- who are the children of you or your spouse and are born or adopted later than 10 months after the date you become covered for Child Critical Illness, neither the *Child moratorium period exclusion* or the *Pre-existing conditions* provision apply.
- other than those described above, the *Pre-existing conditions* provision applies unless proof of good health is required for the child's coverage.

Critical Illness coverage may terminate for one child but continue for your other children. In the event that you only have one child living for whom coverage ends, then your Critical Illness coverage for children terminates.

References to a covered person include children.

Cerebral palsy

Cerebral palsy means a definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements.

The diagnosis of cerebral palsy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Congenital heart disease

Congenital heart disease means a definite diagnosis of at least one of the covered heart conditions described below. It also means the specific conditions described below for which open heart surgery is performed to correct the condition.

Covered heart conditions:

- coarctation of the aorta,
- Ebstein's anomaly,
- Eisenmenger syndrome,
- Tetralogy of Fallot,
- transposition of the great vessels.

The diagnosis of the heart condition must be:

- made by a specialist physician; and
- supported by cardiac imaging acceptable to us.

The covered person must survive for 30 days following the date of diagnosis.

Covered heart conditions if open heart surgery is performed (these heart conditions are covered only if open heart surgery is performed to correct at least one of them):

- aortic stenosis,
- atrial septal defect,
- discrete subvalvular aortic stenosis,
- pulmonary stenosis,
- ventricular septal defect.

Procedures not covered by this definition are:

- percutaneous atrial septal defect closure;
- trans-catheter procedures which include balloon valvuloplasty.

The diagnosis of the heart condition must be made and the surgery must be recommended and performed:

- by a specialist physician; and
- supported by cardiac imaging acceptable to us.

The covered person must survive for 30 days following the date of surgery.

Cystic fibrosis Cystic fibrosis means a definite diagnosis of cystic fibrosis where the covered person has chronic lung disease and pancreatic insufficiency.

The diagnosis of cystic fibrosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Down's syndrome Down's syndrome means a definitive diagnosis of Down's syndrome supported by chromosomal evidence of Trisomy 21.

The diagnosis of Down's syndrome must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Muscular dystrophy

Muscular dystrophy means a definite diagnosis of muscular dystrophy where the covered person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

The diagnosis of muscular dystrophy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Type 1 diabetes mellitus

Type 1 diabetes mellitus means a definite diagnosis where the covered person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

What is not covered

We will not pay for any illness, disorder or surgery not specifically defined under *Covered conditions*.

No benefits are payable for claims resulting directly or indirectly from any of the following:

- intentionally self-inflicted injuries or attempted suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol.

Child moratorium period exclusion

Any child of you or your spouse will be excluded from Critical Illness coverage if:

- that child was born within the 90 day period prior to the date you obtain Child Critical Illness coverage; or,
- that child is born on or within 10 months after the date you obtain Critical Illness coverage for your existing children,

and, before or within 90 days after that child's birth:

- that child is diagnosed with any covered condition; or,
- that child has any signs, symptoms or investigations that lead to a diagnosis of a covered condition within 5 years of the child's birth.

Pre-existing conditions

For any amount of Optional coverage that:

- did not require proof of good health; and
- has been in effect for less than 12 months under the employer's Critical Illness plan,

no benefits are payable for any covered condition that results from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person, during the 12 months prior to the effective date of such amount of coverage:

- had signs, symptoms, consulted a physician or other health care practitioner; or
- was provided any health-related care, advice or treatment; or
- would have consulted a physician or other health care practitioner, acting as a reasonably prudent person with such injury, sickness, medical condition, signs or symptoms.

If coverage ends but the person is covered again under this benefit, we will use the latest date the person's coverage began when applying the above limitation.

This exclusion does not apply where the *Child moratorium period exclusion* applies or to any child of the employee or the employee's spouse who is born or adopted later than 10 months after the date the employee becomes covered for Child Critical Illness.

Portability

If your Critical Illness coverage ends for any reason other than your request, you may apply to transfer the group Critical Illness coverage to a group critical illness policy set up for that purpose by Sun Life without providing proof of good health.

If your spouse's Critical Illness coverage ends for any reason other than your request, your spouse may apply to transfer the group Critical Illness coverage to a group critical illness policy set up for that purpose by Sun Life without providing proof of good health. This is not available for dependent children.

At the time that you and/or your spouse apply to transfer group Critical Illness coverage to another critical illness policy, you or your spouse may also apply to transfer the group Critical Illness coverage for any covered children. We will not require the child's proof of good health. However, if either you or your spouse maintain coverage under this plan, the Critical Illness coverage for the child cannot be transferred.

The request must be made within 60 days of the end of the Critical Illness coverage.

There are a number of rules and conditions in the group contract that apply to the portability of this coverage, including the maximum amount that can be transferred. Please contact your employer for details.

When and how to make a claim

We must receive notice of claim as soon as reasonably possible after the date of diagnosis or surgery. We will provide the claimant with the appropriate claim forms on receipt of notice. Initial notice must be received no later than 30 days and proof of claim no later than 90 days from the date of diagnosis or surgery.

Failure to give notice of claim or furnish proof of claim within the above time limits does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to give notice or furnish proof within the above time limits.

Best Doctors

The services offered by Best Doctors are not insured or administered by Sun Life.

If you or your spouse are covered for Critical Illness, you, your spouse, your children, your parents and your parents-in-law have access to Best Doctors. If only your children are covered for Critical Illness, no access to Best Doctors is provided.

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition, even if it is not a covered condition under this Critical Illness benefit. To learn more about Best Doctors services, or to use these services, please call Best Doctors at 1-877-419-BEST (2378).

Liability and responsibility of Sun Life

Sun Life will not be held liable for any acts or omissions of any person or organization providing services directly or indirectly in connection with Best Doctors.

Sun Life cannot guarantee the availability of Best Doctors services.

Life Coverage

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Life coverage provides a benefit if one of your dependents dies while covered.

The amounts of coverage are indicated in the Benefit Details section.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

If a dependent dies, Sun Life will pay you the benefit for that dependent.

For your spouse’s optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor’s behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Suicide

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or

intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for:

- an uninterrupted period of 6 months, or
- the elimination period for Long-Term Disability if you are entitled to Long-Term Disability payments, whichever is shorter.

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

Spouse Optional Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Spouse Optional Life benefit is terminated.

Child Optional Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Child Optional Life benefit is terminated**.**

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience. However, if you are totally disabled under the Long-Term Disability benefit, you are also considered to be totally disabled under the Life benefit.

Converting Life coverage

If your Life coverage ends or reduces for any reason other than your request, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

If your spouse's Life coverage ends for any reason other than your request, your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends due to the termination of your Life coverage, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days of the reduction or end of the Life coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

Accidental Death and Dismemberment

General description of the coverage

Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you or one of your dependents die or suffer any of the losses listed in the table under *What we will pay*. Any death benefit paid under this coverage is in addition to the Life coverage.

What we will pay

The amounts of coverage are indicated in the Benefit Details section.

We will pay for this benefit if you or one of your dependents:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you are still alive.
- are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages we use to determine the payment.

TABLE OF LOSSES

Loss of life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	75%

Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33 1/3%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four toes on the same foot	25%
Loss of use of both arms or both legs	100%
Loss of use of both hands or both feet	100%
Loss of use of one arm or one leg	75%
Loss of use of one hand or one foot	75%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. We will not pay more than 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay a maximum of 200%.

Loss of an arm means that it was severed at or above the elbow. Loss of a hand means that it was severed at or above the wrist. Loss of a leg means that it was severed at or above the knee. Loss of a foot means that it was severed at or above the ankle. Loss of a thumb, finger or toe means that it was severed at or above the first joint from the hand or foot. Loss of sight, speech or hearing must be total and permanent.

Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

Limit on benefit amounts

If more than one person covered by the group contract is eligible for benefits resulting from the same accident, Sun Life will pay up to a maximum of $3,000,000 for all claims related to the accident.

If the total amount of benefits payable for the accident is more than $3,000,000, then we will pay for each person a percentage of the $3,000,000 that is equal to the percentage the person would have received of the total payable.

Repatriation benefit

If you die as a direct result of an accident 100 kilometres or more from home, we will pay up to $10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.

Rehabilitation program

If you suffer a loss, other than a loss of life, we will pay up to $10,000 of your rehabilitation expenses. We will only pay for the usual and reasonable expenses connected with a rehabilitation program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the rehabilitation program and the expenses must be incurred within 3 years of the accident and while you are covered for this benefit. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the rehabilitation program will be based on the likelihood that it will be successful. The rehabilitation will be made up of training required, because of the loss, to prepare you for a new occupation.

Spouse occupational training benefit

If you die as a direct result of an accident, we will pay up to $5,000 to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the expenses and all expenses must be incurred within 3 years of the date of the accident. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the training program will be based on the likelihood that it will be successful.

Child education benefit

If you die as a direct result of an accident, we will pay for a dependent child's tuition fees in a post-secondary school. We will pay the child 5% of the amount of coverage up to $5,000, each year up to a maximum of 4 years. The child must enrol as a full-time student within one year of your death.

We will only pay for the usual and reasonable tuition expenses. This does not include ordinary living expenses such as room, board, travelling or clothing. This also does not include education expenses incurred prior to your death.

Family transportation benefit

If you suffer a loss as a direct result of an accident and are hospitalized at least 150 kilometres from home, we will pay up to $5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister.

We will only pay for the usual and reasonable travel expenses. We will pay for car travel at a rate of $0.20 per kilometre. Transportation must be by the most direct route to and from the hospital. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Coverage during total disability

If you become totally disabled while covered and premiums are no longer payable for Life coverage, your Accidental Death and Dismemberment coverage will continue without the payment of premiums for as long as premiums are not payable for your Life coverage, but not beyond age 65 or termination of the Accidental Death and Dismemberment benefit.

Your dependents' coverage will also continue without the payment of premiums until the earlier of the following dates:

- the date premiums are no longer waived for your Life coverage.
- the date you reach age 65.
- the date of termination of the Employee Accidental Death and Dismemberment benefit.

However, coverage for your spouse will not continue beyond the date the Spouse Optional Accidental Death and Dismemberment benefit is terminated or the date your spouse reaches age 65, and coverage for your children will not continue beyond the date the Child Optional Accidental Death and Dismemberment benefit is terminated.

Any amount of coverage continued is subject to the terms of this group plan when total disability began.

What is not covered

We will not pay for losses that are the result of:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.
- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- flying in, descending from or being exposed to any hazard related to an aircraft while

- receiving flying lessons.
- performing any duties in connection with the aircraft.
- being flown for a parachute jump.
- a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence.

Converting coverage

If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy. The amount of this Accidental Death benefit cannot be more than the amount of Life coverage you are converting.

This applies to your spouse's coverage as well, but this does not apply to your children's coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.

When and how to make a claim

For any loss other than death, the claim must be received by Sun Life within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

Commission Staff 1-42:

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.

Response:

The 2022 Benefits Guide (US) and 2022 Core Flex Benefit eGuide (Canada) detail the company's life insurance options. Employer and employee contribution rates are contained within the attached materials listed below. **Note:** For employees eligible for and enrolled in the Canadian Benefits Plan, the employer costs are limited to Flex Credits, which employees are allocated each year based on coverage level. Employees choose to spend these Employer provided credits on the options they choose at enrollment (Health, Dental, Vision, Life Insurance, Etc.). For 2022, the flex credit amounts (employer costs) are as follows: 1) Single Employee $2,160 (CAD); and 2) Employee & Spouse $3,650 (CAD); Employee + Family $5,460 (CAD).

Please see the following attachments for more information regarding life insurance policies:

- "PSC DR 1-40 – 2022 Benefits Guide"
- "PSC DR 1-41 – 2022 Core Flex Benefit eGuide"
- "PSC DR 1-41 – SunLife e-Booklet"
- "PSC DR 1-42 – Corix Dental Vision Rates Contributions – 2019 – 2022"
- "PSC DR 1-42 – Corix Medical Rates & Contributions – 2019 – 2022"
- "PSC DR 1-42 – Corix Life Disability Rates – 2019 – 2022"

Witness:

James Kilbane

Corix Infrastructure

2019-2022 Dental & Vision Premium Rates and EE/ER Contributions

		2019				2020				2021				2022			
		EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM
WSC/Corix Dental PPO	Premium Rate	$22.69	$46.95	$55.19	$85.49	$24.28	$50.24	$59.05	$91.47	$25.98	$53.76	$63.18	$97.87	$28.58	$59.14	$69.50	$107.66
	EE Contribution	$6.81	$14.09	$16.56	$25.65	$7.28	$15.07	$17.72	$27.44	$7.79	$16.14	$18.96	$29.36	$8.57	$17.76	$20.86	$32.30
	ER Contribution	$15.88	$32.86	$38.63	$59.84	$17.00	$35.17	$41.33	$64.03	$18.19	$37.62	$44.22	$68.51	$20.01	$41.38	$48.64	$75.36
WSC/Corix Vision Plan	Premium Rate	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53
	EE Contribution	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	ER Contribution	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53

Brown & Brown INSURANCE®

Corix Infrastructure

2019-2022 Life and Disability Rates

	2019	2020	2021	2022
Basic Life (per $1,000 of coverage)	$0.158	$0.158	$0.158	$0.169
AD&D (per $1,000 of coverage)	$0.035	$0.035	$0.035	$0.035
Long Term Disability (per $100 of covered payroll)	$0.369	$0.369	$0.369	$0.369
STD (ASO Only, PEPM)	$4.78	$4.78	$4.78	$4.78

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Corix Infrastructure

2019-2022 Medical Budget Rates and EE/ER Contributions

		2019				2020				2021				2022			
		EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM
Corix PPO Plan	Budget Rate	$706.89	$1,696.53	$1,427.91	$2,474.10	$694.89	$1,667.73	$1,403.67	$2,432.10	$723.19	$1,735.65	$1,460.84	$2,531.15	$781.25	$1,875.00	$1,578.13	$2,734.37
	EE Contribution	$132.49	$347.67	$292.62	$507.03	$138.72	$358.10	$301.40	$522.24	$144.37	$372.68	$313.67	$543.51	$155.96	$402.61	$338.86	$587.15
	ER Contribution	$574.40	$1,348.86	$1,135.29	$1,967.07	$556.17	$1,309.63	$1,102.27	$1,909.86	$578.82	$1,362.97	$1,147.17	$1,987.64	$625.29	$1,472.40	$1,239.27	$2,147.23
Corix HDHP	Budget Rate	$618.52	$1,484.45	$1,249.41	$2,164.84	$608.03	$1,459.27	$1,228.22	$2,128.12	$632.79	$1,518.70	$1,278.24	$2,214.79	$683.60	$1,640.63	$1,380.87	$2,392.61
	EE Contribution	$116.58	$304.21	$256.05	$443.65	$121.83	$313.34	$263.73	$456.96	$126.79	$326.10	$274.47	$475.57	$136.97	$352.28	$296.51	$513.75
	ER Contribution	$501.94	$1,180.24	$993.36	$1,721.19	$486.20	$1,145.93	$964.49	$1,671.16	$506.00	$1,192.60	$1,003.77	$1,739.22	$546.62	$1,288.35	$1,084.36	$1,878.86

Commission Staff 1-43:

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.

Response:

The utility offers retirement plans to all employees who meet the eligibility requirements of the plans, and eligibility is not limited to any one category of directors; managers; supervisors, or employees, whether exempt or non-exempt status. The plans are:

- Corix Group Registered Retirement Savings Plan (RRSP) for Canadian Employees
- Corix Affiliated Companies (US) 401(k) Plan (401k) for US Employees
- Corix Non-Qualified (Non-Q) Deferred Compensation Plan

Note on Non-Q Plan: The non-qualified deferred compensation plan is available to eligible employees that meet the IRS designation of a Highly Compensated Employee (HCE) by earning more than $135,000/year in the previous plan year. The Non-Q plan was established to allow the utility to make a non-elective retirement contribution (NEC) (3% of eligible wages) to those employees while meeting IRS contribution requirements, like the NEC made to the 401(k) plan for non-HCEs. These HCEs are not eligible to receive the 3% NEC contribution in the 401(k)-plan due to their HCE status. Employees can choose to defer a portion of their income to the plan, but the utility only contributes the NEC to the plan.

The employer contributions to the plans are as follows:

Corix Affiliated Companies (US) 401(k) Plan	
Employee Contribution %	Employer Matching Contribution %
0	0
1	1
2	2
3	3
4	3.5
5	4
Above 5%	4
In addition to the match, there is an Employer Non-Elective Contribution (NEC) of 3% regardless of employee participation/deferral election.	

Group Registered Retirement Savings Plan (CA)	
Employee Contribution %	Employer Matching Contribution %
0	0
1	1
2	2
3	3
4	4
5	5
Above 5%	5

Witness:

James Kilbane

Commission Staff 1-44:

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 base period and the base period. Explain any changes in fringe benefits occurring over this 24-month period.

Response:

a. The utility does not offer fringe benefits to an entire group of employees, managers, or other category of personnel. Only one employee within the allocation receives a negotiated vehicle allowance on an individual basis: Steve Lubertozzi, who receives $5,800 (USD) per annum.

While not a fringe benefit, for transparency and disclosure, Corporate Officers (members of the ELT) receive two additional types of cash compensation, as outlined in their employment agreements for use at their discretion. Those are Perquisite Pay and Supplemental Retirement:

- **Perquisite Pay:** $17,500 per annum to cover all other benefits and perquisites including, without limitation: car allowance, club memberships, executive health plans, RRSP contributions, financial counseling, fuel, mileage, parking, etc. Such amounts are payable over the course of the year in each pay period in equal amounts and shall be subject to any required deductions or withholdings. The employee shall be responsible for the full tax liability on this benefit, including the tax liability on the reimbursed expenses and fuel and parking expense, and for all other liabilities arising therefrom, including the use of any car. The foregoing is subject to

any reasonable restrictions, terms and conditions that Corix may set or amend from time to time.

- **Supplemental Retirement:** Corix shall provide an amount equal to 15% of the employee's annual base salary in lieu of a pension plan. Such amounts shall be payable over the course of the year in each pay period in equal amounts and shall be subject to any required deductions or withholdings. The employee shall be responsible for the full tax liability on this benefit. The foregoing is subject to reasonable restrictions, terms and conditions that Corix may amend from time to time.

b. No changes in fringe benefit offerings have occurred during the 24-month period in question.

Witness:

James Kilbane

Commission Staff 1-45:

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.

Response:

a. Please see exhibit 9.6 testimony of Quentin Watkins for a wage and benefits study, submitted confidentially with the application. See exhibit 9.1 testimony of Seth Whitney submitted with the application for a discussion of the consideration of wage and benefit study in forecast period for salaries and wages

b. WSCK performed comparisons and, therefore, this is not applicable.

Witness:

Quentin Watkins and Seth Whitney

Commission Staff 1-46:

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 base period and any adjustments to the base period, are compliant with the board of director's compensation policy.

Response:

a. The utility does not have a written policy regarding compensation. The utility's consistent compensation practice/philosophy, which is executed at the board of directors' direction, is to employ a P50 or market-midpoint-based compensation strategy.

b. To attract and retain top talent, Corix, and its subsidiaries and affiliates, including WSCK, must be competitive in the national, regional, and local markets. The company's total compensation structure for employees includes some or all the following: base pay; variable pay;

and benefits including health insurance, leave, retirement, and other compensation. To remain competitive in the employment market, Corix identifies and targets the market midpoint or median (as applicable for each position) for total compensation. Corix's variable pay programs include the Employee Incentive Plan (EIP) and the Long-Term Incentive Plan (LTIP). Directors, Vice Presidents, Presidents, and Senior Vice Presidents (collectively, "Senior Management Employees") are eligible for EIP. Members of the Executive Leadership Team ("ELT") are eligible for EIP and LTIP.

Senior Management Employees of a Business Unit are eligible to earn variable pay depending on a combination of Corix's performance, their Business Unit's performance, and their personal performance. Senior Management Employees and ELT who are part of the Corporate and Support Services functions do not have a Business Unit score. Employees are eligible to earn variable pay up to a set percentage of their base compensation. ELT employees are eligible to earn LTIP variable pay depending on Corix's performance, over a rolling three-year period. The LTIP averages the same Company Performance scores described above to determine a long-term score. This multi-year average score is multiplied by a target percentage of salary for the position.

Variable pay is a common component of compensation packages because it incentivizes good performance and ties a portion of compensation to an employee's ability to achieve positive results that benefit the company's stakeholders in the near and long-term, including its customers. Variable pay is part of most companies' compensation packages in the U.S.[1]

1https://worldatwork.org/media/CDN/resources/surveys/2021_Incentive%20Pay%20Practices-Privately%20Held.pdf

Specifically, long-term incentive plans such as that offered by Corix are an expected and necessary component of modern compensation plans.

c. The utility's compensation strategy was not developed by an outside consultant; the compensation strategy has been reviewed and applied by consultants performing executive compensation studies as directed by the board of directors.

For non-executive roles, the same compensation philosophy applies, but relies on research rather than consultant work. The utility purchases access to compensation survey data that various credible sources compile and analyze. These sources include but are not limited to: the American Water Works Association (AWWA), Mercer, Willis Towers Watson, PayScale, and the Economic Research Institute. These sources are used to match the utility's positions to the market equivalents and inform the appropriate Company midpoint to which they are aligned based on the utility's market-midpoint compensation philosophy.

d. The utility's compensation practices were last reviewed and/or given consideration in August 2021, when Mercer completed the utility's typical tri-annual review of executive compensation.

e. Yes, the salary, wages, benefits, and other compensation included in the base period are compliant with the board of directors' direction. Further, the board approves any annual performance-based merit process budgets, and any market-based adjustments outside of the merit process are consistent with the board's direction of a P50 or Market-Midpoint compensation philosophy.

Witness: James Kilbane.

Commission Staff 1-47:

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.

Response:

Please see response to response to PSC DR 1-45. Please also see "PSC DR 1-47 – Updated L48 Hiring Entry Point Guidance – 4.20.2022 CONFIDENTIAL," which is being filed with a Petition for Confidential Treatment, and "PSC DR 1-47 – On Call Practices" for results of an internal salary survey.

Witness:

James Kilbane

On Call Practices – US

How do organizations compensate employees that are not called into work during their scheduled on call period?

Data Segments	Flat rate per hour	Flat rate per day	Flat rate per week	% of base pay	Time off in lieu	No compensation
All Data	28% Median rate $2.50	10% Median rate $35.00	5% Median rate $125.00	8% Median rate 15%	3%	46%
Energy Sector	0	0	14%	7%	0	79%

How do organizations compensate employees that are called into work during their scheduled on call period?

Data Segments	Flat rate per hour	Flat rate per day	Flat rate per week	Flat fee per call	% of base	O/T rate	Time off in lieu	No compensation
All Data	9%	1%	2%	1%	16%	54%	3%	13%
Energy	0	0	7%	0	14%	71%	0	7%

When does on call compensation begin if an employee is called in?

Data Segment	From time of first contact	From the time travel starts	At time of arrival
All Data	29%	13%	58%
Energy	31%	31%	38%

What is the minimum amount of time an employee is compensated for when called in?

Data Segment	No minimum	1 hour	2 hours	3 hours	4 hours	More than 4 hours
All Data	25%	8%	33%	9%	23%	2%
Energy	31%	13%	25%	25%	6%	0%

Summary – to be competitive in the Energy sector in the US our on-call practices should include:

- Flat Weekly Rate of $125.00 per week
- When called in to work during on call period pay should be at OT rates
- For when pay starts – to be a head of the market – consider paying at time of call in
- Minimum call out hours to pay of 2 hours.

Commission Staff 1-48:

Provide the average number of customers on the utility's system (actual and projected), by rate schedule, for the base period and the three most recent calendar years.

Response:

Please see "Application Exhibit 29 Schedule A, Revenue Statistics."

Witness: James Kilbane

Commission Staff 1-49:

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.

Response:

All responsive exhibits and excel spreadsheets are being filed with the following file name prefix: "PSC DR 1-49," some of which are being filed in conjunction with a Petition for Confidential Treatment.

Witness:

James Kilbane

Commission Staff 1-50:

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.

Response:

All excel workpapers related to this case that are not included in response to PSC DR 1-49 are being filed with the following file name prefix: "PSC DR 1-50." Other workpapers are attached below.

Witness:

James Kilbane

Corix Infrastructure

2019-2022 Dental & Vision Premium Rates and EE/ER Contributions

		2019				2020				2021				2022			
		EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM	EE	EE+SP	EE+CH	FAM
WSC/Corix Dental PPO	Premium Rate	$22.69	$46.95	$55.19	$85.49	$24.28	$50.24	$59.05	$91.47	$25.98	$53.76	$63.18	$97.87	$28.58	$59.14	$69.50	$107.66
	EE Contribution	$6.81	$14.09	$16.56	$25.65	$7.28	$15.07	$17.72	$27.44	$7.79	$16.14	$18.96	$29.36	$8.57	$17.76	$20.86	$32.30
	ER Contribution	$15.88	$32.86	$38.63	$59.84	$17.00	$35.17	$41.33	$64.03	$18.19	$37.62	$44.22	$68.51	$20.01	$41.38	$48.64	$75.36
WSC/Corix Vision Plan	Premium Rate	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53
	EE Contribution	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	ER Contribution	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53	$7.04	$11.28	$11.49	$18.53

Brown & Brown INSURANCE®

FERN LAKE COMPANY

Revised P. S. C. Ky. No. 1

Cancels P. S. C. Ky. No.

FERN LAKE COMPANY

OF

MIDDLESBORO, KENTUCKY

Rates, Rules and Regulations for Furnishing

AT

CITY OF MIDDLESBORO, KENTUCKY

PUBLIC SERVICE COMMISSION
OF KENTUCKY
EFFECTIVE

JAN 01 1987

PURSUANT TO 807 KAR 5:011,
SECTION 9 (1)
BY: J. Leoghegan

Filed with PUBLIC SERVICE COMMISSION OF KENTUCKY

ISSUED DECEMBER 22, 19 86

EFFECTIVE JANUARY 1, 19 87

ISSUED BY FERN LAKE COMPANY
(Name of Utility)

BY Arthur E. Abshire
ARTHUR E. ABSHIRE
PRESIDENT

FOR Middlesboro, Kentucky

PSC KY NO. _____

_____ SHEET NO. _____

FERN LAKE COMPANY

(NAME OF UTILITY)

CANCELLING PSC KY NO. _____

_____ SHEET NO. _____

CLASSIFICATION OF SERVICE

The sole customer of Fern Lake Company is Water Service Corporation of Kentucky, Inc., a Public Utility, who supplies water to customers at Middlesboro, Kentucky.

(1) Rates: Monthly

First 41,667,000 Gallons (Minimum Bill)		$10,267.00	(I)
Additional 1,000 Gallons	Rate Per 1,000 Gallons	$0.26	(I)

DATE OF ISSUE 12-19-13
MONTH / DATE / YEAR

DATE EFFECTIVE 12/12/13
MONTH / DATE / YEAR

ISSUED BY _____
SIGNATURE OF OFFICER

TITLE President

BY AUTHORITY OF ORDER OF THE PUBLIC SERVICE COMMISSION
IN CASE NO. 2013-00172 DATED 12/12/13

KENTUCKY
PUBLIC SERVICE COMMISSION
JEFF R. DEROUEN
EXECUTIVE DIRECTOR
TARIFF BRANCH
Brent Kirtley
EFFECTIVE
12/12/2013
PURSUANT TO 807 KAR 5:011 SECTION 9 (1)

COMMONWEALTH OF KENTUCKY
PUBLIC SERVICE COMMISSION
730 SCHENKEL LANE
POST OFFICE BOX 615
FRANKFORT, KY. 40602
(502) 564-3940

June 17, 1992

Mr. Arthur E. Abshire
Fern Lake Company
200 Bolivar Street
P. O. Box 233
Lexington, Kentucky 40501

Dear Mr. Abshire:

On June 2, 1992, the Commission received from Fern Lake Company ("Fern Lake"), a letter concerning the need to file a new tariff. Specifically, Fern Lake raises the question of having to file a tariff listing the utilities procedure for monitoring customer usage as required in the newest regulations sent to each utility. Considering the unique circumstances surrounding Fern Lake's wholesale water supply service, the explanation provided in its letter dated May 29, 1992 is sufficient. The letter will be placed with Fern Lake's tariff on file with the Commission. No additional information is required at this time.

If you have any questions, please contact Phyllis Bruning at (502) 564-3584.

Sincerely,

Claude G. Rhorer, Jr.
Acting Executive Director

fb

cc: George Sallee

Railroad Management Company, LLC
Vanessa Walsh
Director -Portfolio Management

October 3, 2017

Steven Vaughn
c/o WATER SERVICE CORP OF KY
PO BOX 818
MIDDLESBORO, KY 40965

RE:

License #	Audit #
NS141237	RHN4001-035
NS141239	RHN4001-033
NS141242	RHN4001-004
NS141244	RHN4001-031
NS141245	RHN4001-024
NS141247	RHN4001-043
NS141250	RHN4001-029
NS141251	RHN4001-006
NS141252	RHN4001-012
NS141254	RHN4001-014
NS141255	RHN4001-001
NS141263	RHN4001-026
NS141267	RHN4001-022
NS141268	RHN4001-041
NS141277	RHN4001-037
NS141278	RHN4001-020
NS141281	RHN4001-016
NS141282	RHN4001-010
NS141296	RHN4001-039

Dear Steven Vaughn

Let this letter agreement serve as confirmation that the countersigned parties, Railroad Management Company IV LLC ("RMC") and Kentucky Water Service Company ("KWS"), have reached an agreement with regard to the annual license fee amounts ("License Fee") as per Exhibit "A."

In lieu of the 2017 originally billed invoices, RMC will accept the discounted amounts described in Exhibit A column "Year 1" ($4,528.33). It is understood that KWS has already paid $5,335.00 for the 2017 year and RMC will credit the amount of $806.67 towards 2018 invoices. KWS shall pay the amounts described in Exhibit A for "Year 2" during 2018 and "Year 3" during 2019. Thereafter the License Fee shall be increased by the Consumer Price Index or a minimum of 3.00%.

All other terms in the original agreements shall remain in full force and effect. Both parties hereto certify they are duly authorized to execute this agreement and agree to keep the terms of this letter agreement strictly confidential.

Agreed and Accepted,

Railroad Management Company IV LLC
By: ~~Howard L Armistead III~~ Cary Newman
Title: Manager
Date: 10/12/17

Agreed and Accepted,

Kentucky Water Service Company
By: Justin Kersey
Title: VP Operations
Date: 10/3/2017

5910 North Central Expressway
Suite 1580
Dallas, Texas 75206
phone 214 750 8028
facsimile 214 750 6844

Railroad Management Company, LLC
Vanessa Walsh
Director -Portfolio Management

EXHIBIT A

No.	Name	Audit No.	Folder No.	DueDate	Year 1	Paid to date	Diff	Year 2	Year 3	Location City	Location County	Location State
NS141245	KENTUCKY WATER SERVICE CO	RHN4001-024	24221	1/10/2017	$ 400.00	$ -	$ (400.00)	$ 824.00	$ 1,273.08	MIDDLESBORO	BELL	KY
NS141252	KENTUCKY WATER SERVICE CO	RHN4001-012	24151	11/1/2017	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141254	KENTUCKY WATER SERVICE CO	RHN4001-014	24165	11/21/2017	$ 258.33	$ -	$ (258.33)	$ 532.17	$ 822.20	MIDDLESBORO	BELL	KY
NS141263	KENTUCKY WATER SERVICE CO	RHN4001-026	24234	1/15/2017	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141267	KENTUCKY WATER SERVICE CO	RHN4001-022	24207	12/22/2016	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	ARBOR	BELL	KY
NS141268	KENTUCKY WATER SERVICE CO	RHN4001-041	24330	1/13/2017	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141277	KENTUCKY WATER SERVICE CO	RHN4001-037	24302	9/2/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	ARBOR	BELL	KY
NS141278	KENTUCKY WATER SERVICE CO	RHN4001-020	24193	12/14/2016	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141281	KENTUCKY WATER SERVICE CO	RHN4001-016	24179	12/5/2016	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141296	KENTUCKY WATER SERVICE CO	RHN4001-039	24315	11/1/2017	$ 215.00	$ -	$ (215.00)	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141237	KENTUCKY WATER SERVICE COMPANY	RHN4001-035	24288	8/1/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	MIDDLESBORO	BELL	KY
NS141239	KENTUCKY WATER SERVICE COMPANY	RHN4001-033	24275	7/22/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	FERN LAKE	BELL	KY
NS141242	KENTUCKY WATER SERVICE COMPANY	RHN4001-004	24109	4/1/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	ARBOR	BELL	KY
NS141244	KENTUCKY WATER SERVICE COMPANY	RHN4001-031	24260	7/20/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	STONY FORK JUNCTION	BELL	KY
NS141247	KENTUCKY WATER SERVICE COMPANY	RHN4001-043	24343	7/1/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	ARBOR	BELL	KY
NS141250	KENTUCKY WATER SERVICE COMPANY	RHN4001-029	24247	8/1/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	ARBOR	BELL	KY
NS141251	KENTUCKY WATER SERVICE COMPANY	RHN4001-006	24123	5/28/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	STONY FORK JUNCTION	BELL	KY
NS141255	KENTUCKY WATER SERVICE COMPANY	RHN4001-001	24095	4/18/2017	$ 215.00	$ 485.00	$ 270.00	$ 365.00	$ 515.00	STONY FORK JUNCTION	BELL	KY
NS141282	KENTUCKY WATER SERVICE COMPANY	RHN4001-010	24137	3/1/2017	$ 430.00	$ 970.00	$ 540.00	$ 730.00	$ 1,030.00	BELT JUNCTION	BELL	KY
					$ 4,528.33	$5,335.00	$ 806.67	$7,926.17	$11,365.28			

5910 North Central Expressway
Suite 1580
Dallas, Texas 75206
phone 214 750 8028
facsimile 214 750 6844